Consumers Union

August 28, 2009

The Honorable Thomas E. Hampton, Commissioner
District of Columbia
Department of Insurance, Securities and Banking
810 First Street, NE, Suite 701
Washington, DC 20002

Re: CareFirst Hearing

Dear Commissioner Hampton:

Consumers Union of United States, Inc. (CU), the nonprofit publisher of *Consumer Reports,* submits this letter in connection with your review of the surplus of Group Hospitalization and Medical Services, Inc. (GHMSI), a subsidiary of CareFirst, Inc. CU has retained an expert in healthcare and health plan management to review GHMSI's actuarial report by Milliman, Inc. Our expert has identified a number of reasons to critically review the surplus recommendations in the Milliman report (see Section II). CU further finds that GHMSI's recommended "optimal" surplus range would allow it to maintain an unreasonably large surplus with little or no regard for its community health reinvestment obligations (see Section III). We believe that any surplus range adopted must hold GHMSI accountable to its nonprofit mission (see Section IV). For these reasons, we urge you to reject GHMSI's recommended surplus range.

I. INTRODUCTION

CU is a national nonprofit organization whose mission is to work for a fair, just, and safe marketplace for all consumers. As part of the Community Health Assets Project, CU works to defend and redirect charitable assets and services for use by communities when nonprofit health plans either formally, or in effect, abandon their prior missions and become for-profit corporations. In so doing, CU strives to maintain and increase access to affordable, quality health care for low- and moderate-income consumers.

Across the country, nonprofit health insurers have amassed capital well beyond required minimums. At the end of 2008, the not-for-profit Blue Cross and Blue Shield plans held more than $41 billion in capital, almost double the approximately $24 billion held just five years earlier.[1] To put this in perspective, if the Blue plans were to reduce their capital to 575% of risk

[1] *See* Carl McDonald, Oppenheimer & Co. Inc., Industry Update, *A Penny Saved Is A Penny Gone – Blue Cross Capital Update*, April 19, 2009, at pgs. 6 and 9 [hereinafter "Oppenheimer Update"]. The number includes nonprofit and mutual Blue Cross and Blue Shield plans; *See also* AM Best, Key Financial Data, Not-for-Profit Blue Cross Blue Shield Plans – 2002 to second quarter 2004, Dec. 2004, cited at www.consumersunion.org/conv/nonprofit_health_inc/use_of_assets/health_plans'_surplus/index.html.

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based capital (RBC) – which is still comfortably above required minimums and higher than the average 532% that for-profit insurers retain – they would free up more than $7 billion.[2]

Last year's economic downturn had only a mild impact on the Blue plans' capital positions. Surplus dropped from 2007 levels; however, the average RBC ratio for Blue plans remained at 700% at the end of 2008, still far above the 200% of the authorized control level (ACL) necessary to avoid regulatory action and maintain the Blue Cross and Blue Shield Association (BCBSA) trademark and the 375% required by BCBSA to avoid an early warning event.[3] In mid-2008, a CareFirst spokesperson stated that the company had not been "materially impacted" by the turmoil in financial markets.[4]

As nonprofits have used their members' dollars to build these massive amounts of capital, consumers have struggled to pay for rising health plan premiums and out-of-pocket costs. In the District of Columbia, family premiums for employer-sponsored insurance average $14,187 per year, about the earnings of a full-time minimum wage job.[5] Average family premiums have increased by 103 percent since 2000, and 24 percent of middle-income District families spend more than 10 percent of their income on healthcare.[6] Further, 11 percent of District residents are uninsured.[7]

Many of our nation's nonprofit health plans have acted contrary to the best interests of consumers by maintaining surplus at the unprecedented levels of the past several years. In some cases, part of this surplus should be redirected toward more affordable premiums for members and non-members who most need help and for charitable healthcare activities for communities.

As one of only a few jurisdictions to enact a framework for addressing the problem of excessive surplus, the District of Columbia has a unique opportunity to set exacting standards for review. The District must provide a transparent and fair review process, in which advocates and community members have access to needed information and have an opportunity to present their views. The District also must carefully evaluate GHMSI's claims regarding its risk exposure and its need for a large store of capital. GHMSI's need for surplus must be balanced with its mission to provide accessible, affordable health care.

