

**Post-Hearing Brief In Support of Group Hospitalization and Medical Services, Inc.'s  
Position Regarding the Commissioner's "Surplus" Review**

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**TABLE OF CONTENTS**

	<u>Page</u>
INTRODUCTION AND OVERVIEW .....	1
I. THE MIEAA PERMITS A FINDING OF EXCESSIVENESS ONLY IF GHMSI’S RESERVES ARE BOTH “UNREASONABLY LARGE” AND INCONSISTENT WITH ITS STATUTORY COMMUNITY HEALTH REINVESTMENT OBLIGATION .....	4
A. The Statute’s Plain Terms Require That Both Criteria Be Met .....	4
B. The Contrary Arguments Of Appleseed And Its Counsel Should Be Rejected .....	5
1. The MIEAA Cannot Be Collapsed Into One Prong.....	5
2. The Statute Does Not Require (Or Allow) The DISB To Divest GHMSI Of Any Reserves Above The Very Bottom Of The Reasonable Range .....	6
3. Then-Commissioner Hampton’s Preliminary “Adequate Surplus Determination” Was Not An “Excessiveness” Finding .....	7
II. GHMSI’S RESERVES ARE NOT “UNREASONABLY LARGE” .....	8
A. GHMSI’s Reserves Are Well Within The Target Ranges Arrived At Independently By Milliman, Lewin, and Invotex .....	8
B. The Actuarial Consensus Demonstrates That GHMSI’s Reserves Are Not Unreasonably Large.....	9
C. The RBC Range Proposed By ARM Is Unreasonably Low .....	9
III. GHMSI’S LEVEL OF COMMUNITY HEALTH REINVESTMENT IS ROBUST AND MEETS THE STATUTORY STANDARD .....	11
A. GHMSI Engages In Extensive “Community Health Reinvestment” .....	11
B. GHMSI’s Community Health Reinvestment Meets The Statutory Requirement.....	12

C.	Appleseed’s Contrary Arguments Are Unavailing .....	14
IV.	ADDITIONAL ARGUMENTS PRESENTED BY APPLESEED AND ARM ARE WITHOUT BASIS.....	15
A.	Appleseed And Its Economist Misconstrue The Koken Report .....	15
B.	Appleseed’s Comparisons Between GHMSI And Other Insurers Are Flawed.....	17
V.	IF EXCESS IS FOUND, RESIDENCY IS THE APPROPRIATE METRIC FOR CALCULATING RESERVES “ATTRIBUTABLE TO THE DISTRICT” .....	18
A.	The Residency Approach Is The Appropriate Attribution Method .....	19
B.	Once GHMSI’s Reserves Are “Attributed,” The Commissioner Would Have To Recalculate The Appropriate RBC From Scratch.....	22
VI.	CONCLUSION.....	23

## INTRODUCTION AND OVERVIEW

Group Hospitalization and Medical Services, Inc. (“GHMSI”) respectfully submits this post-hearing brief to address issues arising from the September 10-11 hearing (“Hearing”) before the Commissioner of the D.C. Department of Insurance, Securities and Banking (“DISB”).

The evidence presented at the Hearing demonstrates that GHMSI’s reserves are not “excessive” under the Medical Insurance Empowerment Amendment Act (“MIEAA”). Below, GHMSI highlights key evidence, explains the legal framework guiding the inquiry, and summarizes supplemental submissions by Milliman, Inc. and the Lewin Group that further illustrate why GHMSI’s reserves are not excessive. We begin with an overview of our primary points.

**First**, the MIEAA creates a two-step inquiry for evaluating whether reserves are “excessive.” As the Commissioner and panelists observed,<sup>1</sup> GHMSI’s reserves may be deemed excessive after a hearing only if the Commissioner determines that they are both (i) “unreasonably large and (ii) inconsistent with the corporation’s [community health reinvestment] obligation.” D.C. Code § 31-3506 (emphasis added). Both prongs must be satisfied. The efforts of some witnesses to collapse the inquiry into one step must be rejected as improper statutory construction.

**Second**, GHMSI’s reserves – 845 percent RBC at the end of 2008 and an expected 825 percent by year-end 2009 – are not “unreasonably large.” The reserves fall (and have long fallen) within the lower half of the target RBC range set by Milliman, the highly-regarded actuarial consulting firm retained by the Company to help it set appropriate reserve goals. They fall within the lower half of GHMSI’s target range (750-1000 percent) as determined by the Lewin Group. They fall within the lower half of the range that other insurance regulators have deemed appropriate for insurers of GHMSI’s size. And notably, they fall squarely in the middle of the target range (700-950 percent) as determined by Maryland’s independent consultant. It is difficult to imagine how GHMSI’s reserves could be deemed “unreasonably large” when multiple independent actuaries – including the one hired by the Maryland Insurance Commissioner – agree that they fall within the reasonable range.

At the Hearing, several witnesses implied that the precipitous rise in health insurance premiums over the last few years is evidence that GHMSI’s reserves are too large; the suggestion seems to be that GHMSI could solve the problem of rising costs by setting aside less money to pay future claims. But the evidence demonstrates that these assertions are incorrect. Premium rate increases are driven not by GHMSI profit-taking, but instead by the spiraling cost of regional (and national) medical care itself – which in turn is driven by increased use of services

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<sup>1</sup> See, e.g., Sept. 10, 2009 Hearing Tr. 6:22-7:7, 317:1-4, 319:22-320:2, 320:21-321:3, 355:11-18.

and the growing load placed on the system by chronic conditions such as obesity and diabetes.<sup>2</sup> These rising costs constitute a “severe and worsening crisis” for our region and nation,<sup>3</sup> but they are not one of GHMSI’s making. Indeed, far from exacerbating the problem, GHMSI has gone to great lengths to combat it: The Company has carefully moderated rate increases to cushion its subscribers against spiraling healthcare costs, and has been operating on razor-thin margins with the goal of making healthcare as affordable as possible for its subscribers. Last year, GHMSI’s underwriting gain (the difference between premiums earned and claims and expenses) was 0.3 percent. This year, it is expected to be 0.5 percent. These figures are much lower than the margins of GHMSI’s for-profit competitors, which generally hover in the 6 to 10 percent range.<sup>4</sup> These data expose as mistaken the suggestion that GHMSI could somehow stop the rise in health insurance costs if only it would reduce its reserves. GHMSI is not the problem; it has been trying hard to be part of the solution.

**Third**, GHMSI already maximizes its “community health reinvestment,” as required by statute. GHMSI values its role as a contributing member of the community and is actively engaged in extensive community health reinvestment. Last year, the Company spent approximately 3.3 percent of its District-based premium revenue – \$14 million – on premium taxes, community giving, and subsidies on open enrollment products.<sup>5</sup> This is a multiple of GHMSI’s anticipated underwriting margin for 2009; in other words, GHMSI gives much more to the community than it makes in “profits” from its sale of insurance policies. GHMSI’s community health reinvestment is more than double the percentages cited as worthy benchmarks in Appleseed’s written testimony<sup>6</sup> and vastly exceeds the contributions made by other comparable health insurers. As Barbara Lang, president and chief executive officer of the District of Columbia Chamber of Commerce, testified, GHMSI is already “one of the largest financial givers in the city.”<sup>7</sup> And as noted at the Hearing, GHMSI’s contributions are expected to jump to at least 5.5 percent of premium revenue in light of the public-private partnership legislation currently pending before the District Council.<sup>8</sup> These unprecedented levels of giving are more than sufficient to meet the MIEAA’s requirements.

Moreover, it should be emphasized that “community health reinvestment” does not equate only to charitable giving, as Appleseed has at times suggested. Instead, the MIEAA recognizes that GHMSI’s effort to moderate premium levels, and otherwise make wise

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<sup>2</sup> Sept. 11, 2009 Hearing Tr. 29:21-32:7, 50:15-55:8.

<sup>3</sup> Id. 29:21-30:1.

<sup>4</sup> GHMSI Pre-Hearing Report at 9, 18.

<sup>5</sup> Burrell Written Testimony at 8.

<sup>6</sup> Appleseed Written Testimony at 3.

<sup>7</sup> Sept. 10, 2009 Hearing Tr. 397:4-5.

