

Testimony of Sondra Roberto, Consumers Union
Hearing on GHMSI Surplus
District of Columbia Department of Insurance,
Securities and Banking
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Good morning. My name is Sondra Roberto and I am a staff attorney with Consumers Union in San Francisco. I thank you for giving me the opportunity to speak to you today about GHMSI surplus. I've come a long way to be here and it's because the question of whether a particular health plan is holding too much surplus is an important issue for healthcare consumers.

Today, I would like to limit my comments to three areas.

First, I will provide some background and discuss why these proceedings are so important to our nation's goal of making healthcare coverage affordable for everyone.

Second, I will discuss why GHMSI's adopted "optimal range" for surplus is too high and, if permitted to stand, would mean that GHMSI will not meet the "maximum feasible" standard of the D.C. statute.

Third, I will respectfully urge the Commissioner to take certain steps with respect to GHMSI's surplus.

CU views these surplus proceedings as part of a widespread and ongoing effort by regulators, advocates, and consumers to hold non-profit healthcare corporations accountable to their

missions. For example, for more than a decade, CU and other groups have worked to protect and redirect the charitable assets of non-profit insurers when they converted to for-profit corporations to ensure that these assets continued to benefit communities and help meet their healthcare needs. This work is based on established legal principles that hold that the assets generated by a nonprofit corporation must further the non-profit's charitable mission and purpose.

The same principles apply to the surplus of a non-profit plan. The plan's surplus is an asset which must be used primarily to fulfill the plan's mission as a charitable and benevolent institution.

Maintaining adequate surplus is no doubt important for the solvency of the plan and fulfillment of its charitable mission. But we have seen that for some non-profit plans, surplus has become excessive to the point where it no longer serves the best interests of the plan's policyholders and the community in which the plan operates.

CU supports your effort to determine whether GHMSI has reached that point. At a time when all of America is debating how we can hold health plans accountable, how we can extend coverage to those in need, and how we can make healthcare more affordable, your proceedings here are an extremely valuable contribution. We welcome the attention that D.C. is giving to the issue of excessive surplus.

On this subject, I note that GHMSI has used considerable space in its pre-hearing reports expressing regret that D.C. has undertaken this

effort. For example, the company stated that "it is important to note that the usual posture of regulators in the health insurance field has been to focus on the solvency and financial strength of insurers ... in essence, the most important question for the regulator, from the standpoint of protecting the consumers who purchase insurance coverage, is whether, come what may, the Company has the solid financial footing necessary to meet its obligations to pay claims." GHMSI believes that, quote, "the notion that an insurer can offer its subscribers too much in the way of financial protection is at odds with historical conceptions of insurance regulation," unquote.

We agree that a regulatory focus on health plan financial stability is critical and must continue. But it need not be to the exclusion of other consumer protections. Our state insurance departments should exercise their authority to the fullest extent possible to increase the numbers of consumers getting access to care and to make sure people are getting their money's worth from their health insurance. We believe that more states should, and will, begin to focus on excessive surplus as premiums continue to escalate and community healthcare needs go unmet.

Other states will look to D.C., as a precedent-setting jurisdiction, to evaluate how you have approached this problem. By adhering to values of transparency, fairness, and thoroughness, you will provide guidance for similar proceedings to come.

We also disagree with GHMSI's suggestion that an insurer can never have too much surplus.

For one, as I already suggested, surplus that is two, three, or more times greater than the authorized control level for risk based capital can indicate that the insurer is not meeting its obligations as a charitable institution. Excess funds held in surplus can and should be redirected toward more affordable premiums for existing and prospective policyholders and for charitable giving to programs that help the uninsured or underinsured.

In addition, rapid growth in surplus, such as we have seen in the past decade among many plans, means that policyholders and employers may be paying too much in premiums. When surplus reaches a comfortable level, where insolvency is a very remote possibility, policyholders should not have to pay contributions to surplus.