II. GHMSI HAS NOT SUFFICIENTLY JUSTIFIED ITS RECOMMENDED SURPLUS RANGE

In their submissions for this review, GHMSI and its actuarial firm, Milliman, contend that GHMSI's "optimal range" for surplus is between 750% and 1050% of RBC.[8] Our expert,

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[2] Oppenheimer Update at pg. 9.

[3] *Id.*

[4] *Despite Falling Markets, Not-for-Profit Blues Plans Expect Adequate Investment Results*, The AIS Guide to Blue Cross and Blue Shield Plans: 2009, pg. 84.

[5] The *Health Care Status Quo: Why the District of Columbia Needs Health Reform*, available at www.healthreform.gov/reports/statehealthreform/districtof columbia.html, citing statistics from the Center for Financing, Access and Cost Trends and the U.S. Census Bureau., accessed on August 24, 2009.

[6] *Id.*

[7] *Id.*

[8] As a threshold matter, GHMSI improperly refers to surplus as "reserves" in its July 31, 2009 report. "'Reserves' ...represent a Plan's best estimate of the funds it needs to pay for claims that have been incurred but not yet paid: they are liabilities. 'Surplus,' however represents what a Plan has in capital after all liabilities have been deducted from assets." *In Re: Applications of Capital BlueCross, Highmark Inc., Hospital Service Association of Northeastern Pennsylvania and Independence Blue Cross for Approval of Reserves and Surplus*, Determination of the Pennsylvania Insurance Commissioner, Feb. 9, 2005, pg. 10, available at http://www.ins.state.pa.us [hereinafter

David Kelleher, a healthcare and health plan management consultant who has used Monte Carlo simulations, has raised a number of concerns with Milliman's analysis, as described in this section. The primary concern is that Milliman has submitted a "trust us" report. The underlying assumptions and probabilities used to develop the recommended range cannot be evaluated or tested because they are not disclosed.

A. Modeling Assumptions

The Milliman report recites a long list of potential risks facing GHMSI. These include competition with for-profit national or regional plans, unanticipated underwriting losses, unpaid claims liabilities and other estimates, prolonged economic downturn and turmoil in the financial markets, membership declines (overhead expense recovery risk) and also growth in membership (which increases RBC requirements), default by self-funded employers, litigation risks, increases in utilization, changes in care management processes, new drugs, diagnostic tests and therapies, member direct marketing strategies and product development, access to capital when needed, the need to invest in information technology and new networks, and catastrophic events such as terrorism, epidemics, pandemics and natural disasters.

In order to quantify these many diverse and sometimes interactive risks, Milliman used Monte Carlo simulations. This approach allows a planner to simulate the combined results of many different variables. The program can run thousands of probability-based scenarios so that a planner may begin to appreciate the range and likelihood of various outcomes. In order to use this tool, each risk or contingency must be, as Milliman states, "divided into a discrete number of representative outcome values ... [and] assigned a probability or likelihood."[9] Because a number of risks are interrelated, the modeler must also specify when risks are independent or dependent.

These results on variation (cumulative probability distributions showing increasing losses) are then used with a baseline pro forma projection to produce a variety of scenarios that can show how often (probable) the plan might violate a number of its capital requirements.

In its modeling, Milliman set two thresholds goals:

- 95% certainty that capital will not decline below 375% of RBC-ACL and
- 98% certainty that capital will not decline below 200%.

This resulted in the recommendation that surplus be targeted in a range from 750% to 1050% of the ACL. The controlling limit is the 95% certainty that capital will not decline below BCBSA's warning level (375%), which means the estimated probability of approaching the District's action plan level (200%) was well below 2% (and, therefore, the probability of approaching the District's 100% control level infinitesimal).