<sup>8</sup> Id. at 38:21-41:3.

investments that keep expenses down, are also important goals that GHMSI must have the flexibility to meet. See D.C. Code § 31-3501(1A) (defining “community health reinvestment” to include expenditures that “benefit current or future subscribers, including premium rate reductions”). That is precisely what GHMSI has done by investing in its infrastructure, using investment earnings to moderate the need for premium increases, and keeping its premium rates barely above the break-even point.

**Fourth**, the contrary arguments of Appleseed and its supporters are without basis in the record. As Milliman and Lewin explain (see Tabs 3 & 4 of GHMSI Rebuttal Report), the analysis conducted by Actuarial Risk Management (“ARM”) is fatally flawed. ARM reached its recommended RBC range by making “corrections” to Milliman’s analysis, but those corrections were unwarranted; ARM simply misunderstood Milliman’s report and the assumptions Milliman used. Moreover, while Appleseed and its supporters rely heavily on the 2005 report produced by then-Pennsylvania Insurance Commissioner M. Diane Koken (“Koken Report”), they ignore the fact that GHMSI’s reserves occupy the bottom half of the 750-950 percent RBC range prescribed by the Koken Report for an insurer of GHMSI’s size.<sup>9</sup>

The regulatory landscape thus does not support Appleseed’s position. And if ARM’s extraordinarily low RBC range were adopted by the DISB, the consequences could be severe both for GHMSI’s subscribers and the community. GHMSI’s reserves would end up well below the RBC figures for GHMSI’s three largest competitors in the National Capital Area<sup>10</sup> and well below the bottom of the ranges prescribed for the Pennsylvania Blue Plans.<sup>11</sup> A slight drop in the financial markets or a slight upturn in claims – neither of which is difficult to imagine at present, as the region grapples with a devastating economic downturn and the spread of the H1N1 (“swine”) flu – could easily send reserves below the 375 percent threshold set by the Blue Cross and Blue Shield Association (“BCBSA”), triggering stringent oversight.

In the final analysis, the record evidence demonstrates that GHMSI’s reserves are not unreasonably large and that the company maximizes its community health reinvestment consistent with financial soundness and efficiency. The Commissioner should find that GHMSI’s reserves are not “excessive” under the terms of the MIEAA.

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<sup>9</sup> In re: Application of Capital BlueCross et al. for Approval of Reserves and Surplus, Misc. Dkt. No. MS05-02-006, Ins. Dept. of the Commonwealth of Pennsylvania, Feb. 9, 2005, at 37, available at [http://www.ins.state.pa.us/ins/lib/ins/whats\\_new/2004bc/BCBS\\_DETERMINATION.PDF](http://www.ins.state.pa.us/ins/lib/ins/whats_new/2004bc/BCBS_DETERMINATION.PDF). ARM also ignores the fact that the only other jurisdiction to set upper-level RBC targets – Michigan – chose an upper boundary of 1000 percent, very similar to the top of Milliman’s target range.

<sup>10</sup> Appleseed Pre-hearing Report, Ex. C at 8.

<sup>11</sup> Koken Report at 37.

**I. THE MIEAA PERMITS A FINDING OF EXCESSIVENESS ONLY IF GHMSI'S RESERVES ARE BOTH "UNREASONABLY LARGE" AND INCONSISTENT WITH ITS STATUTORY COMMUNITY HEALTH REINVESTMENT OBLIGATION.**

**A. The Statute's Plain Terms Require That Both Criteria Be Met.**

The purpose of this proceeding is to determine whether GHMSI's reserves are "excessive" under the MIEAA. The MIEAA defines the term "excessive" to encapsulate several conjunctive findings. Specifically, under the statute, the Commissioner cannot find GHMSI's reserves to be "excessive" unless: (i) she finds that the reserves are "greater than the appropriate risk-based capital requirements"; (ii) after a hearing, she finds that the reserves are "unreasonably large"; **and** (iii) after a hearing, she determines that the reserves are "inconsistent with the corporation's obligation" to engage in statutorily-defined community health reinvestment. D.C. Code § 31-3506(e).

The first part of this tripartite standard – "greater than the appropriate risk-based capital requirements" – was interpreted by the DISB as a very low threshold: the DISB found this prong satisfied on a showing that GHMSI has more than the bare minimum reserves necessary to avoid insolvency and regulatory intervention. *See infra* at 7-8.<sup>12</sup> Thus at the Hearing, two questions remained: Are GHMSI's reserves "unreasonably large"? And if they are, are they also "inconsistent with the corporation's obligation" to engage in statutorily-defined community health reinvestment? Only if the evidence demonstrates that the answers to both questions is "yes" could GHMSI's reserves be deemed excessive.

This understanding of the MIEAA is required by the statute's plain terms. *See Beaner v. United States*, 845 A.2d 525, 534 (D.C. 2004) ("In interpreting a statute, we first look to the plain meaning of its language, and if it is clear and unambiguous and will not produce an absurd result, we will look no further.") (quotation and citation omitted) After all, the MIEAA uses the conjunctive "and." *See* D.C. Code § 31-3506(e) ("surplus may be considered excessive only if . . . "the Commissioner determines that the surplus is unreasonably large and inconsistent with the corporation's obligation . . .") (emphasis added). And it is hornbook law that when "two requisites are joined by the conjunctive 'and', . . . both are necessary." *Orlans v. Orlans*, 238 F.2d 31, 32 (D.C. Cir. 1956). Indeed, no other construction of the MIEAA is possible, because any such construction would "read . . . language out of [the] statute," and "[a]n interpretation of the statute that nullifies some of its language is neither reasonable nor permissible." *Goba v. District of Columbia Dep't of Employment Servs.*, 960 A.2d 591, 594 & n.8 (D.C. 2008).

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<sup>12</sup> *See* 2009 Group Hospitalization And Medical Services Inc. Adequate Surplus Determination (July 23, 2009) ("Adequate Surplus Determination") (available on DISB Website).

In short, because both prongs must be satisfied, if the Commissioner finds that GHMSI's reserves are not "unreasonably large," the reserves cannot be considered excessive as a matter of law, regardless of whether they are "inconsistent with the corporation's [community health reinvestment] obligation." See Beaner, 845 A.2d at 534.

**B. The Contrary Arguments Of Appleseed And Its Counsel Should Be Rejected.**

1. The MIEAA Cannot Be Collapsed Into One Prong.

Despite the MIEAA's clear conjunctive language regarding what "excessive" means – requiring both "unreasonably large" reserves and reserves inconsistent with GHMSI's statutory "community health reinvestment" obligation – Appleseed has repeatedly suggested that only the latter finding is required, or that the latter finding somehow supersedes the former. According to the pre-Hearing submission by Appleseed's counsel, "[t]he purpose of the September 10 hearing is to determine whether GHMSI's surplus is inconsistent with the statutory obligation to engage in community health reinvestment to the maximum feasible extent consistent with financial soundness and efficiency."<sup>13</sup> And Appleseed maintains that "the surplus standard that governs these proceedings . . . requires GHMSI to show that it has committed the maximum feasible amount of its revenues to community health reinvestment, consistent with financial soundness and efficiency."<sup>14</sup> See also Sept. 10, 2009 Hr. Tr. 356:7-20 (Appleseed's counsel describes the "community health reinvestment" inquiry as "the overarching principle that really drives the whole analysis here.").

Appleseed's attempt to collapse the inquiry into one step must be rejected. Under Appleseed's view, as we understand it, reserves are "unreasonably large" by definition anytime a company is not engaging in community health reinvestment to the maximum feasible extent. See Sept. 10, 2009 Hr. Tr. 356:7-20. But that approach strips the "unreasonably large" prong out of the statute altogether by ensuring that anytime the second prong is met, the first prong is met as well. That is not permissible statutory interpretation. See Goba, 960 A.2d at 594 & n.8 ("Each provision of the statute should be given effect, so as not to read any language out of a statute.").

