# Exhibit C

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Prepared for DC Appleseed Center for Law and Justice, Inc

Excess Surplus Review Hearing of
Group Hospitalization and Medical Services, Inc.

District of Columbia
Department of Insurance, Securities, and Banking

August 31, 2009

**STATEMENT OF DEBORAH CHOLLET, PH.D., SENIOR FELLOW**
**MATHEMATICA POLICY RESEARCH, INC.**

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Thank you for this opportunity to participate in the deliberations of the DC Department of Insurance, Securities and Banking (DISB) regarding whether the portion of GHMSI's (Group Hospitalization and Medical Services, Inc.) surplus that is attributable to the District of Columbia is excessive under the Medical Insurance Empowerment Amendment Act (MIEAA) and is unreasonably large and inconsistent with the company's community health reinvestment obligation under MIEAA. This statement reflects solely my own opinions, not those of Mathematica Policy Research, its directors, or employees.

My statement addresses four issues related to GHMSI's accumulation of surplus and obligation under MIEAA:

1. GHMSI's presentation of its surplus position is misleading. Moreover, Milliman's analysis for GHMSI systematically overstates the need for additional surplus and is misleading in its presentation and conclusions.
2. GHMSI's surplus continues to significantly exceed that of other major insurers in the National Capital Area—including other CareFirst companies. Other carriers that serve the District of Columbia and other Care First companies hold substantially less surplus, and yet confront similar risks and obligations.
3. Similar nonprofit companies, including GHMSI's largest competitor, contribute substantially more toward community benefit than GHMSI has. This fact in part motivated the enactment of the MIEAA, which obligates GHMSI to a new, higher standard for contributing to community benefit.
4. The significant health needs in the District and across the National Capital Area that GHMSI is well-positioned to address in meeting its obligation to provide community benefit to the maximum extent consistent with remaining a financially strong insurer.

## 1. GHMSI'S ASSESSMENT OF SURPLUS NEED IS FLAWED

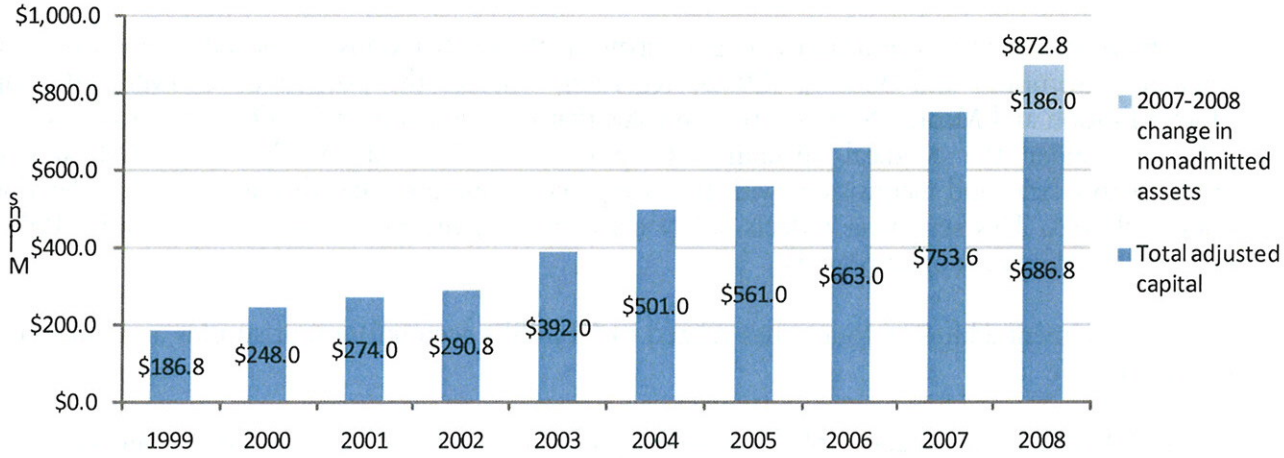
**GHMSI's surplus has increased steadily over the last 10 years.** CareFirst's report to the Commissioner, which indicates that GHMSI's surplus has "fluctuated more than 50 percent over the past decade," is apparently untrue.[1] Since 1999—having recovered from a period of extreme mismanagement in the 1990s—its surplus level has risen every year. Only in 2008 did GHMSI's surplus decline—and then only because the company moved a very large amount of funds into tax-deferred and other unexplained nonadmitted assets (Figure 1). In light of the community benefit