The combination of Monte Carlo simulation with pro forma projections produces information that managers (and overseers) can use to establish reasonable targets for surplus balances. However, this is true only IF the assumptions used in the modeling are reasonable. Monte Carlo modeling is sensitive to assumptions and there are reasons to be concerned with the assumptions used in this case.

"PA Determination"]. The Commissioner should clarify the definitions of reserves and surplus and ask all parties to adhere to proper definitions.

[9] Milliman, *GHMSI Need for Statutory Surplus and Development of Optimal Surplus Target Range*, Dec. 4, 2008, pg. 46 [hereinafter "Milliman Report"].

The first concern is that the assumptions *are not disclosed.* We don't know what risks were included in the model, how they were quantified or how probable each event was assumed to be. Since Milliman lists many, many risks, some as large as pandemics and terrorist attacks, any output is possible.

Many, maybe most, of the assumptions that might be used in this modeling are not "actuarial" in nature. They can be understood and evaluated by people without actuarial or financial expertise.

When assumptions are not disclosed there is no requirement to justify them by history or deduction. Input can be manipulated to produce any result and no external reviewer can challenge the outcome.

B. Underwriting Cycle

The underwriting cycle used in Milliman's analysis also raises concern. The Milliman report contains substantial discussion about underwriting cycles – three years of gain followed by three years of loss. Some of the simulated losses are compared to loss cycles of GHMSI and/or examples from other Blue plans. But the assumption of predictable cycles is somewhat controversial. For example, the chart on page 34 purportedly demonstrating these cycles instead shows that GHMSI has not suffered an underwriting loss since 1994, a period of 14 years if we include the results of 2008. Again, since we don't know the assumptions used by Milliman, we don't know the affect of this potential risk.

C. Efficient Use of Capital

Operating a business involves risk. The question presented by this review is how much capital is prudent in GHMSI's business and when is it excessive. No reasonable amount of capital will be enough if the goal is absolute certainty. Even if all of Milliman's underlying assumptions are reasonable, the question remains: what reasonable amount of risk should the company undertake?

Milliman proposes that GHMSI should be 95% certain that it does not reach the BCBSA warning level. This warning level is 75% higher than the real danger: potential loss of the trademark and, concurrently, having to submit an action plan to regulators. A lower reserve target actually applies to the real risks (loss of license, action plan), and this is with 98% certainty.

What business demands 98% "insurance" against failure? For example, if we review the public commercial health insurers as a group, we find that they have negative tangible net equity.[10] If we eliminate the two largest plans with negative net equity (UnitedHealth Group and WellPoint) the next five largest carriers average tangible net equity of $196 per member. This compares to statutory net equity of $739 per member for GHMSI.

Milliman argues that, as a nonprofit, GHMSI needs to retain more surplus than publicly-traded insurers because it cannot go to the market for capital, suggesting that it is easier for public companies to raise capital than for nonprofits. However, no public company wants to be in the position of selling shares in order to fund losses. The cost of capital in this situation is

[10] Sherlock Pulse report, July 2009. While tangible net equity is not a perfect match to statutory net worth, it is a lot closer than GAAP net equity because intangibles are eliminated, as most of them are in the statutory presentations.

very high and the stockholders will strenuously object to substantial dilution when share prices are declining.

A recent study shows that rather than borrowing from markets, the seven largest publicly traded health insurers spent $52.4 billion buying back their own shares between 2003 and 2005, using "excess cash on hand or borrowed funds," to raise the value of their stocks for shareholders.[11] Thus, for-profit plans wish to use capital efficiently in order to maximize shareholder value. The same logic might be applied to nonprofits: they should wish to use capital efficiently in order to maximize benefits to their members and to the public.

Moreover, the Pennsylvania Insurance Commissioner cast doubt on this "access to capital" argument when she reviewed the surplus of her state's Blue plans. The Commissioner found that "[s]uch statements seem to imply that owner equity is a 'cheaper' or even 'no cost' source of funding. In fact, just the opposite is often the case. Since equity-supplied funding is not contractually guaranteed a specific return, a higher return than interest yields is demanded over time to compensate for additional risk."[12]

D. Investment Risk

From the table on page 47 of the Milliman report, we can determine that investment risk adds anywhere from 11% to 19% to the plan's risk profile.[13] Assumptions, again, are not disclosed but this is an awfully large presumed risk for a plan that invests mostly in bonds and other fixed income securities.

