Excess Surplus Review and Determination Regarding
Group Hospitalization and Medical Services, Inc.

District of Columbia Department of Insurance, Securities, and Banking

Supplemental Report on the Effects of Federal Health Care Reform and Rebuttal Statement

Submitted by the
DC Appleseed Center for Law and Justice, Inc.

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September 20, 2010

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INTRODUCTION AND EXECUTIVE SUMMARY

Pursuant to the Commissioner's August 6 Decision and Order (Decision), DC Appleseed is submitting this response to the September 3 filing of Group Hospitalization and Medical Services, Inc. (GHMSI). As invited by the Commissioner, we are both commenting on the financial impact of Federal Health Care Reform (FHCR)[1] on GHMSI and rebutting certain other contentions in GHMSI's filing.

As explained in the three sections that follow, DC Appleseed wishes to make three essential points to the Commissioner:

First, while FHCR contemplates major changes for health insurers, there is no basis in law or fact for authorizing an increase in GHMSI's surplus requirements in this proceeding. In fact, GHMSI acknowledges in its own filing that (1) it does not have sufficient data yet to calculate the size of any needed surplus adjustment, admitting that "this could take some time—perhaps well into 2011 and beyond"[2] and (2) "because the impacts of FHCR cannot yet be quantified GHMSI has *not* set aside reserves to account for them."[3] And yet, GHMSI has asked the Commissioner to raise the company's allowable surplus—when the company itself says "the impacts of FHCR cannot yet be quantified."

The Commissioner should not do so. In fact, not only is it too early to quantify the impact of FHCR, but based on what *is* known about the overall impacts at this point, they appear to be minimal for GHMSI. Moreover, even if FHCR posed significant downside risks to GHMSI, GHMSI has not shown those risks to be net of the substantial benefits to insurers from the FHCR, nor has GHMSI shown that those downside risks could *not* be captured through premium increases or that those risks would cause reduction in surplus. In addition, the Milliman model, upon which GHMSI has so heavily relied in these proceedings, appears to have already accounted for such risks. That model was designed to protect GHMSI from any and all risks—foreseen and not foreseen—that might cause a prolonged, severe downturn in the company's net earnings. Finally, the appropriate time to account for any additional surplus risks posed by FHCR would be in the Commissioner's *next* surplus review, which under the statute's mandatory three-year review requirement will begin in 2011—the very time GHMSI says data would become available to measure FHCR's impacts. Meanwhile, the Commissioner will of course have the opportunity to review any proposed GHMSI rate increases related to FHCR.

Second, DC Appleseed addresses the report prepared by Rector and Associates, Inc. (Rector) for the Commissioner (Rector Report). As the Commissioner knows, DC Appleseed engaged its own actuarial experts, Actuarial Risk Management (ARM), at a time when it

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[1] All references to "Federal Health Care Reform" or "FHCR" are to the Patient Protection and Affordable Care Act, Pub. L. 111-148, as amended by the Health Care and Education Affordability Reconciliation Act of 2010, Pub. L. 111-152.

[2] GHMSI, Supplemental Report on Effects of Federal Health Care Reform, at 15 (Sept. 3, 2010) ("GHMSI Supplemental Submission")

[3] *Id.* at 13.

appeared that no independent actuarial analysis of GHMSI's surplus would be done, apart from that engaged by GHMSI itself. We therefore welcome Rector's careful analysis in its report. And while we believe it was unfair that DC Appleseed and ARM were not given access to the data and calculations made available to Milliman, Lewin, and Invotex, causing the Commissioner to disregard ARM's work on those grounds, we nevertheless believe that the Rector Report alone provides a strong and sufficient basis for the Commissioner's determination concerning GHMSI's surplus.

Specifically, we believe that the Rector Report demonstrates that a maximum Risk Based Capital (RBC) ratio of 600% should be approved for GHMSI. This figure, as Rector explains, is based on assumptions even more conservative than Milliman's and would be sufficient to ensure with 99% confidence that GHMSI would not fall below 200% RBC. That measure—unlike those favored by Milliman and Lewin—accords with the requirements of the Medical Insurance Empowerment Amendment Act of 2008 (MIEAA) that GHMSI adopt a surplus level that both ensures its financial soundness and efficiency and commits it to the maximum feasible amount of community reinvestment. The peer review analyses conducted by Rector, Invotex, and ARM confirm the reliability of the 600% RBC measure, as does the fact that the RBC ratio of GHMSI's sister company, CareFirst of Maryland, Inc. (CFMI) was 503% in 2008 and 515% in 2009. Finally, as we will show, Rector's 600% measure is consistent with the principles adopted independently by the Pennsylvania Insurance Commissioner.

Third, both the Rector Report and the Decision identified key factors that indicate that 60% to 70% of GHMSI's excess surplus is attributable to the District of Columbia. GHMSI's own 1999-2008 annual statements show that approximately 69% of GHMSI's premiums and claims expenses for that period were attributable to policies or contracts issued in the District.[4] Moreover, as ARM's November 2, 2009 rebuttal report showed, more than 60% of GHMSI's underwriting gains for the last four years (2005-2008) were attributable to DC contracts. GHMSI's sole response to these data is that attribution must be based only on the residence of subscribers because, the company contends, any spend-down of surplus ordered by the Commissioner must go to District residents. However, as we have shown before, this position is completely inconsistent with the statutory requirements that govern this proceeding. It is also completely inconsistent with GHMSI's own longstanding reporting practice.

For all these reasons, set out in detail in this filing, we urge the Commissioner to: (1) decline to further adjust GHMSI's surplus at this time due to potential implications of FHCR; (2) determine that, under the governing statute, GHMSI's RBC ratio must be set no higher than 600%; and (3) conclude that a minimum of 60% of GHMSI's surplus is attributable to the District of Columbia. It is critical to the interests of the citizens of the national capital area that these issues be promptly resolved.

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[4] DISB Decision and Order, Aug. 6, 2010, at 11 *available at* http://disb.dc.gov/disr/frames.asp?doc=/disr/lib/disr/pdf/Surplus_Review_and_Determination_Regarding_Group_Hospitalization_and_Medical_Services_Inc_Decision_and_Order.PDF ("Aug. 6 Decision"); Rector & Assoc., Inc., *Report to the D.C. Dept. of Ins., Sec. and Banking, Group Hospitalization and Medical Servs.*, at 20-21 ("Rector Report").

I. FEDERAL HEALTH CARE REFORM SHOULD NOT AFFECT THE DETERMINATION OF THE LEVEL OF GHMSI'S SURPLUS AS OF DECEMBER 31, 2008 THAT WAS CONSISTENT WITH ITS FINANCIAL SOUNDNESS AND EFFICIENCY.

Introduction

FHCR requires sweeping changes to the U.S. health care system,[5] and the Commissioner understandably wanted to hear from the parties on the possible implications of this new legislation for this proceeding.[6] This effort has been worthwhile, for it confirms that there is no basis in law or fact for increasing GHMSI's surplus above the level that the evidence already in the record supports as the proper level under MIEAA.

Both FHCR and MIEAA provide ample opportunities to factor impacts of the new legislation into GHMSI's surplus needs on a timely and well-grounded, rather than speculative, basis. While some provisions of FHCR go into effect now, others will go into effect over a period extending to 2018, with 2014 a key year for many important provisions. Between now and 2014, the Commissioner could conduct no less than three proceedings under MIEAA to review GHMSI's surplus requirements.

Over these years, numerous public and private entities will be refining their estimates of the effects of the provisions that go into effect in 2014 and beyond. Actual experience will develop under the provisions that go into effect sooner, and there will be a collective maturation of understanding. In contrast, GHMSI's suggestion that the Commissioner make a judgment on this issue now invites action that is contrary to MIEAA, unsupportable on this record, and premature, unnecessary and unwise. That the U.S. Department of Health and Human Services (HHS) has yet to issue implementing regulations, that the Secretary of HHS has warned against "premature" "business decisions," and that Republicans are committed to repealing or substantially modifying the legislation, only underscore these points.