[1] CareFirst, "GHMSI Reserves." Report to Commissioner Thomas E. Hampton, July 31, 2009, page 3 [available at http://www.disb.dc.gov/disr/frames.asp?doc=/disr/lib/disr/pdf/carefirst_7_09_report_2.pdf].

standard that MIEAA has established, it would seem that DISB is obliged to review GHMSI's allocation of funds to nonadmitted assets, and it is incumbent on GHMSI to thoroughly explain changes in nonadmitted assets such as occurred in 2008.

FIGURE 1

GHMSI'S SURPLUS: TOTAL ADJUSTED CAPITAL (TAC) 1999-2008



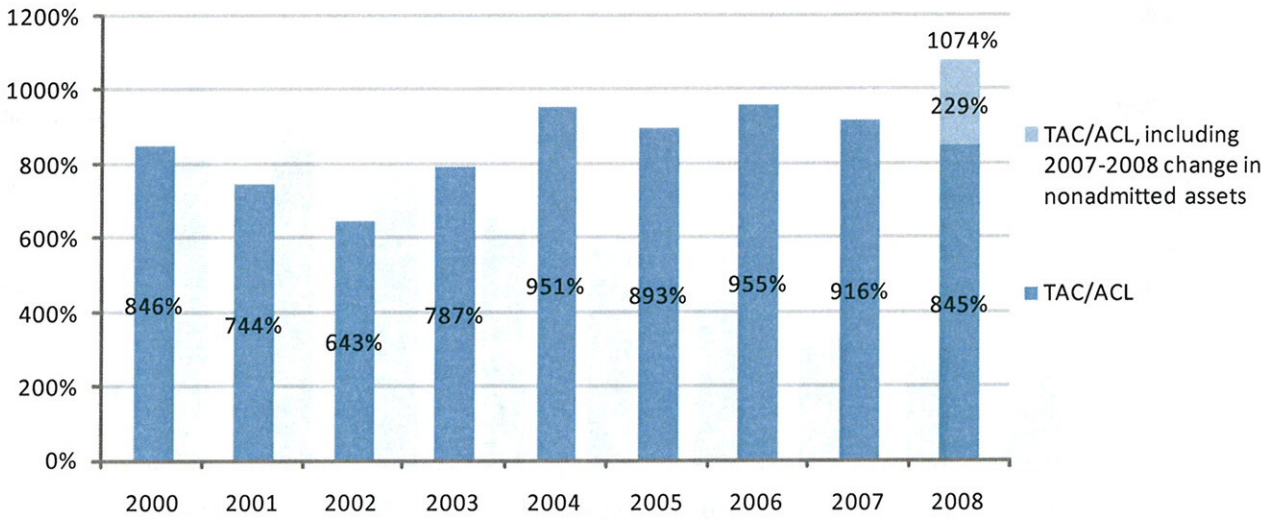

Source: GHMSI Key Annual Statements 2000-2008.

In 2007, GHMSI's surplus was more than 9 times its authorized control level (ACL) (Figure 2).[2] In 2008, GHMSI's surplus (net of the $186 million that was placed in nonadmitted assets) dropped to 845 percent of ACL. However, except for this unprecedented change in nonadmitted assets, GHMSI would have held nearly $873 million in surplus—equal to 1,074 percent of ACL.

[2] Regulators consider insurance carriers' surplus levels relative to a risk-based measure of assets available to pay unanticipated claims. This measure—called Authorized Control Level risk-based capital (ACL)—considers various elements of risk to insurers. Insurer surplus is measured as Total Adjusted Capital (TAC), which also is risk-based.