E. Growth Rates

The pro forma projections use revenue growth rates of 12% to 14%.[14] This presumably neutral forecast leads to the need for more reserves because of how RBC is calculated. However, over the last four years, GHMSI's growth has averaged just over 8%, with only one year above 12%. Blue Choice's revenues grew more rapidly but (given the large membership loss in mid-2008) may decline in 2009. Given this background, GHMSI has not provided enough information to determine why it used 12% to 14% growth rates.

III. GHMSI'S RECOMMENDED RANGE WOULD ALLOW GHMSI TO MAINTAIN AN UNREASONABLY LARGE SURPLUS

GHMSI uses an extraordinarily high optimal surplus range. GHMSI's Board of Directors adopted a policy under which the company "strives to operate with reserves (i.e., surplus) in an optimal range."[15] In 2005, on behalf of GHMSI, Milliman determined the optimal range to be between 800% and 1100% of RBC. The company apparently used this range until Milliman conducted a second review in 2008, and reset the optimal range between 750% and 1050% of RBC. GHMSI argues that its surplus is not unreasonably large because it is within this "optimal" range.

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[11] *Premiums Soaring in Consolidated Health Insurance Market*, Health Care for American NOW!, May 2009, pg. 7.
[12] PA Determination at pg. 14.
[13] Comparison of "all risk" with those excluding asset fluctuations (10% divided by 9% at the low end and 19% divided by 16% at the high end).
[14] Milliman Report at pg. 54.
[15] GHMSI Report, July 31, 2009, pg. 5.

On the basis of comparisons alone, both the minimum and maximum surplus levels recommended by Milliman for GHMSI should be carefully assessed. For example:

- The bottom of the range, or minimum capital level, recommended by Milliman is 750% of RBC-ACL. The average reserve level in 2008 for nonprofit and mutual Blue plans was 700%.[16] This puts the recommended *minimum* far above the average for Blue plans.

- At an 800% RBC ratio, the BCBSA makes "the presumption… that the Plan is sufficiently strong to meet it obligations to its insured *well into the future*."[17] The maximum of the Milliman recommended range is over 30% above this level, where it is presumed by BCBSA that the plan is well capitalized.[18]

- GHMSI's range is higher than both ranges adopted by the Pennsylvania Insurance Commissioner for the state's four Blue plans. The Commissioner determined that a range of 550% to 750% was sufficient for the two larger plans, and 750% to 950% was sufficient for the two smaller plans, such that the plans had "no need for a risk and contingency factor to be applied to their filed rates" while operating within these ranges.[19]

In addition, we are not assured that GHMSI has stopped, or intends to stop, building contributions to surplus into its rates while operating within its recommended range. GHMSI's rate filings indicate that the company continued to include contributions to surplus even as it operated well within its "optimal range." Actual contributions to surplus are not disclosed in the partial rate filings made public for this hearing. But the partial filings indicate that GHMSI contributed 4 cents of every premium dollar to surplus, even while its RBC ratio was above 900%. It apparently was not until August 2008, long after GHMSI's surplus came under scrutiny, that the company stated that "*in certain cases*" its rate filings would "*include less* contribution to reserves than past filings."[20]

GHMSI's policy is to use a comparatively high range of optimal surplus with no requirement to restrict contributions when its capital is within the range. If condoned, this policy will allow GHMSI to maintain an unreasonably large surplus without regard to its community health reinvestment obligation.

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[16] Oppenheimer Update at pg. 9.

[17] PA Determination at pg. 22.

[18] The BCBSA also requires its licensees to participate in a guaranty fund to protect members against insolvency. If the plan does not participate in a fund, it must use an alternative protection mechanism, such as reinsurance or a member protection account. If no alternative is used, the plan must maintain an 800% RBC ratio. GHMSI has not disclosed how it has satisfied this BCBSA requirement, nor has it disclosed whether it uses any other mechanisms for solvency protection, such as reinsurance, and what effect this has on its overall risk profile.