Regulatory review of surplus is important for these reasons. Moreover, surplus review, along with rate review, is necessary to make health insurance markets function as efficiently as possible. Studies have shown that most local health insurance markets across the nation are concentrated, with one or two health plans holding a majority of market share. In D.C., GHMSI is the dominant player. In theory, non-profit plans with sufficient surplus should be able to price aggressively. This drives fiercer competition with for-profits and leads to more competitive pricing for all purchasers. But dominant insurers with market power have little incentive to price aggressively. Regulatory surplus and rate review benefit everyone by helping to address the problem of concentrated markets.

We also disagree with GHMSI's argument that any distribution of excess surplus to public

programs would mean that "existing GHMSI subscribers can be made to shoulder not only their own costs, but those of others who are not subscribers."

In reality, GHMSI's policyholders are already shouldering that burden. The federal government estimates that right now hospitals and doctors in the District of Columbia lose more than \$141 million in uncompensated care, which they often pass along to insured families in the form of a hidden tax on premiums.¹ Remarkably, Milliman itself conducted a recent study which found that in 2008 families across the nation paid an average of more than \$1,000 in higher premiums to cover more than \$42 billion in uncompensated care.² Therefore, any community health reinvestments that directly provide charitable care or subsidize low-cost insurance for those who need it will benefit GHMSI's existing policyholders by alleviating the hidden tax.

Of course, for-profit health plans also must be regulated and held accountable if we are to make healthcare available and affordable for everyone. But here in D.C., where GHMSI has the highest market share, it is best positioned to play the leader in providing community health reinvestments. These reinvestments can and should include rate relief or cost-sharing relief for existing subscribers, low-cost coverage for prospective subscribers AND public health programs that benefit the community at large.

¹ See *How Health Insurance Reform Will Benefit the District of Columbia*, at <http://www.healthreform.gov/reports/statehealthreform/districtofcolumbia.html>

² See Families USA, *Hidden Health Tax: Americans Pay a Premium*, 2009, at pgs. 5-6, available at <http://www.familiesusa.org/assets/pdfs/hidden-health-tax.pdf>

The notion that the plan's community health reinvestment requirement benefits non-subscribers to the detriment of subscribers is false. The plan, along with the Commissioner, can work to identify the most important community needs and develop the right mix of programs or products to address those needs.

Now, I'd like to turn to some specific problems with GHMSI's adopted optimal surplus range of 750 percent to 1,050 percent of the risk based capital authorized control level, or RBC-ACL. As I stated in my pre-hearing letter, CU urges you to reject this range for several reasons. I will not describe them here, but will point out the most glaring shortcomings.

Milliman essentially has developed a range for surplus and said, "trust us, we know it's right." CU had an expert in health plan management review the Milliman recommendations. Our expert could not test or evaluate Milliman's analysis because Milliman did not disclose its underlying assumptions. We don't know what risks were included in Milliman's modeling, how they were quantified or how probable each event was assumed to be. The Commissioner should not accept Milliman's optimal range without learning the assumptions and probabilities used to achieve the outcome.

Our expert also questioned, among other aspects of the report, why Milliman used revenue growth rates of 12 percent to 14 percent when GHMSI's growth rate has averaged about 8 percent with only one year above 12 percent. The higher growth rate leads to the need for more surplus.

Further, when questioned about excessive surplus, non-profit health plans, including GHMSI, repeatedly argue that they need large stores of capital for improvements, new products, or the ability to respond to market changes. They suggest that it is easier for their for-profit competitors to raise money because they can sell stock. However, neither GHMSI or any other non-profit that we know of has put forth evidence showing that for-profit health plans regularly sell stock to raise capital. In fact, in a surplus proceeding in Pennsylvania, the Insurance Commissioner cast doubt on this argument when she pointed out that it misleadingly implies that selling stock is a cheaper source of funding than other forms of borrowing.³

In addition to the questions raised by our expert, Milliman's range is simply too high. It would allow GHMSI to maintain surplus up to five times higher than RBC-ACL. We don't see how GHMSI can maintain surplus at this level and comply with D.C.'s requirement that it engage in community reinvestment to the maximum feasible extent consistent with financial soundness and efficiency.