FIGURE 2

GHMSI'S TOTAL ADJUSTED CAPITAL (TAC) AS A PERCENT OF AUTHORIZED CONTROL LEVEL (ACL) RISK-BASED CAPITAL 2000-2008



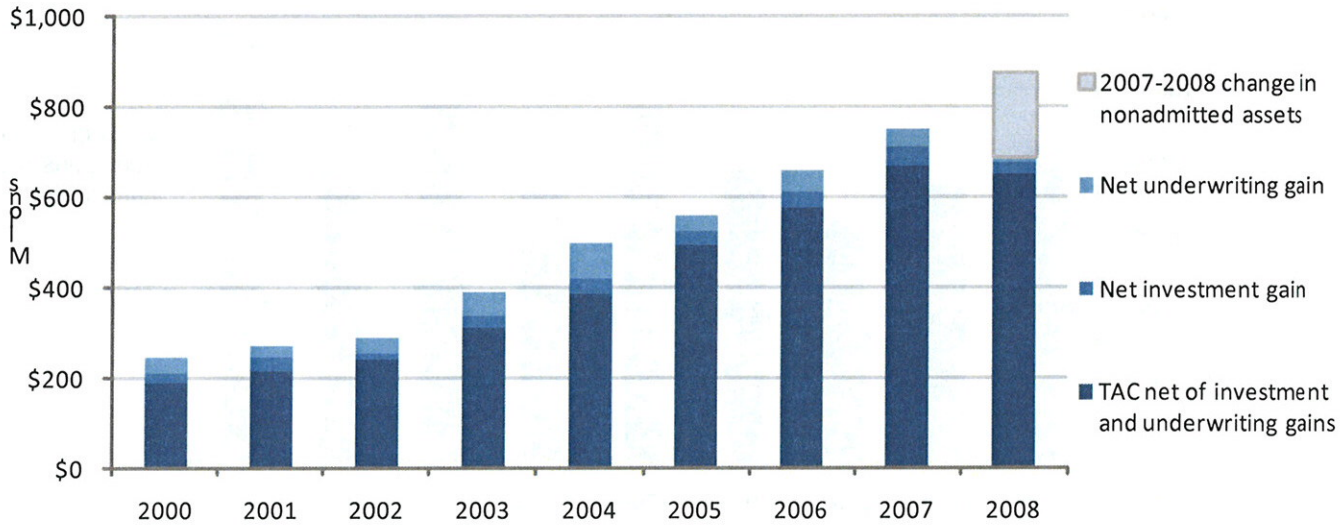

Source: GHMSI Key Annual Statements 2000-2008.

CareFirst's report to the Commissioner also states GHMSI "has been declining in its [surplus] position in the range over the last several years" and that this in part "reflects the generally poor condition of the economy and the financial markets as well as the continued strong upward climb of health care costs".[3] It is clear that GHMSI earned substantially less from investments ($24.3m) in 2008—a year of unprecedented national economic distress—than in any year since 2002 ($14.8m), when the last serious market downturn occurred (Figure 3). Similarly, it is true that GHMSI's net underwriting gain—that is, premium revenue minus medical losses and administrative expenses—in 2008 ($9.5m) was unusually low.

[3] CareFirst, Ibid., page 6.

FIGURE 3

GHMSI'S TOTAL ADJUSTED CAPITAL (TAC) NET OF UNDERWRITING AND INVESTMENT GAINS 2000-2008




Source: GHMSI Key Annual Statements 2000-2008.

However, as the CareFirst report notes, surplus is accumulated over multiple years. Therefore, low investment and underwriting gains or losses in one year are (or should be) only marginally related to the company's surplus position. Indeed, GHMSI avoided net losses in both investment and underwriting in 2008—and the unusual and unexplained addition to GHMSI's nonadmitted assets in 2008 dwarfed the net impact of lower underwriting and investment gains, taken together. Despite all of these considerations, GHMSI continued to hold very high surplus in 2008.