In fact, while the statute authorizes the Commissioner to analyze whether the Company is sufficiently reinvesting in the community, that inquiry is the second step in the process; it can neither precede nor override the Commissioner's analysis of the "unreasonably large" prong. Put another way, the Commissioner cannot make a finding of excess unless she also, first, determines that GHMSI's reserves are "unreasonably large." D.C. Code § 31-3506(e)(2). As Associate Commissioner Barlow correctly observed during the Hearing: "[I]f [GHMSI's

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<sup>13</sup> Appleseed Pre-hearing Report, Ex. A at 2.

<sup>14</sup> Appleseed Pre-hearing Report at 8.

reserves are] not unreasonably large, then the second criteria ceases to exist as an issue.” Sept. 10, 2009 Hearing Tr. 319:22-320:2.<sup>15</sup>

2. The Statute Does Not Require (Or Allow) The DISB To Divest GHMSI Of Any Reserves Above The Very Bottom Of The Reasonable Range.

Appleseed’s counsel also makes a related argument: It asserts that while there may be a reasonable range for GHMSI’s reserves, the MIEAA’s “maximum feasible” community health reinvestment language requires the DISB to divest GHMSI of any reserves above the very bottom of that range.<sup>16</sup> Under this view, even if the DISB agreed that GHMSI’s target reserve range is 750-1050 percent RBC, and even if GHMSI’s reserves fell in the bottom half of that range (which they do), GHMSI would still need to draw down its reserves until they sat at exactly 750 percent.

As an initial matter, this argument altogether ignores the realities of the insurance industry: Reserves swing up and down as claims are incurred, as expenses (both planned and unforeseen) arise, and as investment markets fluctuate.<sup>17</sup> As a result, it is impossible to keep reserves at a precise number. That is why all of the actuarial experts involved in this matter, as well as the Pennsylvania commissioner before them, have developed ranges within which reserves should fall. But in any event, the argument repeats the fallacy, discussed above, of collapsing the MIEAA into one step. The statute does not permit an “excessiveness” finding – and thus does not authorize the DISB to require any draw-down of GHMSI’s reserves – unless the reserves are both “unreasonably large” and inconsistent with the community health reinvestment obligation. Under the scenario posited by Appleseed’s counsel, the reserves would not be unreasonably large, because they would fall within the reasonable range. The question whether they are “inconsistent with the corporation’s [community health reinvestment] obligation,” D.C. Code § 31-3506, therefore would never arise.<sup>18</sup>

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<sup>15</sup> Appleseed’s misunderstanding of the statutory test explains some of its misplaced rhetorical attacks on GHMSI. For example, in its Pre-hearing report, Appleseed expressed its “surpris[e]” at GHMSI’s “complete failure” to “acknowledge – much less apply – the surplus standard that governs these proceedings.” Appleseed Pre-hearing Report at 8. And Appleseed’s counsel called GHMSI’s July 31 preliminary report “astonishing” because it did not focus exclusively on community health reinvestment. Id., Ex. A at 5. But the community health reinvestment inquiry is only part of the analysis here, and the second part at that. The filings Appleseed criticized squarely address the first question under the MIEAA: whether reserves are “unreasonably large.” (And indeed, then-Commissioner Hampton expressly authorized GHMSI to focus on the Milliman analysis in GHMSI’s July 31 report and to address other aspects of the statutory scheme in the comprehensive August 31 filing.)

<sup>16</sup> Appleseed Pre-hearing Report, Ex. A at 9.

<sup>17</sup> See, e.g., GHMSI Rebuttal Report Tab 4 (Lewin post-hearing analysis) at 20.

<sup>18</sup> Appleseed’s counsel cited two cases to support its argument. See Appleseed Pre-hearing Report, Ex. A at 9. Neither is remotely on point. ICC v. Inland Waterways Corp., 319 U.S. 671 (1943), involved interpretation of an unrelated federal statute (the Interstate Commerce Act) with its own particular

3. Then-Commissioner Hampton’s Preliminary “Adequate Surplus Determination” Was Not An “Excessiveness” Finding.

Finally, Appleseed’s counsel asserts that “the Commissioner [of the DISB] recently determined that GHMSI’s surplus is unreasonably excessive.”<sup>19</sup> That is not so; indeed, the assertion betrays a misunderstanding of the statutory scheme.

As discussed above, the MIEAA requires three conjunctive findings before reserves may be deemed excessive. Needless to say, the Commissioner cannot possibly have “determined that GHMSI’s surplus is unreasonably excessive”<sup>20</sup> before making findings with respect to the second and third prongs of the test.

In claiming that the Commissioner had already reached an “excessiveness” finding, Appleseed’s counsel appears to be referring to the July 2009 Adequate Surplus Determination, in which the DISB found that GHMSI’s reserves meet the first of the three conjunctive criteria under the MIEAA – “greater than the appropriate risk-based capital requirements.”<sup>21</sup> But as discussed above, the DISB interpreted this requirement to mean merely that reserves exceed the minimum RBC levels required by District law (200 percent) and the BCBSA’s monitoring requirements (375 percent). Because GHMSI’s reserves of course exceed those minimum thresholds – as all insurers’ reserves should – the DISB determined that the first criterion was satisfied.<sup>22</sup> However, the DISB was explicit that its Order did not mean GHMSI’s reserves were unreasonably large:

[T]he Commissioner has determined that the surplus as of December 31, 2008, is “greater than appropriate risk-based capital requirements,” as that phrase is defined in Emergency Rule 4601.4. It should be noted that use of the term “appropriate” in this and the preceding section is not meant to suggest that the statutory and BCBSA minimum RBC levels cited above should be deemed advisable for GHMSI or that they are adequate or sufficient to meet GHMSI’s insurance and other needs.<sup>23</sup>

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statutory language; that language drove the Court’s analysis. Alabama Electric Co-op., Inc. v. F.E.R.C., 684 F.2d 20 (D.C. Cir. 1982), addressed the requirements of the Federal Power Act. The fact that there are various alternative tests for determining whether rates violate the Interstate Commerce Act and the Federal Power Act says absolutely nothing about the plain statutory requirements of the MIEAA.

<sup>19</sup> Appleseed Pre-hearing Report, Ex. A at 8.

<sup>20</sup> Id.

<sup>21</sup> D.C. Code § 31-3506(e)(1). See Adequate Surplus Determination (available on DISB Website).

<sup>22</sup> Adequate Surplus Determination at 3. See also Koken Report at 20-21 (explaining that the 200 percent threshold is a level to avoid, not a target to strive for).

<sup>23</sup> Id.

And the DISB further clarified that its determination did not constitute a finding of excessiveness: It wrote that the September 10-11 Hearing, instead, would be the hearing contemplated by the MIEAA in which “to determine whether the company surplus as of December 31, 2008, attributable to the District of Columbia is excessive.”<sup>24</sup> It is therefore incorrect to suggest that the DISB has somehow already classified GHMSI’s reserves as excessive.

## **II. GHMSI’S RESERVES ARE NOT UNREASONABLY LARGE.**

Perhaps the most important facts before the Commissioner are these: GHMSI’s reserves fall within the target range as determined by Milliman, within the target range as determined by Lewin, and – last but certainly not least – within the target range as determined by Invotex, the independent actuary hired by Maryland to review GHMSI’s reserve levels. Reserves falling within a range deemed reasonable by multiple leading actuaries cannot, as a matter of law, be unreasonably large. They accordingly are not “excessive” under the MIEAA and the Commissioner’s inquiry need not reach any other issues.

### **A. GHMSI’s Reserves Are Well Within The Target Ranges Arrived At Independently By Milliman, Lewin, and Invotex.**

GHMSI held reserves of 845 percent RBC at the end of 2008, and the Company estimates that that figure will stand at 825 percent at year-end 2009. The Company’s reserves thus fall in the bottom third of the target range as determined by Milliman.<sup>25</sup> Indeed, as discussed in GHMSI’s previous filings, the Company’s reserves have been within that target range for at least the last 10 consecutive years.<sup>26</sup>

Moreover, Lewin has now conducted a separate review of GHMSI’s reserve levels, using a different analytical approach.<sup>27</sup> And that review has produced very similar conclusions to those reached by Milliman: Lewin’s model derived a target range for GHMSI’s reserves of 750 to 1000 percent RBC.<sup>28</sup> GHMSI’s reserves fall within the lower half of that range as well.