Moreover, to consider increases in GHMSI's surplus for costs that are not yet resolved in rate adjustments is putting the cart before the horse. GHMSI has stated that it has not yetaccounted for the effects of FHCR, but anticipates the need for rate increases of 2% to 6%.[7] Premiums are the first means of cost recovery and customarily include load factors to cover unquantified contingencies. In contrast, surplus is intended to cover revenues that are overestimated or costs that are underestimated in premiums. The effect of increasing GHMSI's surplus would be to defer its having to justify rate increases under the enhanced rate-review

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[5] These health insurance reforms are intended to hold insurance companies more accountable, lower health care costs, guarantee more health care choices, and enhance the quality of health care. *Understanding the Affordable Care Act*, Healthcare.gov, *available at* http://www.healthcare.gov/law/introduction/index.html (last visited Sept. 12, 2010) ("Healthcare.gov Affordable Care Act").

[6] *See* Aug. 6 Decision, at 16; GHMSI, Supplemental Submission, at 1, 5.

[7] *Health care reform:*? Not the costs, Baltimore Business Journal, Sept. 9, 2010 *available at* http://washington.bizjournals.com/washington/blog/2010/09/health_care_reform_not_the_costs.html?surround=lfn ("Health care reform?").

procedures that the District is developing with the aid of a federal grant under FHCR. The evidence that GHMSI has offered to support a surplus increase attributable to the new legislation is far short of the standard for regulatory approval of an increase in its contingency load in new rates.[8]

The federal agencies charged with implementing and studying the new legislation expect insurers to recover cost related to the provisions that go into effect now through premiums. The federal estimates indicate that the premium increases will be small—on the order of a fraction of a percent for some provisions to two percent for others.[9]

In its filing, GHMSI obscures the role of surplus, which (as stated above) is not the primary means of cost recovery, and it fails to mention any steps taken to adjust surplus in anticipation of FHCR impacts. GHMSI speaks a good deal about the present uncertainty, but it fails to acknowledge that uncertainty around a small value is still a small value. A 10% underestimate of a 1% expected cost increase is an error of one-tenth of 1%; this is the error that surplus addresses. This basic point highlights the gap between the wholly qualitative discussion of risks in the latest Milliman and Lewin reports, and their unexplained suggestion that increases in surplus of 100 to 200 percentage points (Milliman) or 10% (Lewin) are now in order.

As in earlier reports, GHMSI proffers its latest assertions without acknowledging the balance struck in MIEAA. As a general legal proposition, it is doubtful that MIEAA would allow GHMSI's permitted surplus as of December 31, 2008 to be increased on the basis of legislation enacted in 2010. However, that issue need not be resolved because it is clear that the record does not support such an increase.

There are at least eight independent reasons why the Commissioner should not adjust GHMSI's surplus measure to account for FHCR in this proceeding:

1. GHMSI's description of the effects of FHCR omits key provisions that protect insurers from unforeseen risk or provide upside benefits, together potentially

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[8] GHMSI makes the unfounded assertion that the possibility of rate increases should be discounted because of possible "arbitrary" denials by the Commissioner. GHMSI Supplemental Submission, at 4. The possibility of arbitrary denials by the Commissioner is hardly a reason for the Commissioner to increase surplus. Further, one of the most basic safeguards applicable to regulatory agencies is the prohibition on arbitrary action, and it is fundamental that reviewing courts must set aside such actions.

See D.C. Code. § 2-510 (requiring a reviewing court to "hold unlawful and set aside any [agency] action" found to be "[a]rbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law"); *President & Dirs. of Georgetown Col. v. District of Columbia Bd. of Zoning Adjustment*, 837 A.2d 58 (D.C. 2003) (holding that certain requirements imposed by the Board of Zoning Adjustment on Georgetown were arbitrary and capricious); *Cf.* 5 U.S.C. § 706(2)(A).

[9] *See* 75 Fed. Reg. 37,188, 37, 216 (June 28, 2010); HHS Letter to America's Health Ins. Plans ("AHIP")(Sept. 9, 2010), *available at* http://www.hhs.gov/news/press/2010pres/09/20100909a.html. ("HHS Letter to AHIP").

offering insurers net benefits, and highlighting GHMSI's unsupported assumption that the risks will substantially outweigh the benefits.

2. As Invotex's analysis expressly confirms, Milliman's model, which Rector also adopts, already accounts for potential risks associated with FHCR. Therefore, to adjust GHMSI's surplus again to account for such risks would double count their effects.

3. The available evidence demonstrates that, to the extent that FHCR impacts can be quantified, they will be minimal and recaptured through modest premium increases, without need to adjust surplus. GHMSI's own public statements confirm this.

4. It is in any case premature to adjust GHMSI's surplus level in this proceeding for changes not scheduled to take effect until 2014 or later—even assuming that a rate review does not address those changes and, therefore, they might affect surplus. If this occurs, it can and should be considered in a later surplus proceeding when any impacts can be better measured.

5. It is premature to adjust surplus based on perceived risks from FHCR, given that the legislation may be repealed or substantially modified in the next Congress, or overturned in the courts.

6. GHMSI's request for an increase of 100-200 percentage points in its RBC is unsubstantiated. Moreover, it is contradicted by the company's admission that it cannot calculate the impacts of FHCR until 2011 and has not yet attempted to adjust its surplus for FHCR.

7. It is not in keeping with the purpose of MIEAA to permit such an unsubstantiated request for increase in surplus. Such an increase contravenes the statute's requirement that the company maximize community reinvestment and forces subscribers to pay higher premiums, in effect skirting the enhanced rate review processes that the Commissioner is developing under a federal grant.

8. The Commissioner will have ample opportunity to evaluate any need for surplus increase due to FHCR in future proceedings, when there is sufficient certainty about FHCR's impacts to warrant such an increase.

These points are developed further in the four sections immediately below.

A. Federal Health Care Reform Includes Important Provisions to Help Insulate Insurers from Risk, and Milliman's Conservative Model Already Accounts for Any Remaining Risks.

1. GHMSI Ignores Critical Protections in Federal Health Care Reform and Potential Upside Impacts.

GHMSI relies on analysts that recognize the potential upside benefits of FHCR for insurers—for example, market expansion and premium growth resulting from the mandate for individuals to purchase insurance coverage—but GHMSI does not acknowledge these upsides, and instead simply assuming that the downside risks of FHCR outweigh any potential benefits. In fact, as we discuss below, FHCR includes important protections that constrain insurer's risks, as well as other provisions expected to benefit insurers.

a) Numerous provisions of FHCR reduce insurer risk.

Risk Corridors. The law requires the Secretary of HHS to establish a risk corridor program effective 2014 through 2016.[10] Under this program, HHS will make payments to qualified health plans[11] if their non-administrative (medical) costs, *after* deducting risk adjustment or reinsurance payments as described below, exceed 103% of their medical cost target.[12]

These payments will cover half of carriers' medical costs above 103% of their target and, for those whose medical costs exceed 108% of their target, 2.5% of their target plus 80% of medical costs above 108% of their target.[13]

Reinsurance. FHCR also requires each State to establish (or contract with a reinsurance entity to provide) a transitional reinsurance program for carriers in the individual market for plan years 2014 through 2016.[14] Insurers that insure high-risk individuals will receive payments based either on a schedule of payments for each high-risk medical condition or another method recommended by the American Academy of Actuaries.[15] This program will "help stabilize premiums for coverage during the first 3 years of operation of [the state health insurance

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[10] FHCR, § 1342. This program is to be based on the program for regional participating provider organizations under Medicare Part D.

[11] Section 1301 of FHCR defines a "qualified health plan" as a health plan that meets the criteria for an offer through a state health insurance exchange, provides the essential health benefits package, and is offered by a health insurance issuer that is licensed and in good standing in each State in which it offers health insurance coverage under FHCR.

[12] The plans must make payments to HHS if that ratio is below 97%. *Id.* § 1342.

[13] *Id.*

[14] *Id.* § 1341.