**GHMSI's loss experience prior to being a regulated entity is not material to its current need for surplus.** Within just two years of becoming a regulated entity in 1993, GHMSI began posting consistent underwriting gains—that is, its premium revenue has consistently exceeded the sum of medical claims and administrative expense. GHMSI has not experienced underwriting losses that other Blue Cross companies have experienced in downturns of the underwriting cycle—either in its federal employee plan (FEP) business or in its non-FEP lines.

Milliman's Monte Carlo analysis of GHMSI's surplus needs appears to include distant years and recent years as equally relevant—a suspect assumption in any case, as there are myriad circumstances that contribute to underwriting losses and arguably many could not recur. However, it is a badly flawed assumption in GHMSI's case especially. Including years prior to regulation—when GHMSI's extreme mismanagement became the subject of Congressional hearings—vastly overstates the volatility of GHMSI's subsequent loss experience and, therefore, the magnitude of its surplus needs.[4] In effect, GHMSI appears to be pointing to its own earlier mismanagement to justify the accumulation of high surplus now.

[4] See: United States Senate Committee on Governmental Affairs, Permanent Subcommittee on Investigations, Fourth Interim Report on United States Government Efforts to Combat Fraud and Abuse in the Insurance Industry: Problems in Blue Cross/Blue Shield Plans in West Virginia, Maryland, Washington, DC, New York, and Federal Contracts. Report 104-92. Washington, DC: U.S. Government Printing Office, June 1995.

**GHMSI is not especially susceptible to investment losses, either absolutely or relative to its competitors that hold lower surplus.** Aside from the magnitude of GHMSI's surplus, its stable build up of surplus is notable. Indeed, GHMSI has added to surplus in every year but 2008, during an extraordinarily severe downturn in financial markets. Moreover, insurance regulators expect that all insurance companies—not only GHMSI—invest conservatively so as not to be highly vulnerable to downturns in financial markets. Indeed, the financial troubles of AIG, the sole insurance company that came to the brink of collapse in 2008, arguably stemmed from financial speculation, mismanagement, and inadequate regulatory oversight—but not from instability of any of its core insurance business units.

**GHMSI is not undiversified.** In its report to the Commissioner, CareFirst refers to GHMSI's standing as a "one-product-line, one-region company with no diversification" as an important reason for its unusually high level of surplus. However, with respect to its exclusive focus on health coverage, GHMSI is not materially less diversified than its major competitors—Kaiser Foundation Health Plan and United Healthcare and its Maryland affiliates—or most other BlueCross Blue Shield plans. Indeed, GHMSI's role as a major FEP carrier offers the company an unusual level of financial stability—an important consideration that Milliman overlooked in its analysis of GHMSI's surplus needs. Moreover, GHMSI's affiliation with CareFirst offers a substantial resource base, should GHMSI have unprecedented and unforeseen capital needs. Again, in this respect it as diversified as many other companies that hold lower surplus.

The analysis prepared Actuarial Risk Management (ARM) for DC Appleseed[5] identifies several peer companies, all with business lines similar to GHMSI, and with comparable ACL—$77m to $86m in 2008, compared with GHMSI's $81m (Table 1). All are arguably less diversified than GHMSI, and all hold surplus well below GHMSI—in 2008, 384 to 563 percent of ACL, compared with GHMSI's 845 percent.

TABLE 1

PEER ANALYSIS OF AUTHORIZED CONTROL LEVEL (ACL) RISK-BASED CAPITAL AND SURPLUS RATIO 2007-2008

| | ACL | | TAC/ACL | |
|---|---|---|---|---|
| | 2007 | 2008 | 2007 | 2008 |
| Horizon (BCBS) Healthcare of NJ | $72.0 | $81.6 | 483% | 384% |
| BCBSMI | $108.9 | $106.2 | 596% | 489% |
| BCBS of Georgia | $78.2 | $77.3 | 678% | 551% |
| Regence BCBS | $74.4 | $86.4 | 745% | 563% |
| **GHMSI** | **$82.3** | **$81.2** | **916%** | **845%** |

Source: Actuarial Risk Management 2009.