Finally, GHMSI has been informed that Invotex’s report, due to be released in the coming days, will derive a target reserve range for GHMSI of 700 to 950 percent RBC. Thus GHMSI’s reserves also fall right in the middle of the target range as determined by the actuary the Maryland Insurance Administration hired to examine the issue.

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<sup>24</sup> Id.

<sup>25</sup> See CareFirst Pre-hearing Report at 8.

<sup>26</sup> See, e.g., id. at 7.

<sup>27</sup> See GHMSI Rebuttal Report Tab 4 (Lewin post-hearing analysis).

<sup>28</sup> See id. at 2.

**B. The Actuarial Consensus Demonstrates That GHMSI’s Reserves Are Not Unreasonably Large.**

In short, GHMSI’s reserves fall comfortably within the target range as determined by every independent actuarial review conducted in this matter.<sup>29</sup> It follows that GHMSI’s reserves are not “unreasonably large” (and thus that they are not “excessive”).

As discussed above, the first step in interpreting a statute is to determine the plain meaning of its language. Beaner, 845 A.2d at 534. “In determining the plain meaning, ‘the words of [the] statute should be construed according to their ordinary sense and with the meaning commonly attributed to them.’” Tippett v. Daly, 964 A.2d 606, 610 (D.C. 2009) (quoting 1618 Twenty-First Street Tenants’ Ass’n v. Phillips Collection, 829 A.2d 201, 203 (D.C. 2003)). The D.C. Court of Appeals has specifically endorsed the use of dictionaries in this exercise, id., and dictionaries define the term “unreasonable” to mean “[n]ot guided by reason; irrational or capricious” or “absurd.”<sup>30</sup> Holding a level of reserves within the range defined as proper by multiple independent actuaries can hardly be deemed irrational or absurd.

**C. The RBC Range Proposed By ARM Is Unreasonably Low.**

ARM, of course, reached a different result: It concluded that GHMSI should hold reserves in a range from 400 to 525 percent RBC.<sup>31</sup> But the weight of the record evidence demonstrates that that range is both unreliable and unreasonably low.

As an initial matter, the low end of the range – where, according to Appleseed, GHMSI’s reserves should be maintained<sup>32</sup> – is a mere 25 percentage points above the warning level that triggers stringent BCBSA oversight. This is a critical threshold. As Lewin explains, such BCBSA oversight would signal to the market that “GHMSI is under financial duress and would likely result in a loss of customer confidence and a subsequent loss of business.”<sup>33</sup> And as recent experience demonstrates, reserves can easily fluctuate by scores or even hundreds of points in a given year.<sup>34</sup> Nothing more than common sense is required to reject the notion that reserve levels should be set so close to regulatory minima.

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<sup>29</sup> ARM, of course, derived a much lower RBC range. But it did not conduct an independent review; it instead worked off of Milliman’s results and merely adjusted some of Milliman’s assumptions. In any event, the ARM report was deeply flawed for reasons discussed infra at 10-11.

<sup>30</sup> See, e.g., Black’s Law Dictionary 1537 (7th ed.); Webster’s Third New International Dictionary 2507 (1986).

<sup>31</sup> Appleseed Pre-hearing Report, Ex. B at 5.

<sup>32</sup> Appleseed Pre-hearing Report at 11.

<sup>33</sup> See GHMSI Rebuttal Report Tab 4 (Lewin post-hearing analysis) at 2.

<sup>34</sup> See id. at 20 (noting that other plans’ RBCs have fluctuated as much as 400 points in a two-year period).

But there are many additional reasons to reject the ARM range as unreasonable. First, it is much lower than the ranges derived by every actuary that did what ARM did not: namely, conduct a full independent review of GHMSI's reserve needs. Second, the entire ARM range – low and high end – is well below the RBC ratio that Commissioner Koken identifies as “the median surplus operating ratio for all insurers.”<sup>35</sup> Third, it is well below the RBC figures for GHMSI's three largest competitors in the National Capital Area.<sup>36</sup> Fourth, it is much lower than the ranges prescribed by Commissioner Koken for Pennsylvania Blue Plans with similar profiles.<sup>37</sup> Fifth, the bottom of Appleseed's range is only half the RBC ratio identified by the BCBSA as giving rise to a “presumption . . . that [a] Plan is sufficiently strong to meet its obligation[s] to its insureds well into the future.”<sup>38</sup> In short, every available benchmark in the record demonstrates that the ARM range is much too low.

Finally, it is now clear that ARM's findings were based largely on its misunderstandings regarding Milliman's work. Milliman addressed these misunderstandings at the Hearing,<sup>39</sup> and it has done so in more detail in its attached Response (see Tab 3 of GHMSI Rebuttal Report). We will not recount that Response in detail. But it is worth noting the following crucial points: First, ARM “corrected” for what it believed was Milliman's failure to account for GHMSI's low-risk FEP business,<sup>40</sup> but that “correction” itself was an error. In fact, Milliman's “model includes a separate component for the FEP business,” and “[t]he projected gains from FEP business are used to directly offset the losses that are modeled for the non-FEP business.”<sup>41</sup> Second, ARM used a much smaller premium growth rate than Milliman (7-8 percent instead of 12-14 percent), contending that the smaller number was “[c]onsistent with GHMSI's actual experience from 2003-2008.”<sup>42</sup> But Milliman demonstrates in its Response that the historical data support the growth rate selected by Milliman, rather than ARM's revised figure; indeed, it is not even clear how ARM arrived at the figure it has chosen to use.<sup>43</sup> Finally, ARM asserted that Milliman failed to account, in its loss modeling, for the fact that GHMSI already includes a “risk and

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<sup>35</sup> Koken Report at 36 (identifying 600 percent as the 2006 median). The Report noted that that figure includes for-profit insurers, which may have lesser reserve needs. Id.

<sup>36</sup> Appleseed Pre-hearing Report, Ex. C at 8.

<sup>37</sup> Koken Report at 37 (prescribing a range of 750-950 percent).

<sup>38</sup> Koken Report at 22.

<sup>39</sup> See Sept. 10, 2009 Hearing Tr. 70:5-75:11 (refuting the various misunderstandings and observing that “uninformed allegations presented as fact do a disservice to the Commissioner, the District Council, GHMSI subscribers, and the citizens of the District”).

<sup>40</sup> Appleseed Pre-hearing Report, Ex. B at 26.

<sup>41</sup> See GHMSI Rebuttal Report Tab 3 at 4.

<sup>42</sup> Appleseed Pre-hearing Report, Ex. B at 26.

<sup>43</sup> See GHMSI Rebuttal Report Tab 3 at 5, 10.

contingency” factor in its rate setting.<sup>44</sup> But that is simply incorrect; Milliman clarifies in its Response that it “does, in fact, directly recognize the premium margins that are generated by the risk and contingency factors” and that “[t]hese premium margin amounts offset the loss amounts that are otherwise determined based on the monte carlo simulations.”<sup>45</sup>

For these reasons, and the many others discussed by Milliman in its Response, the ARM analysis is both factually flawed and at odds with the results reached by every other actuarial professional to examine the data. The ARM range should be rejected.

### **III. GHMSI’S LEVEL OF COMMUNITY HEALTH REINVESTMENT IS ROBUST AND MEETS THE STATUTORY STANDARD.**

Because GHMSI’s reserves are not unreasonably large, the Commissioner need not even reach the question whether GHMSI’s reserves are consistent with its “community health reinvestment” obligation. But in any event, it is clear that GHMSI’s level of community health reinvestment is robust and that GHMSI’s reserves are consistent with GHMSI’s obligations under the second prong of the statutory test – *i.e.*, to “engage in community health reinvestment to the maximum feasible extent consistent with financial soundness and efficiency.” D.C. Code § 31-3505.01.

#### **A. GHMSI Engages in Extensive “Community Health Reinvestment.”**

The undisputed testimony at the Hearing demonstrated that GHMSI’s Board of Trustees and management have been actively increasing community health reinvestment every year, subject only to the constrictions of running the Company in a cost-effective way for the benefit of subscribers. GHMSI’s commitment to the community falls into a few separate categories:

- First, GHMSI spends tens of millions of dollars on programs that benefit the community. In 2008, GHMSI reinvested \$31.3 million in its service area.<sup>46</sup> When broken out by jurisdiction, that community investment constitutes 3.3 percent of GHMSI’s District-based total premium revenue. This figure is significantly higher than the percentages of total premium revenue that GHMSI spends on these programs and obligations in Maryland and Virginia – 1.7 percent and 2.3 percent, respectively – notwithstanding the

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<sup>44</sup> Appleseed Pre-hearing Report, Ex. B at 19.