[15] *Id.*

exchanges] when the risk of adverse selection related to the new rating rules and market changes is greatest."[16]

Risk Adjustment. Finally, FHCR requires each State to establish a permanent program to make payments to qualified individual and small group health plans with more high-risk enrollees than the average among all insured (individual, small group, and large group) living in that State.[17]

Although no guidance has yet been issued on these provisions, individually and collectively they are intended to limit the risk of adverse selection associated with FHCR. While both the Congressional Budget Office (CBO)[18] and the American Academy of Actuaries[19] have recognized their important effects, GHMSI disregards them.

b) FHCR affords significant benefits for insurers.

GHMSI fails to fairly account for a number of widely acknowledged, major upside benefits that health insurers can expect from the new legislation. For example:

- Milliman identifies upside benefits to include: (a) the potential for more customers due to the individual mandate, government subsidies, and penalties for remaining uninsured; (b) potentially higher revenue per customer due to enhanced benefits; (c) growth opportunities from changes in the competitive environment and Medicaid expansion; (d) the operation of state health insurance exchanges that simplify administration and offer an effective new distribution channel; and (e) potentially reduced health care cost trends achieved through accountable care organizations.[20]

- PricewaterhouseCoopers (PwC) similarly notes that "[m]oving business to the exchanges creates an important opportunity to grow membership while compensating for dwindling group market membership. Leveraging the existing network of providers in an exchange plan will mean less marketing and underwriting and lower or standardized commissions to insurance brokers."[21] PwC also indicates that the insurance exchanges, which will be implemented beginning in 2014, are likely to improve carriers' medical loss ratios (MLRs), which "are lower in the individual market because of the higher costs involved

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16 *Id.*

17 *Id.* § 1343. Moreover, each State must assess health plans if the actuarial risk of their enrollees is less than the average actuarial risk in that State. *Id.* The Secretary of HHS must establish criteria and methods for these risk adjustment activities. *Id.*

18 CBO, Key Issues in Analyzing Major Health Insurance Proposals, at 88 (2008) ("CBO Key Issues").

19 American Academy of Actuaries, Risk Assessment and Risk Adjustment, *available at* http://www.actuary.org/pdf/health/Risk_Adjustment_Issue_Brief_Final_5-26-10.pdf ("Academy of Actuaries").

20 Milliman, CareFirst, Inc., *GHMSI, Need for Statutory Surplus and Development of Optimal Surplus Target Range,* at 2-3 (Dec. 4, 2008), Att. A to GHMSI Supplemental Submission ("Milliman Report").

21 PricewaterhouseCoopers, *Health Reform* at 22 (2010), a*vailable at* http://www.pwc.com/us/en/health-industries/publications/prospering-in-a-post-reform-world.jhtml ("PWC").

in selling and administering policies."[22] All else equal, this would imply reduced need for surplus.

- Independent analyst Edward Jones notes that the impact of exchange rules requiring insurers to accept subscribers with pre-existing conditions, to remove lifetime spending limits, and to guarantee coverage to all legal residents, "could be largely offset if reform also attracts enough younger, healthier people (who typically have lower costs) into the system."[23] Other "[p]ositives include the potential of adding many newly insured Americans, and the companies' opportunity to work with the government in shaping the individual mandate and minimum medical spending ratio."[24]

- Booz & Co. similarly notes that broader risk spreading resulting from the individual mandate to purchase insurance should ameliorate concerns about potential adverse selection.[25]

- A study by the Pennsylvania Health Access Network, a coalition of organizations that promote fair and widespread health insurance coverage, commented that large insurance companies, in particular, could benefit from FHCR by increasing their customer base: "All of these companies will have access to a gigantic new market of customers, and are likely to profit significantly from this expansion."[26]

- Lewin goes so far as to project "reduced risk for insurers because individual coverage will increase by 19.3 million, to a total of 31.0 million covered under [FHCR,] . . . [providing] a broad base for spreading risk."[27] In fact, Lewin projects *overall savings* and counters GHMSI's claim that the excise tax will lead to increased costs.[28]

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22 *Id.*

23 Edward Jones, *Health Care Reform: Understanding the Investment Implications* at 2 (Apr. 15, 2010), *available at* http://www.edwardjones.com/groups/ejw_content/@ejw/@us/@research/documents/web_content/web222678.pdf ("Edward Jones")

24 *Id.*

25 Booz & Co., *2010 Health Industry Perspective* at 2 (2010), *available at* http://www.booz.com/media/uploads/Health_Perspective_2010.pdf ("Booz & Co.").

26 Michael Wood, Alison Chen and Sharon Ward, *adultBasic Sings the Blues: 45,927 Pennsylvanians Will Lose Health Insurance in 2011*, PA Health Access Network, at 17 ("Wood, Chen and Ward") (study concerning the Blues' refusal to voluntarily extend their funding of adultBasic, a health insurance program for low-income residents not eligible for Medicare or Medicaid).

27 Lewin Group, *Patient Protection and Affordable Care Act (PPACA): Long Term Costs for Governments, Employers, Families and Providers* at 19, June 8, 2010, *available at* http://www.lewin.com/content/publications/LewinGroupAnalysis-PatientProtectionandAffordableCareAct2010.pdf ("Lewin PPACA"). Lewin explains: "This means that plans can eliminate preexisting condition exclusions while enrolling both healthy and sicker people currently excluded from coverage. This broadened risk pool for individual coverage is necessary to eliminate medical underwriting in the individual market without causing large increases in premiums [.]" *Id.*

(continued...)

It appears that GHMSI, Milliman and Lewin accorded little, if any, weight to the many potential upside impacts of FHCR in suggesting the need for a GHMSI surplus increase. Instead, while emphasizing that they cannot quantify FHCR effects, they conclude that GHMSI requires very substantial increases in surplus—100-200 percentage points (Milliman) or 10% (Lewin).[29] Thus, they offer a quantification that they acknowledge cannot fairly be made. And in offering that quantification, they assume that the downside risks will exceed the upside by a substantial and quantifiable amount. The evidence that they present simply does not support their conclusions, and to utilize such conclusions to justify a significant surplus increase would be unsustainable under MIEAA.

2. The Milliman Model Already Captures Remaining Potential Risks Associated with Federal Health Care Reform.

As discussed above, GHMSI is suggesting significant upward adjustment in its allowable surplus to protect against what it asserts will be a prolonged and significant downturn in net income as a result of FHCR. But as we understand the Milliman model, it was designed to address precisely those risks. It is owing to such risks (among others) that Milliman, Invotex, and Rector argue, respectively, for a surplus of 750% to 1050% RBC-ACL, 700% to 950% RBC-ACL, and (after making certain adjustments to the model), 600% or 850% RBC-ACL. All three applications of the model included, among other things, what Milliman called "Business Risks," "Catastrophic Events," and "Unidentified Development and Growth."[30]

In short, the Milliman model is designed to guard against any and all risks that might befall the company and cause a downturn, and therefore appears to capture the impacts of legislative action that might cause such a downturn—especially when risk is appropriately measured as a residual net of federal reinsurance and state risk adjustments. The Milliman model therefore *already accounts* for FHCR, and the resulting surplus calculations should not now be adjusted for a second time.

Indeed, Milliman appeared to confirm this point at the September 2009 hearing. At that hearing, Mr. Dobson testified about the content of each of the risk factors in the model and said as to the "provision for unidentified development and growth" that it "reflects the possibility of unanticipated investment needs, such as new systems, or administrative processes, development of new products, *or response to legislation.*"[31] Invotex was even more explicit on this point,

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[28] Specifically, Lewin anticipates "savings of about $26.7 billion under [FHCR] due to changes in benefits over the 2011 through 2019 period. These include the effects of increased competition in the exchanges and benefits reductions in response to the increased prices resulting from the excise taxes of [FHCR]." *Id.*]

[29] GHMSI Supplemental Submission, at i (citing Milliman Inc., *Impact of Federal Health Care Reform on* GHMSI's *Risk Profile and Optimal Surplus Targets*, at 3-4 (Sept. 1, 2010) ("Milliman Impact of FHCR Report") and Lewin Consulting, *Reaction to Rector Report and DC DISB 8/6/2010 Order*, at 6 (Sept. 2, 2010) ("Lewin Reaction to Rector Report")).

[30] Milliman Report, at 43-44.