[5] Actuarial Risk Management, Excessive Surplus: Assessment of GHMSI, Inc. Surplus Position. Report to DC Appleseed, August 2009 (Appendix B).

**Milliman's analysis uses assumptions that bias its results consistently toward a high estimate of surplus need.** In its report, ARM identifies numerous instances in which the Milliman analysis produces inflated estimates of GHMSI's surplus needs. These include:

- Use of underwriting loss experience in years predating regulation of GHMSI, despite recognition that this experience is extremely unlikely to recur;
- Ignoring GHMSI's dominant and growing market share in the District; the stability of that dominance; the marked lack of success of for-profit competitors in the District, [and the exit of some major for-profits in recent years.
- Assuming a 4-year adverse underwriting cycle (versus 3 years, which is typical of underwriting cycles historically)
- Exclusion of FEP premiums, which account for nearly half of GHMSI's premium revenues, and other insurance lines on which GHMSI has posted underwriting gains every year.
- Assuming a premium trend that is twice its average premium trend historically and clearly much higher than would be feasible in an economic downturn

Simply by correcting for these last two assumptions—that is, by including FEP premiums and a more reasonable premium trend (and, furthermore, including asset valuation risk in the calculation of GHMSI surplus need, which the Milliman analysis excluded and which generally increases GHMSI's need for surplus), ARM concludes that a surplus in the range of *400 to 525 percent* of ACL is more appropriate than Milliman's suggested range of 750 to 1050 percent. This lower surplus range equates to GHMSI holding $261 million to $362 million in *excess* surplus in 2008—that is, assets that exceeded the company's reasonable needs for surplus to remain financially strong, even in a sustained economic downturn.

The numerous, obvious flaws that ARM has identified in Milliman's analysis constitute a strong argument for an independent assessment of GHMSI's surplus needs, as MIEAA anticipates. ARM accepts CareFirst's invitation to provide briefings and "guided tours" of Milliman's methodology, and has asked for information to conduct its own more thorough analysis. GHMSI should provide both the briefings that it offered and the data that were requested immediately.

## 2. GHMSI'S SURPLUS REMAINS MUCH HIGHER THAN ITS COMPETITORS

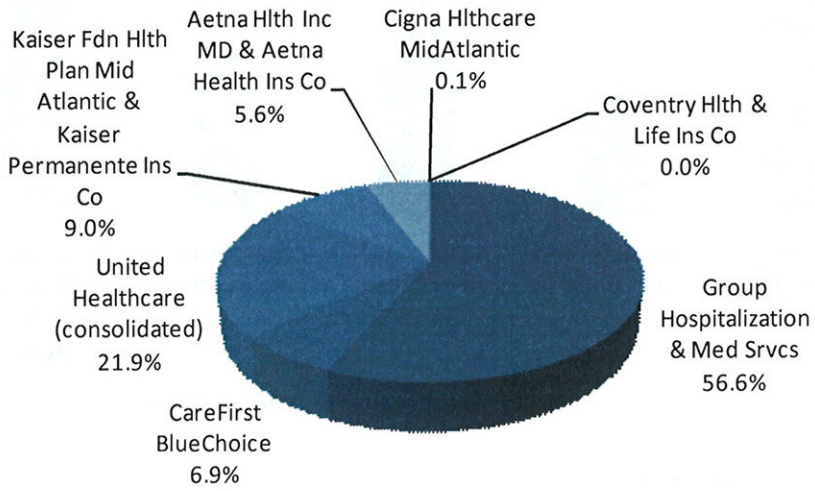
**GHMSI dominates the market in the District of Columbia.** The CareFirst report states that "GHMSI operates in one of the most competitive marketplaces in the country."[6] In fact, in nearly every state and in DC, the market for comprehensive health insurance products is remarkably concentrated.[7] In 2008, GHMSI held nearly 57 percent of the market in DC (Figure 4). GHMSI and CareFirst Blue Choice together held nearly two-thirds (63 percent) of the market. In fact, GHMSI

[6] CareFirst report, page 3.