<sup>45</sup> See GHMSI Rebuttal Report Tab 3 at 8.

<sup>46</sup> As explained in GHMSI’s testimony and previous submissions, premium tax payments should be taken into account along with other forms of community giving when seeking to compare GHMSI’s contributions in the District to its contributions in other jurisdictions or to the contributions of other Plans. Pennsylvania, Maryland, and Virginia all provide offsets to premium tax obligations in light of community giving, while the District does not. See Sept. 10, 2009 Hearing Tr. 36:6-37:16. And the MIEAA specifically requires that in reviewing GHMSI’s reserves, the Commissioner take into account the “premium tax paid” by the Company. D.C. Code § 31-3506(f).

fact that approximately 90 percent of GHMSI's subscribers live in those two states. And the figure is expected to jump to at least 5.5 percent of premium revenue in light of the public-private partnership legislation currently pending before the District Council.<sup>47</sup>

- Second, the MIEAA defines “community health reinvestment” to include those expenditures that “benefit current . . . subscribers, including premium rate reductions.” D.C. Code § 31-3501(1A). GHMSI has provided such benefits by holding premium levels just above the break-even point; as discussed at page 2, GHMSI's underwriting margin was a mere 0.3 percent in 2008 and is expected to be 0.5 percent for 2009.
- Third, the income GHMSI generates from investing its reserves accrues directly to the benefit of GHMSI's individual and small group subscribers by further moderating the need for premium increases. As GHMSI testified: “Everything we can get from earnings on the portfolio we don't have to get from subscribers through premium rate increases.”<sup>48</sup>

In addition, as GHMSI testified at the Hearing, the Company has a Board committee and staff dedicated to reviewing and funding worthy projects in the community. In so doing, GHMSI specifically seeks to target those projects that would have the “greatest beneficial impact on the community” or generate catalytic changes and improvements in the quality of healthcare provided locally.<sup>49</sup> For example, in 2008, GHMSI contributed more than \$15 million in subsidies and funding to community organizations and initiatives, ranging from free healthcare clinics to programs that seek to lower the rates of HIV/AIDS and childhood obesity to the open enrollment program.<sup>50</sup> Detailed information regarding GHMSI's contributions are available on the DISB website under the heading “CareFirst Community Giving.”

## **B. GHMSI's Community Health Reinvestment Meets The Statutory Requirement.**

The activities described above represent “community health reinvestment” to “the maximum feasible extent consistent with financial soundness and efficiency.” D.C. Code § 31-3505.01.

That is so for several reasons. First, GHMSI's level of giving is massive, both in absolute amounts and in comparison to that required by other jurisdictions. The Company's community health reinvestment is more than double the percentages cited as worthy benchmarks

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<sup>47</sup> Sept. 10, 2009 Hearing Tr. 38:21-41:3.

<sup>48</sup> Id. at 33:15-22; Sept. 11, 2009 Hearing Tr. 52:13-19.

<sup>49</sup> Sept. 10, 2009 Hearing Tr. 95:3-99:20.

<sup>50</sup> See CareFirst Commitment, 2008 Year In Review, available at [http://disb.dc.gov/dsr/frames.asp?doc=/disr/lib/dsr/pdf/dcappleseed/microsoft\\_powerpoint\\_-\\_2008\\_contributions\\_cfmi\\_\\_nca\\_giving\\_disb\\_req\\_\\_mt.pdf](http://disb.dc.gov/dsr/frames.asp?doc=/disr/lib/dsr/pdf/dcappleseed/microsoft_powerpoint_-_2008_contributions_cfmi__nca_giving_disb_req__mt.pdf).

in Appleseed’s written testimony.<sup>51</sup> It vastly exceeds the contributions made by other comparable health insurers.<sup>52</sup> And as mentioned above, GHMSI already spends much more of its total premium revenue on community health reinvestment in the District than it does in Maryland or Virginia, even though the vast majority of GHMSI’s subscribers live in those states. Indeed, as a percentage of premium revenue, GHMSI’s commitment appears to be far in excess of that required of any non-profit Blue Plan anywhere in the nation, based on information available to GHMSI. There is no reason to believe the statute requires still more.

Second, as explained at the Hearing, the MIEAA’s reference to “maximum feasible extent,” D.C. Code § 31-3505.01, does not mean – as Appleseed seems to believe – that the Company must dedicate every penny above bare minimum reserve levels to charitable giving. The statute is more sensible than that. By defining “community health reinvestment” to include “expenditures that . . . benefit current or future subscribers,” D.C. Code § 41-3501(1A), the District Council recognized that charitable giving is beneficial to GHMSI subscribers, but that GHMSI must also take care to keep its premiums down, make sound investments, and invest in its own infrastructure – all of which also benefit its subscribers.

GHMSI works hard to strike the correct balance between community giving that fosters improved health and healthcare and more directly tamping down subscriber costs. The Company gives tens of millions in grants and other community expenditures. But it also takes care to hold a necessary level of reserves – the pool of money available to pay claims – for the benefit of its subscribers. Likewise, it uses reserve funds to upgrade its infrastructure, thus improving services and reducing their cost. (For example, as noted in GHMSI’s August 26, 2009 Pre-Hearing Report, GHMSI is currently engaged in a multi-year, multi-million dollar effort to upgrade enrollment and claims processing systems which will improve customer service and provide new and innovative ways of managing health care quality and cost.) And finally, the Company’s reserves serve as income-generating capital, and the earnings produced by that capital further offset the need for premium increases. As GHMSI explained at the Hearing: “We do have a substantial portion of our bottom line come from the earnings on our reserve, and we return that, in effect, in the form of lower premiums than we otherwise would have charged . . . . It helps make it more affordable. The lower the reserve gets, the lower the earnings go and the less it helps.”<sup>53</sup>

When it engages in “community health reinvestment,” in short, GHMSI must perform a complex balancing test: It must weigh its premium tax obligations and community expenditures against alternative investments that would moderate premiums or otherwise reduce costs for its subscribers. Every expenditure reducing the size of GHMSI’s reserves leaves less money

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<sup>51</sup> Appleseed Written Testimony at 3.

<sup>52</sup> See CareFirst Pre-hearing Report at 29.

<sup>53</sup> Sept. 10, 2009 Hearing Tr. 249:9-19.

available for the payment of claims and internal upgrades. And every expenditure reducing the size of GHMSI's reserves leaves less income-generating capital available to offset the need for premium increases. The bottom line is "affordability to [GHMSI's] subscriber[s]." <sup>54</sup> And there is nothing in the evidence to suggest that GHMSI has not struck that balance correctly.

For these reasons, the Commissioner should conclude that GHMSI has engaged in "community health reinvestment" to "the maximum feasible extent consistent with financial soundness and efficiency." D.C. Code § 31-3505.01. It would be imprudent to force the Company to increase its level of "community health reinvestment" any further – particularly at this time, in this economy. Such a requirement would render GHMSI's reinvestment obligations in the District even more disproportionate to the obligations imposed by any other jurisdiction, including Maryland and Virginia. <sup>55</sup> And as GHMSI has explained, the additional burden would fall on those least able to bear it – specifically, individual subscribers and small and medium-sized District-based employers who built and benefit from GHMSI's reserves. <sup>56</sup>

### **C. Appleseed's Contrary Arguments Are Unavailing.**

Appleseed argues that GHMSI does not give as much as it should, but its contentions are unpersuasive.