[31] *Public Hearing on Surplus and Review of GHMSI Before the District of Columbia Department of Insurance, Securities and Banking* at 33 (Sept. 10, 2009). ("Hearing Sept. 10"), (emphasis added).

expressly stating in its report that the "Catastrophic events" element of the Milliman model includes "provision for events such as federal health care reform activities that could produce losses to the companies."[32]

For Milliman now simply to assert that it believes that its prior estimates were too low would not rebut the existence of a double-count. Even if such an assertion were credible, it could at most indicate that there is a partial, but not a total, double-count. Moreover, it would still fail to justify increasing GHMSI's allowed surplus now: much of any claimed under-estimate would relate to provisions that will go into effect in 2014 and, as we demonstrate below, premium adjustment (not addition to surplus) is the appropriate means of financing any anticipated cost increases due to FHCR.

B. The Impacts of Federal Health Care Reform Are Properly Addressed in Rate Review, Not by Surplus.

1. The Minimal Impacts of Reforms that Take Effect in 2010 Should be Addressed through Premium Adjustments.

Recent evidence confirms that the Blue Cross Blue Shield plans are able to quantify much of the impact of FHCR provisions that go into effect in the near term, and that they intend to cover them through premium adjustments, not surplus increases. GHMSI's CEO, Chet Burrell, recently predicted that FHCR would add between 2% and 6% to premiums in the short run.[33] GHMSI itself indicated its intent to address FHCR through rate adjustments when it highlighted uncertainties in its "pricing" in the wake of reform.[34] While GHMSI points to some of the more immediate changes in FHCR,[35] to support its assertion that its surplus needs have increased,[36] it forthrightly acknowledges that it will address the MLR provisions through premium adjustments ("the MLR mandate will make GHMSI's pricing decisions extremely

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[32] Invotex Group, *Report on: Surplus Evaluation Consulting Services for the Maryland Insurance Administration,* at 52 (Oct. 30, 2009), *available at* http://www.mdinsurance.state.md.us/sa/documents/InvotexReporttoMIA-10-30-09FINAL.pdf.

[33] *See Health Care Reform?*, supra n.7.

[34] *See* GHMSI Supplemental Submission, at 1-2.

[35] FHCR requires health insurance issuers offering individual or group coverage (including grandfathered plans) to submit to HHS, for each plan year, a report on the "ratio of the incurred loss (or incurred claims) plus the loss adjustment expense (or change in contract reserves) to earned premiums." *See* 42 U.S.C. § 300gg-18. The reporting requirement will apply to plan year 2010. Beginning in 2011, health insurers must provide annual rebates to enrollees if their MLRs are not at least 85% for issuers in the large group market, or 80% for issuers in the small group market or individual market. Id. States may set higher MLR percentages by regulation, and HHS may adjust the 80% figure with respect to a State if HHS determines that the application of that percentage will destabilize the individual market in that State. *Id* at 2.

[36] *See id.*

challenging going forward").[37] Moreover, Mr. Burrell has indicated that GHMSI's administrative costs are low, which suggests that the MLR provisions will not be problematic.[38]

The effects of FHCR provisions that take effect in 2010 are likely to be small, and recent estimates anticipate that carriers will manage them by adjusting premiums. In preliminary estimates, HHS and the Departments of Labor and Treasury (collectively, the Departments) have projected that prohibiting preexisting condition exclusions for children would, on average, increase premiums one percent or less in the individual market and negligibly in the group market.[39] Similarly, the provisions relating to annual and lifetime limits would increase premiums approximately one-half of one percent in the group market and less than one percent in the individual market.[40] The effects of restricting rescissions will potentially increase premiums a few tenths of one percent, while patient protections will increase premiums by less than one tenth of one percent.[41] The Secretary of HHS, Kathleen Sebelius recently summarized the expected cumulative premium effects of FHCR in a letter to America's Health Insurance Plans (AHIP):

> According to our analysis and those of some industry and academic experts, any potential premium impact from the new consumer protections and increased quality provisions under [FHCR] will be minimal. We estimate that the effect will be no more than one to two percent. This is consistent with estimates from the Urban Institute (1 to 2 percent) and Mercer consultants (2.3 percent) as well as some insurers' estimates. Pennsylvania's Highmark, for example, estimates the effect of the legislation on premiums from 1.14 to 2 percent.[42]

Clearly, the Departments expect that "any changes in insurance benefits will be directly passed on to the consumer in the form of changes in premiums."[43] Indeed, Secretary Sebelius has warned health insurers that they are not to use FHCR as a basis for unjustified rate

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[37] GHMSI Supplemental Submission, at 2. Moreover, recent reports have indicated that other insurance companies, including some BlueCross BlueShield plans, have requested premium increases of between 1% and 9%, which they attribute specifically to new health care reform coverage mandates. See *Health Insurers Plan Hikes; Rate Increases Are Blamed on Health-Care Overhaul; White House Questions Logic*, Wall Street Journal, Sept. 9, 2010; *Health Outlays Still Seen Rising*, Wall Street Journal, Sept. 8, 2010.

[38] Specifically, Mr. Burrell has testified that "[n]early 90 percent of all [GHMSI] costs is medical claims. The rest is administration and related matters." *Public Hearing on Surplus and Review of GHMSI Before the District of Columbia Department of Insurance, Securities and Banking* at 51:21-22, 52:1 (Sept. 11, 2009) ("Hearing Sept. 11).

[39] *See* 75 Fed. Reg. 37,188, 37,216 (June 28, 2010).

[40] *Id.*

[41] *Id.*; *see also* 75 Fed. Reg. 41,726, 41,738 (July 19, 2010) (estimating that, as a result of the regulations regarding coverage of preventive health services, "premiums will increase by approximately 1.5 percent on average for enrollees in non-grandfathered plans.").

[42] HHS Letter to AHIP.

[43] 75 Fed. Reg. 41,726, 41,738 (July 19, 2010); *see also* 75 Fed. Reg. 43,330, 43,338 (July 23, 2010) ("[G]roup health plans and health insurance issuers subject to these provisions will have to take these changes into account in establishing their premiums, and in making other changes to the designs of plan or policy benefits.").

increases.[44] In a similar vein, Illinois Department of Insurance Director Michael McRaith commented: "We've heard of companies increasing rates at just explosive levels, at abusive levels, and telling [policyholders] they're increasing rates because of health reform."[45]

As these estimates suggest, and as we have noted, carriers should be and are managing the predictable effects of these provisions by adjusting premiums, not by adding surplus.

Moreover, while GHMSI seeks to leave the impression that the new FHCR provisions present risks that are *terra incognita* (and thus justify a substantial increase in allowable surplus), that is not so. GHMSI already has relevant experience on which to base estimates of impacts, minimizing uncertainty around their estimates. For example, the new law prohibits denial of coverage of children under the age of 19 based on pre-existing conditions. GHMSI already provides benefits to children who develop such conditions while covered. Further, it knows how many children it historically has denied due to preexisting conditions, and what those conditions were. GHMSI may also cover some children with preexisting conditions in the open enrollment program that it historically operated for the District. In short, GHMSI has experience with the incidence and medical costs of preexisting conditions among children and does not face entirely unknown risks from this new provision.

To take another example, the new law bans annual limits on insurance coverage. GHMSI knows how many of its subscribers reach its existing annual limits, and it knows what conditions those subscribers have. While GHMSI's existing data may not wholly capture its likely experience under the new provision, the data substantially reduce its uncertainty. To take one more example, the new law prohibits deductibles, co-pays or coinsurance for certain preventive services, such as mammograms and colonoscopies, as recommended by the United States Preventive Services Task Force. GHMSI knows the frequency with which subscribers use such services, the costs of those services, and how frequently those tests identify a need for further medical care. The elimination of cost-sharing under the new law may increase utilization, but, again, GHMSI is not starting here with a blank slate, and it will recover reasonable estimates of cost increases by adjusting premiums. It cannot reasonably ask the Commissioner at this time, in this proceeding, to quantify and place these risks into surplus.[46]

In summary, to the extent near-term changes have been quantified, they support neither significant increases in premiums nor any adjustments to surplus in this proceeding. Secretary

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[44] HHS Letter to AHIP.