[7] See: American Medical Association, "Most metro areas dominated by 1 or 2 health insurers" (March 9, 2009) at http://www.ama-assn.org/amednews/2009/03/09/bisb0309.htm.

held substantially greater market share in 2008 (57 percent) than in 2003 (42 percent).[8] Maryland's health insurance market is similarly concentrated.[9]

FIGURE 4
PERCENT OF THE MARKET HELD BY COMPREHENSIVE HEALTH INSURANCE CARRIERS IN THE DISTRICT OF COLUMBIA 2008




Source: Key Annual Statements 2008.

**GHMSI continues to hold unsually high surplus compared with other CareFirst companies and its major competitors.** Even when not considering its unusually large holding of nonadmitted assets in 2008, GHMSI's surplus in 2008—845 percent of ACL—was very high compared with the vast majority of insurers in the National Capital Area (Figure 4). Kaiser Foundation Health Plan, GHMSI's largest competitor and also a nonprofit company, held 632 percent of ACL. Only United Healthcare (consolidated across its four major business units, and even on a consolidated basis a relatively small company in the National Capital Area), held more surplus relative to ACL in 2008 than GHMSI, reflecting a very large increase in capital and somewhat lower ACL compared with 2007. Still, United Healthcare companies together account for about a third of GHMSI's business alone and hold 65 percent less capital than the CareFirst companies taken together.[10]

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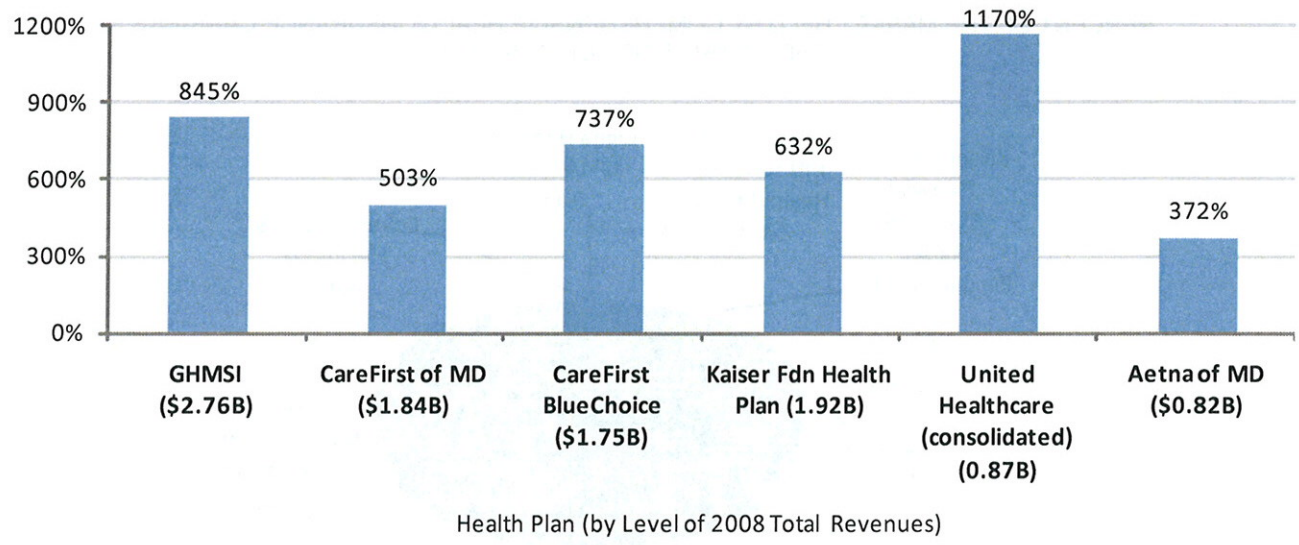
[8] D. Chollet, S. Liu, and L. Felland, Opportunities and Capacity for Community Benefit: GHMSI's Potential Role in the National Capital Area (December 2004) [Available at: http://www.dcappleseed.org/projects/ publications/DCA-Final-CareFirst-12-6-04.pdf].