First, Appleseed points to Kaiser Permanente and the four Pennsylvania Blue Plans as benchmarks for appropriate rates of community giving. But the comparison to Kaiser Permanente is apples-to-oranges: Kaiser Permanente runs hospitals and medical centers, and of the \$28.9 million attributed by Kaiser Permanente to "community reinvestment" in the mid-Atlantic region in 2008, the majority arises from the company's participation in programs like Medicaid and the Children's Health Insurance Program. <sup>57</sup> And as to the Pennsylvania Blue Plans, with the exception of their for-profit subsidiaries, they are exempt from state and local taxation (including premium taxes) – unlike GHMSI. And even putting these distinctions aside, GHMSI's commitment of 3.3 percent of total premium revenue in the District is more than double the percentages attributed to Kaiser and the Pennsylvania Blue Plans in Appleseed's written testimony. <sup>58</sup>

Next, Appleseed points to the report issued over four years ago by then-Commissioner Mirel, which stated, in part, that "GHMSI should be engaging in charitable activity significantly

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<sup>54</sup> Id. at 29:9-21.

<sup>55</sup> See, e.g., id. at 36:6-37:6.

<sup>56</sup> See, e.g., id. at 37:12-16; CareFirst Pre-hearing Report at 5.

<sup>57</sup> See Kaiser Permanente, 2008 Community Benefit Report at 30, available at [http://info.kp.org/communitybenefit/assets/any/about\\_us/global/annualreport08/KP\\_CB\\_Annual\\_Report.pdf](http://info.kp.org/communitybenefit/assets/any/about_us/global/annualreport08/KP_CB_Annual_Report.pdf).

<sup>58</sup> Appleseed Written Testimony at 3.

beyond its current activities.”<sup>59</sup> Appleseed has cited this statement repeatedly through this proceeding, claiming that over the last four and a half years, GHMSI’s reserves have increased, while its level of charitable giving has decreased. Neither assertion is correct. In May 2005, when then-Commissioner Mirel issued his report, GHMSI’s reserves were 950 percent of RBC. Since then, GHMSI’s reserves have steadily decreased as a percentage of RBC and are currently approaching 825 percent. In spite of this significant decline, however, GHMSI has consistently increased its level of community giving each year since 2005.<sup>60</sup> In 2006, GHMSI contributed \$28.3 million. In 2007 and 2008, GHMSI contributed \$31.2 million and \$31.3 million, respectively.<sup>61</sup> And in 2009, GHMSI’s contributions are projected to reach \$45 million, nearly \$17 million more than 2006.<sup>62</sup>

#### **IV. ADDITIONAL ARGUMENTS PRESENTED BY APPLESEED AND ARM ARE WITHOUT BASIS.**

We have already addressed the flaws in Appleseed’s and ARM’s submissions with respect to the RBC range and the applicable statutory test. Below we address several additional problems with their arguments.

##### **A. Appleseed And Its Economist Misconstrue The Koken Report.**

In their pre-Hearing submissions and testimony, Appleseed and its economist Deborah Chollet repeatedly referred to, and repeatedly misinterpreted, the findings set forth in the Koken Report regarding the reserves of Pennsylvania’s Blue plans.

At the Hearing, Ms. Chollet, who is not an actuary, attempted to analogize GHMSI to two of the companies addressed in Commissioner Koken’s report. She chose as her points of comparison the two large Pennsylvania Blue plans whose size and diversity resulted in the establishment of a relatively low RBC range. Ms. Chollet based her approach on the fact that GHMSI, like the two large Pennsylvania plans, has many customers in metropolitan areas.<sup>63</sup> But that analysis is without any basis in actuarial principles; the urban setting of an insurer’s customer base has nothing to do with its risk profile. That, no doubt, is why the urban-versus-

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<sup>59</sup> Mirel Report at 19.

<sup>60</sup> Sept. 10, 2009 Hearing Tr. 133:2-21.

<sup>61</sup> See GHMSI Rebuttal Report Tab 1 at 1.

<sup>62</sup> See id. at 1-2.

<sup>63</sup> Ms. Chollet expressed surprise and concern that GHMSI would compare itself to Capital BlueCross, another of the companies addressed in Commissioner’s Koken’s report, in light of her understanding that Capital BlueCross “serves a largely rural central Pennsylvania area.” Sept. 10, 2009 Hearing Tr. 352:12-353:9.

rural makeup of a Plan’s subscriber base is not listed among the many risk factors affecting reserves, as enumerated in Commissioner Koken’s report.<sup>64</sup>

In fact, if one were to compare GHMSI to any of the Pennsylvania Blues, the appropriate reference point is Capital BlueCross. According to Milliman, GHMSI has more in common with Capital BlueCross than the two large plans discussed above because (i) the plans are closer in size, in terms of premiums written, and (ii) they have similar levels of diversification – the two factors considered by Commissioner Koken in classifying the Pennsylvania Blue Plans into RBC categories.<sup>65</sup> Commissioner Koken determined that the appropriate RBC range for Capital BlueCross was 750-950 percent.<sup>66</sup> The reserve ranges set by Commissioner Koken thus support GHMSI’s position.

Furthermore, Commissioner’s Koken’s report, on which Appleseed places so much weight, actually endorses many of the points made by GHMSI:

- Commissioner Koken observed that the regulatory threshold levels are not appropriate guides for a “healthy” level of reserves. She cited the NAIC Research Quarterly for Winter 2002, which states that surpassing the “no action” level “does not necessarily mean the insurer is in strong financial condition. It simply means the insurer has not triggered one of the regulatory intervention levels. An insurer can be in weak financial condition and still pass the RBC test.”<sup>67</sup>
- Commissioner Koken explained why it is important to prescribe a range for reserves, rather than a specific target. She stated: “While we cannot precisely measure risk, RBC ratios, surplus and appropriate operating ranges for each given moment, due to both the dynamic nature of business and the limitations of these actuarial and accounting tools, we can develop bounds for these values.”<sup>68</sup> Appleseed ignores this reality in insisting that GHMSI’s reserves be set, and maintained, at “the lower end of that [target] range.”<sup>69</sup>
- Finally, Commissioner Koken took note of the fact that, as non-profits, the Blue plans are unable to “access capital markets through the sale of equity securities.”<sup>70</sup> In light of that limitation, she allowed for a broad range in reserves, enabling Plans to retain additional capital in their reserves, in order to meet investment and infrastructure needs as they

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<sup>64</sup> See Koken Report at 10-11.

<sup>65</sup> See GHMSI Rebuttal Report Tab 1 at 3-4.

<sup>66</sup> Koken Report at 37.

<sup>67</sup> Id. at 21 (emphasis deleted).

<sup>68</sup> Id. at 28.

<sup>69</sup> Appleseed Pre-hearing Report at 8-9.

<sup>70</sup> Koken Report at 36.

arise.<sup>71</sup> Appleseed ignores this finding, too, in insisting that GHMSI's reserves be set at the bottom of the target range.<sup>72</sup>

Ultimately, the RBC ranges designated by Commissioner Koken are relevant to this proceeding only as loose analogues. The companies she reviewed have no relationship to GHMSI, and she explained that the "optimally efficient level of surplus for each Blue Plan necessarily varies among the Plans and the unique circumstances they may face at any given point in time."<sup>73</sup> Nevertheless, for the reasons explained above, to the extent her findings are relevant here, they support the analysis put forward by GHMSI, not that of Appleseed.

## **B. Appleseed's Comparisons Between GHMSI And Other Insurers Are Flawed.**

Ms. Chollet, Appleseed, and ARM also try to support their findings by comparing GHMSI's level of reserves to that of purported competitors and peers around the nation. These arguments are fundamentally flawed. As a preliminary matter, as indicated above, calculating the appropriate level of reserves requires a complex individualized assessment. An appropriate level cannot be determined by observing the levels maintained by other companies – each of which faces a unique set of risk factors and circumstances. But even putting that limitation aside, the companies identified by Ms. Chollet, Appleseed, and ARM are not appropriate benchmarks for GHMSI.

For example, of the three companies described by Ms. Chollet as GHMSI's local competitors – Kaiser Foundation Health Plan, United Healthcare, and Aetna of Maryland – two are for-profits.<sup>74</sup> In general, as noted above, for-profit companies enjoy greater margins than non-profits like GHMSI. They also have greater access to capital.<sup>75</sup> They accordingly are able to rebuild reserves at a much faster pace following a downturn or large expenditure, and they do not need as high a level of reserves in the first instance.