[45] *Ill. Ins. Regulators Want More Oversight on Health Rates*, Insurance Journal, August 9, 2010, *available at* http://www.insurancejournal.com/news/midwest/2010/08/09/112300.htm?print=1. In contrast, health insurers in Maryland have not even attempted to use health reform as a justification for raising rates. "Maryland's top insurance regulator said . . . that most health insurers doing business in the state have not asked for premium rate increases as a result of the federal health care reform law." See *Health Reform Hasn't Affected Md. Insurers' Rates*, Baltimore Business Journal, Sept. 8, 2010, *available at* http://www.bizjournals.com/losangeles/othercities/baltimore/stories/2010/09/06/daily19.html ("Reform Hasn't Affect Md. Rates").

[46] Some of the FHCR provisions that go into effect this month will already have generated six months of actual experience for the surplus review of GHMSI's 2009 surplus that the Commissioner is required to conduct in 2011 and that, as a practical matter, would not get underway any earlier than the end of March 2011.

Sebelius has specifically warned insurers that it is "premature" to "make business decisions about participation in particular markets based on rules that have yet to be published, or to apply for exemptions to rules that have not yet been drafted."[47] Authorizing increases in allowed surplus for FHCR is similarly premature.[48]

2. The Key Provisions of Federal Health Care Reform Do Not Take Effect Until 2014.

The most far-reaching and potentially costly health insurance reforms under FHCR will not take effect until 2014. These reforms include:

- a mandate that all U.S. citizens and legal residents obtain qualifying health coverage;
- the establishment of state health insurance exchanges, through which individuals and small business can purchase qualified health insurance coverage;
- new insurance rating rules for coverage offered in the exchanges and the individual or small-group markets;
- a requirement that all carriers selling health plans in the exchanges and individual and group markets must guarantee availability and reviewability of coverage;
- a prohibition on preexisting condition exclusions;

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[47] *Making Sure Your Premiums Pay for Care*, Healthcare.gov, http://www.healthcare.gov/news/blog/naic_mlr.html (last visited Sept. 13, 2010) (emphasis added).

[48] GHMSI further raises the possibility that its community health reinvestment expenditures would be included in the MLR denominator. GHMSI Supplemental Submission, at 3. This concern is premature, implausible, and highly revealing:

GHMSI's concern is premature because HHS has not yet even proposed the regulations to implement the MLR provisions. Moreover, if GHMSI properly undertakes "maximum feasible" community health reinvestment and manages surplus in accordance with that undertaking by holding premiums in check, the issue would be moot.

GHMSI's concern is implausible because GHMSI will have every opportunity to bring the requirements of the MIEAA to the attention of HHS in the rulemaking proceedings. The argument that GHMSI should not be required to include the amount of its community health reinvestment in the denominator appears to be a reasonable one: mandated community health reinvestment expenditures are simply not a "deduction" or a "charitable contribution" or an administrative expense" (GHMSI Submission, at 3) in the ordinary sense of those terms. While revenues that GHMSI would need to spend down if and when it accumulates surplus in excess under the MIEAA might never have been collected at all, such expenditures in any case would not be discretionary; they would fulfill GHMSI's obligation under the MIEAA, a law whose goals are wholly aligned with those of FHCR, including in particular the MLR provisions. Thus, there would appear to be a strong argument that revenues that GHMSI is prohibited by law from retaining do not properly belong in the MLR denominator. GHMSI's apparent belief that it would be unable to succeed with these and related arguments in a rulemaking process that has yet to begin is wholly unfounded and surely provides no reason to increase GHMSI's surplus in this proceeding.

GHMSI's reference to a possible National Association of Insurance Commissioners (NAIC) position concerning "gifts" (GHMSI Supplemental Submission, at 3) is irrelevant and reveals GHMSI's misunderstanding of its statutory *obligation* under MIEAA to engage in community health reinvestment.

- a prohibition on discrimination based on health status; and

- imposition of an annual assessment on the health insurance sector ($8 billion in 2014).[49]

GHMSI apparently acknowledges that it is premature to try to quantify the costs of these reforms before these provisions take effect and before any regulations interpreting them have been promulgated.[50] Just as GHMSI will have years to determine how to take into account the risks and costs of these reforms, the Commissioner can conduct multiple surplus reviews (one of which is mandated in 2011) before these provisions take effect. As we have noted, these surplus reviews should come after, not before, rate proceedings. At this early date, when the impacts of the 2014 provisions have only begun to be studied, they should not affect the determination of GHMSI's permitted surplus as of December 31, 2008.

3. Increased Scrutiny of Rate Increases Has Identified Filing Errors, But Has Not Resulted in "Arbitrary Caps" or Denials.

In its September 3 report, Milliman warns that "the potential for rate restriction based on arbitrary caps" could adversely affect GHMSI's financial profile.[51] As evidence, Milliman points to a recent Department of Insurance, Securities, and Banking (DISB) regulatory action that reduced rate increases on several GHMSI product lines.[52] According to Milliman, increased scrutiny of rate increases, together with federal and local health reform provisions that improve rate review procedures, pose a "substantial" risk to GHMSI.[53]

However, as the Commissioner well knows, the recent review process that served as the foundation for Milliman's conclusion can hardly be considered "arbitrary." In fact, in the episode Milliman describes, DISB discovered a "material misrepresentation" in GHMSI's rate increase filings, and acted in accordance with the law and in the public interest.

a) DC Council's emergency legislation

Responding to complaints from District residents about unreasonably large increases in health insurance premiums, the DC Council unanimously approved emergency legislation in March 2010, temporarily limiting increases in health insurance premiums to 10% of the previous year's level.[54] The Emergency Act authorized the DISB to grant increases of up to 15% if

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49 *See* FHCR; *see also Timeline: What's Changing and When*, Healthcare.gov, *available at* http://www.healthcare.gov/law/timeline/index.html (last visited Sept. 13, 2010) ("Healthcare.gov Timeline")

50 *See* GHMSI Supplemental Submission, at i.

51 Milliman Impact of FHCR Report, at 3.

52 *Id.* at 1.

53 *Id.* at 3.

54 A18-328, Reasonable Health Insurance Premium Increase Emergency Amendment Act of 2010, 57 DCR 2546 ("Emergency Act"). The bill's sponsor, Councilmember David A. Catania, cited some rate increases that exceeded 50%. Press release, *Catania Commends Insurance Commissioner for Rolling Back Massive Premium* (continued...)

provided with adequate documentation.[55] The legislation remained in effect for 90 days, and was allowed to expire on June 12.[56]

b) DISB rescinds rate increases

At the same time, the DISB was also reviewing the rate increases on several GHMSI product lines that it had previously approved. The DISB rescinded rate increases as high as 35% when it discovered that GHMSI incorrectly applied a target loss ratio. The Commissioner concluded that the erroneous information "constitutes a material misrepresentation and was improperly used to support the increase in rates requested by GHMSI."[57] The company agreed with the Commissioner's findings. The Commissioner reduced the increases to 12%, and ordered GHMSI to refund the overpayments to subscribers.[58]

c) Strengthening the District's rate review process

Under current DC law, GHMSI must file a proposed rate increase with the Commissioner at least 60 days before it becomes effective.[59] This applies to individual and all group subscriber contracts, except "experience rated groups."[60] The Commissioner has 60 days to review, and if she does not disapprove, the rate increase goes into effect. The standard for review is that the increase "shall not be excessive, inadequate, or unfairly discriminatory in relation to the services and benefits offered."[61] GHMSI has 30 days to file a contest with the DISB, which must then hold a hearing within 10 days.[62] The appeals process is considered a contested case, which means the final decision of the DISB may be appealed to the DC Court of Appeals.[63]

Councilmembers Bowser and Catania have introduced permanent legislation revising the District rate review process, "[giving] the DISB Commissioner broader authority to protect

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Hikes, available at http://www.davidcatania.com/content/view/373/68/ ("Catania Press Release'). Councilmember Catania noted that while GHMSI's premiums were increasing exponentially, the inflation rate for medical services had remained stable at 3.2%. *See* Consumer Price Index. Bureau of Labor Statistics, July 2010, available at http://www.bls.gov/news.release/cpi.nr0.htm ("Consumer Price Index").