[19] PA Determination at pg. 37.

[20] Rate Filings 1127, 1168, 1198, and 1203. GHMSI states that its policy is to increase premium margins as surplus nears the bottom of the range and "moderate" rates or delay rate increases as surplus nears the top of the range. *See* GHMSI Report at pg. 5.

IV. GHMSI MUST BE HELD ACCOUNTABLE TO ITS NONPROFIT MISSION

CU recognizes the need for nonprofit insurers to maintain adequate surplus to protect against risks. But surplus levels also must comport with a nonprofit insurers' charitable and benevolent mission. The Medical Insurance Empowerment Amendment Act of 2008 [MIEAA] requires GHMSI to "engage in community health reinvestment to the maximum feasible extent consistent with financial soundness and efficiency." D.C. Code § 31-3505.01. Community health reinvestment is defined as "expenditures that promote and safeguard the public health or that benefit current and future subscribers, including premium rate reductions." D.C. Code § 31-3501(1A).

We see little evidence that GHMSI intends to determine the "maximum extent" to which it might fulfill these obligations and remain financially sound. Its actuarial report focuses entirely on the maximum amount of risk that GHMSI may or may not face. But, "[t]he reality is, no individual insurer can or should be permitted to collect or accumulate enough premiums to cover any and all catastrophic events no matter how remote or unforeseeable."[21]

Moreover, GHMSI places its members and its community in a catch-22. It argues that the best way to fulfill its mission is to maintain the extraordinarily high levels of surplus recommended in the Milliman report.[22] This circular argument ignores the community health reinvestment mandates of the MIEAA.

Maintaining solvency is important to fulfilling GHMSI's mission, but the evidence indicates that GHMSI has sacrificed its mission for the sake of "strength" even long after solvency and stability were well assured. GHMSI's rate filings provide just one example. In July 2008 – when GHMSI had $760 million in capital surplus – it tightened its underwriting requirements to make it harder for women and newborns to obtain coverage for pregnancy and pregnancy-related conditions.[23]

GHMSI must be held accountable to its nonprofit mission. Effectively, the public is the only "shareholder" of nonprofit GHMSI. The communities that "own" GHMSI simply can no longer tolerate this type of behavior from their financially-strong nonprofit health plan. GHMSI must be required to consider how to best serve the long-term healthcare needs of the communities it serves.

V. CONCLUSION

For the reasons stated above, we urge the Commissioner to take the following steps as part of its review:

- Require GHMSI to disclose, to the Commissioner and the public, the assumptions used in the Monte Carlo modeling and in the pro forma projections so that they may be reviewed for reasonableness.

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[21] PA Determination at pg. 12.

[22] *See* Milliman Report at pg. 3: "In order to fulfill its corporate mission, GHMSI must be stable and strong financially"; GHMSI Report at pg. 9: "Maintenance of strong reserves is not in avoidance of, but is, in fact, critical to maintaining the company's ability to deliver on its community mission through infrastructure improvements, community giving and rate moderation that benefits subscribers"; Milliman Report at pg. 11: " A significant requirement of meeting this mission and competing effectively is to maintain sufficient equity capital resources."

[23] *See* GHMSI Third Quarter Financial Statement, Sept. 30, 2008; Rate Filing 1151.

- Require GHMSI to clearly and comprehensively disclose for public review its annual charitable giving amounts and all expenditures that would qualify as community health reinvestment under the MEIAA.

- Develop a lower, more appropriate range for GHMSI sufficient surplus and restrict contributions to surplus within the range. Require a distribution plan if surplus exceeds the range, in accordance with the MEIAA.

- Set standards for GHMSI to meet the maximum contributions to community health reinvestment. For example, require GHMSI to commit a percentage of health premiums toward community health reinvestment.

We thank the Commissioner and the D.C. City Council for affording CU the opportunity to participate in this process.

Sincerely,

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