I note that Milliman's range for GHMSI is higher than both ranges adopted by the Pennsylvania Insurance Commissioner for the state's four Blues plans. The Commissioner determined that a range of 550 percent to 750 percent was sufficient for the two larger plans, and 750 percent to 950 percent was sufficient for the two smaller plans. The Commissioner rejected Milliman's recommended range in that case as too high.

³ *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, at pg. 14.

GHMSI has submitted a brief report from the Lewin Group, which GHMSI says supports Milliman's conclusions. However, the Lewin report is tepid at best. The Lewin Group stated that its review "does not allow us to comment as to whether we would have produced the same range of surplus requirements as shown in the Milliman report." Significantly, after the Pennsylvania Commissioner established a sufficient surplus range of 550 percent to 750 percent for plans similar in size to GHMSI, the Lewin Group wrote a report for the state legislature in which it stated that the Commissioner, quote "set reasonable bounds on the Pennsylvania Blue plans' accumulation of surplus, and is unlikely to disrupt the Pennsylvania insurance market" unquote.⁴

For these reasons, and others set forth in my pre-hearing letter, the Commissioner should reject GHMSI's and Milliman's optimal range.

So if Milliman's range is too high, what is an appropriate surplus range for GHMSI? And is GHMSI's surplus unreasonably large right now? To conclude my testimony, I would like to urge the Commissioner to take the following steps to answer these questions.

1. Seek more information from GHMSI. As noted, we don't know how Milliman reached its optimal range or why it used certain assumptions.

In addition, our analysis of GHMSI's 2008 financial statement shows a large increase in non-admitted assets, which led to a decrease in surplus. The Commissioner needs to know what these

⁴ The Lewin Group, *Considerations for Regulating Surplus Accumulation and Community Benefit Activities of Pennsylvania's Blue Cross and Blue Shield Plans*, June 13, 2005, at pg. 22 ["the Lewin PA Report"].

increases were and why they were accounted for at this time.

Also, more information is needed about GHMSI's other risk protection mechanisms. For example, the Blue Cross Blue Shield Association requires all of its licensees to participate in a guaranty fund, use an alternate mechanism such as a subscriber protection account, or, in the absence of either of these conditions, maintain surplus at 800 percent of ACL.⁵ We would like to know how GHMSI has satisfied this requirement and whether it was considered in the company's risk profile.

2. We urge the Commissioner to require GHMSI to annually report all activities that meet the definition of community health reinvestments and how much money was used for each activity. This report should be clear, comprehensive, and made public. Consumers need to be able to see exactly how GHMSI is meeting the statutory requirements.

3. We urge the Commissioner to hire an independent actuary to determine an appropriate sufficient range for GHMSI surplus that takes into account the requirement that GHMSI contribute to community health reinvestment to the maximum extent feasible.

4. After determining a sufficient surplus range, the Commissioner should limit contributions to surplus while GHMSI is operating within the range.

5. We urge you to use your authority under D.C.'s prior approval statute to consider surplus when reviewing rate increase requests for individuals and small groups. Rhode Island, for example, has

⁵ See Lewin PA Report, at pg. 12.

rejected requested increases based on the amount of surplus held by that state's Blue plan. Rate approval should not be merely a rubber stamp. Going forward, we urge the Commissioner to carefully consider, in light of its surplus, GHMSI's need for increases, or the need for other measures imposing hardship on its existing and prospective subscribers, such as tightening underwriting requirements for pregnant women and newborns as it did in July 2008.

I'll conclude with a final comment regarding the determination of surplus that is attributable to the District. We believe that using a residency standard, as GHMSI believes you should, would lead to an unfair result. After all, D.C. employers paid for large portions of the premiums that funded GHMSI's surplus. The Commissioner should work with all jurisdictions involved to create a more appropriate standard for this determination taking into account several factors, including revenue and subscribers in each jurisdiction, the contracting entities, the providers, and the needs of the relevant communities.

Thank you for having me here today and for engaging in this important process.