55 Emergency Act, § 3(a)

56 Under the Home Rule Act, approved Dec. 24, 1973 (87 Stat. 813; see D.C. Code § 1-206.02), the D.C. Council may enact Emergency Bills that become effective immediately but expire after 90 days. *See* D.C. Code § 1-204.12(a).

57 *In re GHMSI, D.C. Dept. of Ins., Sec. and Banking,* Case No. IB-RF-01-10 (March 3, 2010); *see also* Case No. IB-RF-02-10 (March 12, 2010); Case No. IB-RF-03-10 (March 12, 2010); Case No. IB-RF-04-10 (April 13, 2010).

58 *Id.*

59 D.C. Code § 31-3508(c).

60 *Id.*.

61 D.C. Code § 31-3508(e)

62 D.C. Code § 31-3522

63 *Id.*

District residents during the rate approval process."[64] The proposed legislation generally tracks reform efforts recently enacted in other jurisdictions.[65] Such legislation is designed to increase public transparency of the health insurance rate review process and expand the authority of the Commissioner by requiring a thorough review and prior approval of rate increases.[66] There is no indication that the proposed rate review legislation will in any way limit GHMSI's ability to contest arbitrary or unreasonable denials of premium increases, nor could there be any such limitation.

d) Federal rate review reform

The District of Columbia is one of 46 jurisdictions awarded federal grants under FHCR to enhance its rate review process.[67] HHS notes that under the rate review reforms, "[t]he District will begin to require all insurers to file premium changes, previously only Blue Cross Blue Shield and HMOs were required to file premiums."[68] It is difficult to imagine how increasing the reporting requirements of other insurers somehow burdens or adds to GHMSI's uncertainty.

Nevertheless, Lewin argues in GHMSI's September 3 filing that regulators may limit insurers' ability to recover for pricing errors, stating that "early outcomes on reform have clearly shown a willingness of HHS and [the Centers for Medicare and Medicaid Services (CMS)] to pressure payers to reduce rate increases or deny them realistic rate levels."[69] Lewin appears to be referring to an incident earlier this year when Secretary Sebelius wrote to Anthem Blue Cross and asked the company to justify its proposed 39% rate increases.[70] The California State Department of Insurance retained an actuarial consulting firm to review Anthem's rate filings,

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64 Press release, *Councilmember Muriel Bowser, Bowser's introductions today focus on health insurance rates and the creation of a board to implement federal healthcare reform,* (May 4, 2010), *available at* http://www.dccouncil.us/bowser/downloads/pr/5-4-2010-LegSession.pdf ("Bowser Press Release").

65 ORS § 743.018 (the amendments to § 743.018 by section 31, chapter 595, Oregon Laws 2009, apply to rate filings submitted on or after April 1, 2010); 24-A M.R.S. § 2736 (2009); N.Y Laws, Relates to prior approval of health insurance premium rates, A. 11369, S. 8088 (June 7, 2010), *available at* http://assembly.state.ny.us/leg/?bn=A11369.

66 The Committee on Public Services and Consumer Affairs and Committee on Health held a joint hearing on B18-792 on June 30, 2010. Although GHMSI officials attended the D.C. Council hearing, they did not offer public testimony. The bill has not yet been scheduled for committee mark-up.

67 HHS News Release, *$46 Million in Grants to Help States Crack Down on Unreasonable Health Insurance Premium Hikes* (August 16, 2010), *available at* http://www.hhs.gov/news/press/2010pres/08/20100816a.html ("HHS News Release") (last visited Sept. 19, 2010). The District's plans include technology upgrades to make rate increase filings accessible to the public, a standardized filing format, and a review of best practices in rate review procedures.

68 *Id.*.

69 Lewin Reaction to Rector Report, at 4.

70 Letter from Kathleen Sebelius, Sec. of Health and Human Services, to Leslie Margolin, President, Anthem Blue Cross, (Feb. 8, 2010), *available at* http://www.hhs.gov/news/press/2010pres/02/20100208c.html .

which found "substantial errors."[71] California overturned Anthem's rate increases but ultimately allowed it to increase premiums by 14 to 19%.[72] The Anthem situation does not warrant a conclusion that HHS or CMS will require reductions in premium increases, but rather that insurers will be expected to justify their filings based on accurate information. This is one more indication that GHMSI's cost increases owing to FHCR can and will be fairly addressed through premium adjustment.

C. GHSMI Makes an Unsubstantiated Request for a Significant Increase in Surplus.

1. GHMSI Has Not Substantiated its Purported Quantification of its Surplus Needs.

Notwithstanding the facts that the overall financial impact of FHCR on insurers cannot yet be quantified, that these costs are expected to be minimal and to be captured through rate increases, and that the risk adjustment and risk corridor provisions of FHCR provide unprecedented protection to GHMSI, GHMSI nevertheless suggests that FHCR requires increased *surplus* requirements of at least 100% to 200% of RBC-ACL (and potentially more) to hedge against potential future costs. This suggestion includes an implicit calculation that the downsides of FHCR will exceed the upsides. But, as we have shown, neither Milliman's 100-200 percentage point estimate nor Lewin's 10% estimate is substantiated on this record. Further, both are contradicted by GHMSI's admissions that: (1) it cannot quantify the impact of FHCR until the end of 2011; and (2) the company itself has not yet made any attempt to adjust its surplus or rates in light of FHCR. On this record, GHMSI has not substantiated its suggestion that the Commissioner should now authorize an upward adjustment of 100 to 200 percentage points.

2. Federal Health Care Reform May Be Substantially Amended by Congress or Overturned in the Courts.

A new Congress may repeal or significantly modify FHCR and the courts may overturn it. In particular, a number of congressional leaders have called openly for repeal or substantial modification of FHCR—indeed, it is a signature issue for Republican leaders. For example, John Boehner, current House Minority Leader, promises that, if he were to become Speaker of the House following congressional elections this November, his top priority would be to "repeal Obamacare."[73] Other attacks on FHCR have been launched in courts around the country. The

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[71] Axene Health Partners, LLC, *Review of Anthem Blue Cross 2010 Rate Increases,* California Dept. of Ins., (April 28, 2010), *available at* http://www.insurance.ca.gov/0400-news/0100-press-releases/2010/upload/AnthemActuarialReview.pdf ("Axene Review of Rate Increases").

[72] *Calif. Regulators Approve Anthem Blue Cross Rate Hike of 14% to 20%,* BestWire Services, Aug. 26, 2010, *available at* http://insurancenewsnet.com/article.aspx?id=221119 .

[73] Lisa Mascaro, *GOP's Man of the House; Boehner Says End of "Obamacare" would be Job #1 as Speaker,* Sun-Sentinel, Aug. 22, 2010. His counterpart in the Senate, Minority Leader Mitch McConnell of Kentucky, also says that Republicans intend to repeal the law. *See* Carl Hulse, *New G.O.P. Slogan: 'Repeal and Replace' Health Care Law,* New York Times, March 23, 2010, *available at* http://thecaucus.blogs.nytimes.com/2010/03/23/new-g-o-
(continued...)

attorneys general of twenty states have formed a coalition to file a lawsuit against the Departments, seeking to overturn FHCR on constitutional grounds.[74] An additional 15 to 20 lawsuits are pending, each aiming to overturn at least one aspect of FHCR.[75] Thus, even if the Milliman model had not already accounted for FHCR's impacts (as we have shown that it has), it is premature to make adjustments to surplus based on legislation that may yet be overturned or substantially modified.