Moreover, all three companies named by Ms. Chollet are local subsidiaries of large national health insurance companies. While we do not have access to the specific financial data of these organizations, it is not uncommon for such companies to pay profits or gains to the parent company in the form of dividends. This enables the parent company to amass its own pool of reserves, which can be made available to the subsidiary in the event of financial

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<sup>71</sup> Id.

<sup>72</sup> Appleseed Pre-Hearing Report at 8-9.

<sup>73</sup> Koken Report at 34. Moreover, Commissioner Koken applied a different legal standard than that prescribed by the MIEAA. She sought to determine the "efficient" level of surplus. But efficiency is just one factor to be considered under the MIEAA. Without a finding that GHMSI's surplus is "unreasonably large," GHMSI's surplus cannot be considered excessive under the statute.

<sup>74</sup> See Appleseed Pre-hearing Report, Ex. C at 5-8.

<sup>75</sup> See CareFirst Pre-hearing Report at 18.

difficulty. In light of these arrangements, the reserves held within the local subsidiaries do not represent the full amounts actually available to the subsidiary and offer a poor basis for comparison.

As to the purported “peer companies” identified by ARM and Ms. Chollet for purposes of comparing RBC ratios, it is not clear why or how ARM concluded that they served as appropriate points of comparison. In addition, the facts presented regarding these companies were misleading. For example, Ms. Chollet seems to suggest that the four entities discussed in her report had ACLs in the range of \$77 million to \$86 million in 2008, but that is not true; her own chart shows that one company’s ACL was well in excess of this range.<sup>76</sup> Likewise, by cutting off her list at an ACL level of \$86 million, Ms. Chollet managed to exclude a Blue entity (Regence Blue Shield) with an ACL of \$86.9 million and an RBC ratio substantially higher than that of GHMSI.<sup>77</sup> And several of the companies on Ms. Chollet’s list, including BCBS of Georgia, are either for-profit or are owned by for-profit companies – a particularly poor point of comparison for a non-profit like GHMSI, as discussed above.

Ultimately, the only thing the so-called “peer companies” chosen by Ms. Chollet seem to have in common is an RBC ratio below that of GHMSI. But that proves nothing, as there are many insurers with RBC ratios higher than that of GHMSI, to which one can just as easily point. Indeed, a comparison of GHMSI to all the non-profit Blue Plans with a 2008 RBC-ACL value within 25 percent of GHMSI’s value reveals that GHMSI’s RBC ratio ranks fifth out of ten – hardly an outlier.<sup>78</sup>

**V. IF EXCESS IS FOUND, RESIDENCY IS THE APPROPRIATE METRIC FOR CALCULATING RESERVES “ATTRIBUTABLE TO THE DISTRICT.”**

The Commissioner does not need to reach the question of attribution. As even Appleseed indicated in its written testimony, “[a]ll agree that the determination of excess is to be made on a corporate-wide basis.”<sup>79</sup> And since GHMSI’s reserves are not excessive, there is no need to determine what portion of GHMSI’s reserves is attributable to the District.

However, if the Commissioner were to determine that GHMSI’s company-wide reserves are excessive, that would trigger several additional complications. First, the Commissioner

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<sup>76</sup> See Appleseed Pre-hearing Report, Ex. C at 5.

<sup>77</sup> See Exhibit A to this brief (RBC chart).

<sup>78</sup> See id. See also GHMSI Rebuttal Report Tab 4 (Lewin post-hearing analysis) at 22-23 (summarizing Lewin’s validation of its recommended range by comparing GHMSI with like Blue Cross Blue Shield Plans).

<sup>79</sup> Appleseed Written Testimony, Ex. B at 1. That approach is consistent with the MIEAA because GHMSI’s total reserves are an appropriate proxy for determining whether the portion of the reserves attributable to the District is “unreasonably large.” If GHMSI’s total reserves are not unreasonably large, the reserves attributable to any single geographical area cannot be unreasonably large, either.

would have to determine how to “attribute” GHMSI’s reserves. For the reasons discussed in GHMSI’s previous filings, the Commissioner should do so based on a residency approach. Second, once the Commissioner had determined what percentage of the reserves is properly “attributable” to the District, she would then have to recalculate the appropriate RBC, because the appropriate RBC for a subset of GHMSI will by definition be higher than the appropriate RBC for the Company as a whole. We explain these points in turn.

**A. The Residency Approach Is The Appropriate Attribution Method.**

For all of the reasons explained in GHMSI’s August 31, 2009 Pre-Hearing Report, to the extent the Commissioner finds it necessary to determine the portion of GHMSI’s reserves “attributable to the District,” attribution should be conducted based on the residency of GHMSI’s subscribers.<sup>80</sup> The results of this analysis are described in that report and in the August 31, 2009 pre-Hearing submission prepared by Milliman and attached thereto as Exhibit A.<sup>81</sup> We will not repeat the analysis contained in those filings, but instead will briefly respond to some points raised by Appleseed’s counsel.

1. Situs Is An Inappropriate Basis For Attribution.

In its written testimony, Appleseed’s counsel argues that attribution should be based on the jurisdiction in which GHMSI’s insurance policies were written – i.e., the “situs” of the insurance contracts. (In the case of a group policy, this generally refers to the jurisdiction where the employer signing a group policy is located.) This contention is, of course, an attempt to target a greater share of GHMSI’s reserves. It also is based on a misinterpretation of the law and the relevant facts.

First, Appleseed’s counsel argues that situs-based attribution is appropriate in light of D.C. Code § 31-3506(i). This provision of the MIEAA empowers the Commissioner to penalize GHMSI for failure to submit or execute a plan to dedicate any excess reserves by “deny[ing] for 12 months all premium rate increases for subscriber policies written in the District.” D.C. Code § 31-3506(g) & (i). Appleseed’s counsel insists that this is evidence that any benefits from the MIEAA are intended to accrue to the parties contracting in the District – i.e., employers, in the case of a group plan.<sup>82</sup>

Not so. As GHMSI established at the Hearing, outside the context of FEP, anywhere from about 50 percent (in the case of many small and medium-sized premium-paying group plans) to 100 percent (in the case of individual subscribers) of GHMSI’s premiums are paid by

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<sup>80</sup> CareFirst Pre-hearing Report at 8-9, 31-36.

<sup>81</sup> See id. & Ex. A thereto.

<sup>82</sup> Appleseed Written Testimony, Ex. B at 1.

subscribers.<sup>83</sup> Moreover, as discussed in GHMSI's Pre-hearing Report, even the portions of premium paid by employers should be deemed to stem from individual employees; after all, the health benefits paid by the employer are part of the employee's compensation, just like salary. See generally NEA-Coffeyville v. Unified Sch. Dist. No. 445, 996 P.2d 821 (Kan. 2000). Thus, contrary to Appleseed's contention, the MIEAA's remedy provisions are aimed more directly at subscribers than employers. Similarly, as also noted in GHMSI's Pre-hearing Report, another provision of the MIEAA explicitly serves to tie the Commissioner's inquiry to the benefit of GHMSI's subscribers. D.C. Code § 31-3506(g)(2) provides that if GHMSI's reserves were to be deemed excessive by the Commissioner, GHMSI could draw down the excess "entirely [by] expenditures for the benefit of current subscribers of the corporation."

Taken together, these provisions indicate the MIEAA's focus is on the welfare of subscribers, not on their corporate employers. This is not surprising in light of the legislative history of the MIEAA<sup>84</sup> and GHMSI's congressional Charter, which mandates that GHMSI be conducted for "the benefit of [its] certificate holders."<sup>85</sup> To the extent it becomes necessary to attribute GHMSI's reserves under the MIEAA, it therefore makes sense to do so based on the location of GHMSI's subscribers rather the location of employers.

Moreover, as explained at the Hearing, GHMSI's reserves arise in large part from the difference between premiums and claims.<sup>86</sup> And both of those metrics are driven by individual subscribers, not groups: Premiums are paid in large part by GHMSI's subscribers, as already discussed, and the number and size of claims are driven exclusively by the actions of subscribers. See NEA-Coffeyville, 996 P.2d at 832 (holding that "surplus was created by the actions of the subscriber-teachers in filing fewer and/or smaller claims than were anticipated when [the insurance provider] set the premiums"). Thus the lion's share of GHMSI's reserves are generated by the contributions and actions of GHMSI's subscribers. In light of this fact and the fact that the reserves are held for the benefit of GHMSI's subscribers, it makes sense to attribute GHMSI's reserves based on the location of those subscribers.