[9] See: http://mhcc.maryland.gov/spotlight/health_ins_prem_spotlight_0305.pdf.

[10] United Healthcare affiliates in Maryland include United Healthcare of Maryland, MD IPA, MAMSI, and Optimum Choice.

FIGURE 4

TOTAL ADJUSTED CAPITAL AS A PERCENT OF AUTHORIZED CONTROL LEVEL
RISK-BASED CAPITAL: MAJOR COMPANIES IN THE NATIONAL CAPITAL AREA, 2008




Source: Key Annual Statements 2008.
Note: Each company's total revenues are reported for all markets that the company serves, including but not exclusive to the District of Columbia.

While GHMSI may have business considerations that are not apparent in its annual financial statements available to the public, it seems unlikely that they would differentiate its surplus needs so substantially from those of its competitors. It is notable that Pennsylvania's standard for similarly sized Blue companies is 550 to 750 percent of ACL—substantially less than GHMSI has held in any of the past 5 years or more, and approximately in line with Kaiser Foundation Health Plan's surplus position in 2008.[11]

## 3. GHMSI'S CONTRIBUTION TO COMMUNITY BENEFIT IS LOWER THAN OTHER NONPROFIT INSURERS

In my December 2004 report prepared for DC Appleseed, I determined that other nonprofit insurers—often with lower revenues and less market share than GHMSI—spend 1.5 to 2 percent of gross premiums for community benefit. Indeed, in its 2008 Community Benefit Report, Kaiser Permanente (which includes Kaiser Foundation Health Plan) reported expenditures of more than $28.9 million in the mid-Atlantic states in 2008—equal to more than 1.5 percent of Kaiser Foundation Health Plan's gross revenues. Pennsylvania's Community Health Reinvestment Agreement with its Blues companies uses a similar standard: 1.6 percent of gross premiums.

[11] See: http://www.ins.state.pa.us/ins/lib/ins/whats_new/2004bc/Surplus_Statement.pdf.

In contrast, CareFirst reported contributing $40 million to community benefit in 2008, across all affiliates and across all locations—in Maryland, the District, and northern Virginia.[12] This amount equaled just 0.6 percent of the combined revenues of GHMSI, CareFirst of Maryland, and CareFirst Blue Choice. While CareFirst's community benefit expenditures included voluntary support of various programs and donations, a significant share was required in lieu of premium taxation in Maryland, as payment of the $4 million that Maryland requires CareFirst to contribute to the Senior Prescription Drug Assistance Program when its surplus exceeded 800 percent of the consolidated ACL in 2007,[13] or as GHMSI's support of the individual open enrollment product in DC (as was required in 2008) net of assets that GHMSI had accumulated for this purpose over the years in lieu of paying the DC premium tax.[14]

## 4. COMMUNITY BENEFIT NEEDS IN DC AND THE NATIONAL CAPITAL AREA

The longstanding and pervasive health needs in DC are well known. They range from ongoing public health crises, such as the District's phenomenally high rates of HIV infection and AIDS, to unmet oral and mental health care needs, to health insurance coverage that is affordable to low- and middle-income residents. As the area's largest insurer, GHMSI could be a pivotal player in any of a large number of critical roles that it has not yet developed significantly or at all.

In 2004, we conducted a series of extensive interviews with health leaders in the National Capitol Area.[15] They identified a number of areas where a major insurer such as GHMSI could lead important initiatives—and indeed, is uniquely poised to do so. These initiatives encompass direct delivery of services, as well as leadership in systemic change to improve the quality and cost effectiveness of health care. While national health reform may overtake the most obvious role that GHMSI could have played much more actively— participating in the District's Medicaid program and developing an affordable comprehensive open-enrollment product—the urgent need for action in other areas has not changed. These include—but certainly are not limited to—the following:

- Developing programs to improve access to oral health care among low- and moderate-income residents—including persons with disabilities—in cooperation with area governments.