3. *The Suggested Upward Adjustment in Surplus is Contrary to the Policies Embedded in MIEAA.*

In addition to being unsubstantiated, GHMSI's suggested adjustment is contrary to the critical policies underlying MIEAA. As Mr. Burrell himself acknowledged in the hearing before the Commissioner, "it is well to remember where GHMSI's reserves come from. They come directly from individuals and small and medium group policy holders, and only from them."[76] He stated: "Keeping premiums as low as possible is the most essential good we can do for the community, and is certainly the thing most sought after by our premium ratepayers, particularly individuals and small groups."[77] Mr. Burrell recognized that "GHMSI's subscribers are struggling greatly to pay premiums that are escalating faster than their incomes, and their ability to pay for them."[78] These subscribers, he said, "are the working backbone of the community, of the District, and of the larger region."[79] And he acknowledged that "if any legitimate excess is ever found...it can only mean one thing, that subscribers were overcharged."[80]

DC Appleseed agrees with all these statements. Moreover, we believe that MIEAA captures Mr. Burrell's views precisely, requiring that GHMSI limit its surplus to an efficient level, and otherwise devote the maximum feasible amount to the community, including restraining premiums for subscribers. Nevertheless, GHMSI has made a premature,

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p-slogan-repeal-and-replace-health-care-law/?scp=2-b&sq=healthcare+republican+repeal&st=nyt (last visited Sept. 16, 2010). Moreover, Republican Congressmen Wally Herger (R-Calif.) and Steve King (R-Iowa) have each submitted petitions to repeal health care reform, which House Minority Leader John Boehner (R-Ohio) and House Republican Whip Eric Cantor of Virginia have signed. Simmi Aujla, *Republican Party Tries for Health Reform Repeal,* Politico, Aug. 10, 2010, *available at* http://www.politico.com/news/stories/0810/40922.html (last visited Sept. 16, 2010).

74 Amended Complaint, *Florida et al. vs. U.S. Dep't of Health and Human Servs. et al.*, No. 3:10-cv-91-RV/EMT (N.D.Fla. May 14, 2010); N.C. Aizenman, *Opponents present case against Obama's health-care law in 20-state lawsuit,* Washington Post, Sept. 14, 2010, *available at* http://www.washingtonpost.com/wp-dyn/content/article/2010/09/14/AR2010091402458.html (last visited September 16, 2010) ("Aizenman 20-state lawsuit"). In addition, the State of Virginia has established standing and is set for oral arguments on summary judgment motions in its pending case on October 18, 2010.

75 Aizenman 20-state lawsuit.

76 Hearing Sept. 10, at 33: 10-14.

77 *Id.* at 34: 9-13.

78 *Id.* at 48: 2-5.

79 *Id.*

80 *Id.* at 51: 3-6.

unsubstantiated, and speculative request for a significant increase in its surplus. If granted, such an increase will necessarily cause further increases in premiums that, as Mr. Burrell acknowledged, its subscribers already have difficulty affording.

The record before the Commissioner, and the statute that applies to that record, make GHMSI's suggested increase in its surplus—thereby further harming its subscribers — inappropriate. It should be denied.

D. The Commissioner Will Have Ample Opportunity to Reevaluate GHMSI's Surplus in Future Rate and Surplus Review Proceedings.

GHMSI urges the Commissioner to defer her surplus determination until an unspecified date *after* the "critical [FHCR] regulations are in place and the experience under them emerges," whenever that might be.[81] Postponing the Commissioner's surplus evaluation is unnecessary and inconsistent with the purpose of MIEAA to provide a framework for an objective, periodic evaluation of GHMSI's surplus, notwithstanding uncertainties surrounding the likelihood or amount of future expenditures.

The Commissioner will have ample opportunity to reevaluate GHMSI's surplus when there is greater certainty about the financial impacts, if any, of FHCR. Lewin recognizes that "it will take another two to three years for employers and consumers to respond to the new features of the law" that will be implemented in 2014.[82] MIEAA mandates a re-evaluation of surplus levels at least every three years,[83] and the Commissioner may undertake a surplus review more frequently if she chooses. Thus, there is already a vehicle for the Commissioner to take account of changes in GHMSI's circumstances, whether attributable to FHCR or to other causes. The current state of FHCR does not warrant further adjustment in GHMSI's surplus, and the Commissioner should proceed to decide the propriety of GHMSI's surplus on the record before her.

II. THE COMMISSIONER SHOULD DETERMINE THAT A GHMSI SURPLUS NO HIGHER THAN 600% RBC-ACL IS REQUIRED BY MIEAA.

Introduction

The Rector Report confirms many of DC Appleseed's and ARM's contentions. That Report, taken together with the MIEAA standard, demonstrates that the Commissioner should approve an RBC ratio for GHMSI's surplus not higher than 600%.

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81 GHMSI Supplemental Submission, at 8.

82 Lewin PPACA, at 41.

83 Med. Ins. Empowerment Amendment Act, § 2(e) ("MIEAA"); D.C. Code § 31-3506(e).

We say that for essentially five reasons, each presented in this section:

1. As Rector makes clear, the MIEAA standard—which none of the other experts (Milliman, Lewin, or Invotex) considered—must govern the Commissioner's analysis of GHMSI's surplus. That standard requires the Commissioner to select a specific number that best accords with the statute, not a broad range of numbers.

2. Under the MIEAA standard, the Milliman model, as corrected by Rector, shows that a 600% RBC-ACL—sufficient to ensure with near-certainty that GHMSI's surplus ratio will not drop below 200% —is more than adequate to protect the company's financial soundness and efficiency;

3. Both the adjustments that Rector made to several of Milliman's assumptions, as well as the RBC ratios of peer companies, strongly confirm the conservatism of the 600% RBC-ACL measure.

4. Allowing the Blue Cross Blue Shield Association (BCBSA) reporting standard of 375% to determine the permitted surplus ceiling would be inconsistent with MIEAA. It would give the association reporting standard greater weight than the 200% regulatory standard, drive GHMSI's surplus ceiling even further above the RBCs of peer companies, and impose a huge cost on ratepayers.

5. Increasing GHMSI's RBC ratio above 600% to be more in accord with the "overlap" of "ranges" offered by Milliman, Invotex, and Lewin would be illogical, and would allow the 375% reporting standard to determine the outcome instead of the 200% regulatory standard that should properly determine the outcome under MIEAA. Such an increase would reject both Rector's conclusion that the other analyses applied the Milliman model inappropriately, and its recommended ratio, which would still enable GHMSI to hold surplus much larger than that of efficient peer companies.

A. Rector Correctly Understood That MIEAA Governs this Proceeding and Requires Selection of a Specific Level of RBC for GHMSI that Accords with the Statute.

Unlike Milliman, Lewin, and Invotex, Rector makes clear in its peer review analysis and its use of the Milliman model that MIEAA must govern the Commissioner's determination in this proceeding. Therefore, Rector disagreed with the other experts that there is a "range" of acceptable surplus for GHMSI. As Rector explained, the ranges produced by the other experts are simply "data points" defined by two calculations—the surplus required for GHMSI to avoid falling to 200% RBC-ACL, and the amount required to avoid falling to 375% RBC-ACL. Accordingly, Rector calculated each of these data points using a corrected Milliman model and then explained that the choice between these data points must accord with the requirements of

this proceeding. Because MIEAA, not the actuarial experts, establishes those requirements, Rector declined to choose between the two data points.[84]

We agree with this. The Commissioner should not be selecting an acceptable "range." To do so using the Milliman model would be to say that any number within $200 million of a certain number is permissible. Instead, we submit, as Rector indicated, that the Commissioner should be selecting a surplus level that best accords with the standards of MIEAA—that is, a figure that most closely ensures GHMSI's soundness and efficiency while maximizing its community reinvestment.

Rector finds that a surplus of 600% RBC-ACL on December 31, 2008 would have ensured that GHMSI would remain above 200% of RBC-ACL with 99% probability, assuming a 2.5 year trend miss.[85] Further, Rector finds that, if the test under MIEAA is what is "necessary" for GHMSI to remain above 200% RBC-ACL, then surplus above 600% is "excessive."[86] Such "excess" begins at the point at which GHMSI on December 31, 2008 would have had the surplus that, in the language of the regulation, it "needed" to meet its "expected and unanticipated contingencies"[87]—including unanticipated technology and infrastructure investments.[88] The "excess" of surplus over that level measures the "maximum feasible" amount that GHMSI could have and, by law should have, spent on community health reinvestment.