Attribution based on residency is particularly sensible in light of the fact that 67 percent of GHMSI's subscribers seek medical care at facilities in the jurisdictions in which they reside.<sup>87</sup> Appleseed argues that "GHMSI contracts with employers to provide insurance coverage regardless of an individual employee's residence,"<sup>88</sup> but this in no way diminishes the importance of a subscriber's residence. It is at their residence that the subscribers subtract from

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<sup>83</sup> Sept. 10, 2009 Hearing Tr. 32:5-17; 186:20-188:2; see GHMSI Rebuttal Report Tab 1, Ex. B.

<sup>84</sup> See CareFirst Pre-hearing Report at 36.

<sup>85</sup> Ex. A (Charter).

<sup>86</sup> Sept. 10, 2009 Hearing Tr. at 137:9-138:10.

<sup>87</sup> See GHMSI Rebuttal Report Tab 1 at 1.

<sup>88</sup> Appleseed Written Testimony, Ex. B at 1.

their net worth to make their share of premium payments; it is at their residence that they eventually will be benefited by claims payments; and it is at or near their residence where they typically will visit healthcare providers, incur healthcare costs, and generate claims – all of which draw down reserves and help determine appropriate premium rates going forward.

2. The Regulations Are Consistent With A Residency Approach.

The DISB regulation issued shortly before the Hearing, and designed to guide the attribution inquiry, comports with a residency approach. Under the applicable regulation, in determining the amount “attributable to the District,” the Commissioner shall consider the following:

- (a) The number of policies by geographic area;
- (b) The number of health care providers under contract with the company by geographic area; and
- (c) Any other factor that the Commissioner deems to be relevant based on the record of [the Hearing].

D.C. Mun. Regs., tit. 26, § 4699.2.

The first factor is best read to cut in favor of a residency approach because the term “polic[y]” is best interpreted to refer to the policy issued to each individual subscriber. To be sure, the word is sometimes used in the insurance industry to refer to a group policy. But in layman’s terms, “policy” refers to the coverage enjoyed by each individual, even if that individual is part of a group; if one asked a corporate employee whether he had an “insurance policy,” the answer would be yes; he would not respond “no, I have a certificate, but my employer has a policy.” That is significant because statutes (and regulations) must be interpreted in layman’s terms, except where the statute provides otherwise. See Beaner, 845 A.2d at 534.

Moreover, this understanding of “policy” is consistent with the terminology used by GHMSI in its own coverage documents; those materials use the term “policy” to refer to an individual’s coverage, even when the individual is part of a group. See, e.g., GHMSI Certificate of Coverage (available upon request) at 5.1 (stating that individuals within a group are covered by a “Health Plan” and defining “Health Plan” as “this Certificate and any other . . . health contract or policy”) (emphasis added); id. at 5.4 (stating that certain automobile accidents are “covered under medical payment provisions of a . . . policy issued to or otherwise covering the Member,” with “Member” defined to mean any individual under a group contract) (emphases added).

Finally, the alternative – counting each group policy as a single “policy” – would lead to a skewed outcome: A group policy featuring 1,000 subscribers for an employer headquartered in the District would carry the same weight, for attribution purposes, as a group policy featuring

only five subscribers for an employer headquartered in Maryland. For all of these reasons, “policy” is best understood to refer to the coverage held by individuals, including those within groups – an understanding that squarely supports a residency analysis.

The second factor – “number of health care providers under contract with the company by geographic area” – likewise supports a residency approach to attribution. As explained in greater detail at Tab 1 of the GHMSI Rebuttal Report, GHMSI’s provider network features 4,423 providers located inside the District and 30,900 located outside of the District. That percentage – approximately 12.5 percent in the District – is substantially in harmony with the attribution results produced by a residency analysis (11.6 percent). In contrast, it bears no relation to the 60 percent attribution, based on a situs methodology, that has been proposed by Appleaseed.

As for the third, “catch-all” factor, Mr. Rector expressed interest during the Hearing in learning about “what caused the surplus, what generated the surplus, who paid it.”<sup>89</sup> These are pure residency questions: For the reasons above and those in GHMSI’s Pre-hearing Brief, the majority of GHMSI’s reserves are generated by the actions (through claims experience) and contributions of GHMSI’s subscribers, rather than those of employers. This factor accordingly also weighs in favor of residency-based attribution.

**B. Once GHMSI’s Reserves Are “Attributed,” The Commissioner Would Have To Recalculate The Appropriate RBC From Scratch.**

If the Commissioner were to decide that attribution is necessary, and were to choose an attribution methodology, that would trigger yet a further step: She would need to recalculate GHMSI’s RBC requirements to reflect the smaller pool of insured business at issue. And as noted in GHMSI’s pre-Hearing filing,<sup>90</sup> that RBC range would end up being higher than any of the ranges calculated for GHMSI as a whole.

This is so because, all else being equal, smaller insurers require more reserves, as a percentage of RBC, than do larger insurers.<sup>91</sup> Smaller insurers typically enjoy less diversification, and have less of a subscriber base over which they can spread risk. If the Commissioner were to attribute some subsection of GHMSI’s reserves to the District – thus essentially finding that that portion of the reserves protects District subscribers, while the remaining portion is walled-off for the protection of Maryland and Virginia subscribers<sup>92</sup> – each

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<sup>89</sup> Sept. 10, 2009 Hearing Tr. 185:13-17.

<sup>90</sup> See CareFirst Pre-hearing Report at 27 n.27.

<sup>91</sup> See Koken Report at 31, 33 (explaining that different Blue plans face “dramatic differences in potential underwriting results due to size”).

<sup>92</sup> For the reasons discussed in previous filings, this sort of attribution is arbitrary and unprecedented in insurance regulation. Reserves are an undifferentiated whole, meant to guard against claims and expenses wherever they may arise. See CareFirst Pre-hearing Report at 8.

of the two “sub-companies” would enjoy a smaller subscriber base and would require more reserves, as a percentage of RBC, to protect against adverse events.

Of course, the Commissioner need not ever reach this calculation, for the reasons above. But if she did, supplemental briefing and analysis would be required to determine how much higher the appropriate RBC should be for a pool of insurance business reflecting only GHMSI’s reserves “attributable to the District.”

## **VI. CONCLUSION**

GHMSI’s reserves are reasonable in size and consistent with the Company’s community health reinvestment obligation. For these reasons – and because GHMSI has shown that it can successfully balance the needs of its subscribers and the broader community – the Commissioner should conclude that the Company’s reserves are not “excessive” under the MIEAA.

Respectfully submitted,

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**EXHIBIT A**

**Summary of Total Adjusted Capital as a Percent of ACL-RBC  
for Non-Profit BCBS Plans  
with 2008 ACL Ranging from 75% to 125% of GHMSI ACL**

<b>BCBS Plans</b>	<b>ACL (\$ Millions)</b>		<b>TAC /ACL</b>	
	<b>2007</b>	<b>2008</b>	<b>2007</b>	<b>2008</b>
Regence Blue Shield	\$80.8	\$86.9	1145%	917%
BCBS of Tennessee Inc	\$87.9	\$101.4	1311%	891%
Louisiana Health Service & Indemnity Co	\$63.8	\$67.3	937%	880%
Capital Blue Cross	\$92.2	\$73.4	866%	851%
<b>Group Hospitalization &amp; Med Svcs</b>	<b>\$82.3</b>	<b>\$81.3</b>	<b>916%</b>	<b>845%</b>
Premera Blue Cross	\$96.3	\$101.5	814%	662%
BCBS of Massachusetts	\$99.7	\$96.0	708%	640%
Health Now New York Inc	\$73.2	\$77.7	678%	573%
Regence BCBS of Oregon	\$74.4	\$86.4	745%	563%
Carefirst of Maryland Inc	\$63.6	\$78.4	808%	503%

Source:

Annual Reports (Highline, LLC.)

*Prepared by Milliman*