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[12] See: CareFirst BlueCross BlueShield Giving Tops $40 Million for Community Health Initiatives in 2008 [Available at: http://www.carefirst.com/media/NewsReleasesDetails/NewsReleasesDetails_20090127.html].

[13] Chapters 557 and 558 of 2008 require CareFirst, beginning January 1, 2009, to annually provide $4.0 million to the Senior Prescription Drug Assistance Program (SPDAP). Funds must be provided only if CareFirst's surplus exceeds 800% of the consolidated RBC for the preceding calendar year. Funds must be used to subsidize the Medicare Part D coverage gap. SPDAP, which terminates December 31, 2010, provides an annual subsidy up to the full amount of the Medicare Part D coverage gap, subject to the availability of funds. Although CareFirst's surplus was below 800 percent of the consolidated RBC in calendar 2008, CareFirst voluntarily agreed to contribute the $4.0 million to SPDAP for calendar 2009. See: http://mlis.state.md.us/2009rs/fnotes/ bil_0002/hb1472.pdf

[14] CareFirst prices the DC PPO Open Enrollment Medical and Rx products at a 25.0 percent load of the rates for comparable underwritten products. In 2009, CareFirst estimates its subsidy to this program to equal as much as $4.9 million in 2009 net of its $550,000 maximum tax offset. See: http://disb.dc.gov/disr/frames.asp?doc=/disr/lib/disr/pdf/cfap-125900997_1176_open_enrollment.pdf.

[15] Chollet, Liu, and Felland, December 2004. Ibid.

- Sponsoring school-based mental health services in primary, middle, and high schools that serve low-income children.

- Sponsoring clinics and other safety-net systems to serve underserved populations, and sponsoring language interpreters trained in cultural competency.

- Cooperating with area governments to develop wellness centers and programs to promote health improvement and disease and injury prevention, especially for the elderly.

- Developing systems and programs to address obvious sources of low-quality care and unnecessary cost in the national capital area—for example, coordinating primary care, coordinating payment rules so that designated primary care providers are appropriately reimbursed, and addressing failures of access to prescription drugs.

- Cooperating regionally with providers (as has recently been done in New York City and in Pennsylvania) to develop and disseminate best practices to improve the efficiency and quality of care, reducing cost and improving health outcomes.

- Developing and disseminating diagnostic and care protocols for management of public health emergencies, training health care providers in how to respond to public health emergencies and how to coordinate with public health departments.

Taking a leadership role in addressing the community health needs in the District and the National Capital Area would enhance its image not only as an efficient and well-managed company but also as a real force for positive change in the community.

## 4. CONCLUSIONS

In summary, three major conclusions are apparent:

- GHMSI's surplus substantially exceeds that of peer companies in other states, other CareFirst companies, and its largest nonprofit competitor in the District. Indeed, when its size and market dominance, its diversity and corporate affiliation, and the low risk of its FEP business are considered, GHMSI's need for surplus relative to ACL is arguably *lower* than many of its competitors, not higher.

- The many, significant, and obvious flaws in Milliman's analysis of GHMSI's surplus needs apparently bias their results consistently toward finding greater surplus need. Both the flaws and their apparent, strong bias indicate the necessity of an independent assessment of GHMSI's surplus position as MIEAA anticipates. ARM's analysis makes a compelling case for DISB to obtain and provide the information that an independent, expert evaluator needs to make this assessment. In addition, CareFirst should immediately provide to interested parties, as it has offered, additional information about Milliman's methods and assumptions and the impacts on their conclusions.

- CareFirst's contribution to community benefit is much lower than other nonprofit insurers nationally and in the National Capital Area. This is true despite the significant and well-known health care needs in the District and regionally, and GHMSI's unique capacity to exercise leadership in addressing many of these health care needs. MIEAA

was enacted with the expectation that GHMSI will not only continue to pursue its role as a strong and financially stable insurer in the District but also step us to its obligation as a community leader, committed to improving the health and safety of the community—its current and future policyholders—to the maximum extent feasible.