Thus, a surplus that might be deemed to be within some "reasonable" range in other contexts is not permissible here if it is materially above the point that accomplishes the statutory balance.[89] MIEAA implements GHMSI's charitable and benevolent obligation by explicitly recognizing what considerations of economic efficiency illuminate—that, after a certain point, there are competing higher-valued uses for surplus. It then gives concrete direction with respect to those alternative uses, defining them as community health reinvestment and obligating GHMSI to engage in such reinvestment to the maximum feasible extent.

DC Appleseed will show that it is the 200% regulatory threshold—*not* the BCBSA 375% reporting standard—that properly drives the outcome on this record. If Rector's conclusion is

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84 *Id.*

85 Rector Report, at 4.

86 *Id.*

87 D.C. Mun. Regs. Title 26, § 4601.8 (2009).

88 Rector Report, at 7.

89 In the words of the Pennsylvania Commissioner's decision, a surplus above that level "fails to balance . . . marginal reduction in risk [from accumulating more surplus] against the benefits of using these same surplus funds in an alternative fashion." *In re: Applications of Capital Blue Cross, Highmark Inc., Hospital Service Ass'n of Northeastern Pennsylvania d/b/a Blue Cross of Northeastern Pennsylvania and Independence Blue Cross for Approval of Reserves and Surplus*, Misc. Dkt. No. MS05-02-006, Ins. Dept. of the Commonwealth of PA, at 15 (Feb. 9, 2005), *available at* http://www.ins.state.pa.us/ins/lib/ins/whats_new/2004bc/BCBS_DETERMINATION.pdf ("PA Surplus Decision"). The MIEAA explicitly identifies the alternative uses as community health reinvestment, and establishes the priority of community health reinvestment once surplus is consistent with financial soundness and efficiency.

correct that 600% RBC-ACL is required with respect to the 200% regulatory standard, then GHMSI had $199 million in excess surplus as of December 31, 2008.[90]

Moreover, DC Appleseed will show that 600% is the *maximum* ratio that could properly be allowed under MIEAA.[91] That conclusion follows even if the 375% reporting standard generates a higher surplus number (thereby creating what might be characterized as a "range"). As DC Appleseed has explained in prior filings, MIEAA requires that the surplus ceiling be set at the lower end of any "range."[92] And GHMSI itself has acknowledged that a figure in the lower end of a range bounded by the regulatory and BCBS industry standards is permissible.

To support our position that 600% is the maximum RBC the Commissioner should approve, we first show that 600% is a conservative number, both because it is the number suggested by the peer review analyses done by Rector, Invotex, and ARM, and because it is based on Rector's yet more conservative adjustments to assumptions embedded in the Milliman model. We next show that using the much higher surplus needed to avoid dropping below 375% RBC with a very high confidence level is neither in accord with MIEAA nor supported by GHMSI itself. Finally, we show that adjusting GHMSI's allowed surplus ratio beyond 600% to take account of the higher ranges computed by Milliman, Invotex, and Lewin would be inappropriate.

B. 600% is a Conservative Number.

Rector made a number of assumptions and adjustments to Milliman's already conservative assumptions. Rector's adjustments would increase permitted surplus when other reasonable choices would not have had that effect. We will discuss those choices in detail. However, it is appropriate first to consider the perspective provided by multiple real-world comparisons of the RBC-ACLs of companies similar to GHMSI. Those comparisons support the conclusion that 600% is a conservative result .

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[90] GHMSI reported a surplus at year-end 2008 of $687 million, equal to 845% RBC-ACL. Decision, at 11, 15. The dollar amount of GHMSI's excess surplus is calculated as follows: 600% ÷ 845% = 0.71. 0.71 x $687 million = $488 million. $687 million - $488 million = $199 million. We further note that at year-end 2009, GHMSI's surplus was approximately $761 million, equal to 902% RBC-ACL.

[91] Based on work done by ARM, DC Appleseed believes that 600% is in fact higher than what was necessary for GHMSI to enjoy a near-certainty of remaining above 200% under assumptions that are proper under the MIEAA. While we understand that the Commissioner and Rector have declined to consider ARM's application of the Milliman model due to our lack of access to confidential GHMSI data, there are elements of ARM's analysis that are based solely on public data and that use standard statistical methods. We will refer to those elements from time to time, to provide further support or to amplify Rector's conclusions.

[92] *See* Excess Surplus Review Hearing of GHMSI, DC DISB , Rebuttal Statement Memorandum by D.C. Appleseed (Nov. 2, 2009) ("D.C. Appleseed Rebuttal Statement"), App. A, *Rebuttal Statement - Applying the Medical Insurance Empowerment Act*, by Covington & Burling LLP, at 12 (Nov. 2, 2009) ("C&B Rebuttal Statement").

1. *Analyses of Peer Companies Do Not Support GHMSI's Conclusions Regarding Surplus.*

Rector, alone among the actuarial studies remaining in the record, explicitly recognized that it is important to consider for-profit health insurers in a peer review under MIEAA, "in part because of the provisions of DC law that GHMSI engage in community health reinvestment to the maximum feasible extent consistent with financial soundness and 'efficiency'"[93] Under that standard, Rector found for-profit insurers particularly relevant because they "often are recognized as having efficient operations due to the pressures exerted by the capital markets."[94]

Accordingly, Rector conducted a peer review of a large number of such companies. Even after confining its calculation to "companies . . . that have AM Best ratings of A- or higher; *i.e.*, the more highly capitalized companies," Rector found weighted average surpluses of 471% for Wellpoint companies and 464% for Humana companies.[95] Rector's recommendation of 600% for GHMSI is 27% more than the greater of those two numbers.[96] Thus, Rector's 600% RBC-ACL figure would provide GHMSI with an additional cushion of $102 million of surplus over the higher of the two weighted average RBC ratios of these most efficient and highly capitalized companies.[97] The magnitude of that cushion—the excess over the weighted average for these well-capitalized and efficient companies—underscores the conservatism of Rector's 600% RBC-ACL calculation.

GHMSI attempts to dilute the significance of Rector's finding by asserting that for-profit companies can access capital at the holding company level.[98] GHMSI's assertion is simply a way of pointing out that GHMSI does not have equity capital supplied by shareholders. But, as the Pennsylvania Commissioner has pointed out in the context of a surplus determination for the Blues plans in that state, it is unclear whether access to equity capital provides a significant advantage.[99]

GHMSI's general assertion that holding companies may supply capital to their operating subsidiaries implies that operating insurance subsidiaries enjoy blank checks for intercompany capital transfers from their holding companies, and that the parent companies can capitalize their

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93 Rector Report, at 12.

94 *Id.*.

95 *Id.* at 13.

96 600% ÷ 471% = 1.27.

97 471% ÷ 600% = 0.79. 0.79 x $488million = $386 million. $488 million - $386million = $102 million.

98 GHMSI Supplemental Submission, at 10.

99 A for-profit structure itself has costs that GHMSI does not face. As the Pennsylvania Commissioner noted, equity-supplied funding demands "a higher return than interest yields" in order to "compensate for additional risk . . . . The Blue Plans are in fact not subject to the operational constraints to which publicly traded for-profit corporations are subject. The Plans do not have to earn a market-determined rate of return on owner-supplied equity." PA Surplus Decision, at 14.

insurers "as needed."[100] But it ignores the variety of practical and legal reasons why that may not be so.[101] Nothing in the record demonstrates that companies routinely use a corporate parent to obtain capital via "surplus notes."

In addition, GHMSI fails to acknowledge the Intercompany Agreement among GHMSI, CFMI, and CareFirst Inc., which "provides a means to utilize enterprise-wide resources to stem risk." The Agreement states that, "in the event of a surplus shortfall," each of the three signatories "will fund the shortfall" through a loan, so long as remaining surplus of the entity providing the funds would remain above statutory surplus requirements and the transfer would satisfy regulatory requirements.[102]

In short, the dollar size of the difference between GHMSI's surplus at 600% RBC-ACL and the surplus that would be required at the highest weighted average of the for-profit companies—$102 million—is too great to be wholly explained away by a vague assertion concerning equity capital. It is not necessary for the Commissioner to determine whether the surplus levels of well-capitalized publicly traded companies, which are subject to the efficiency discipline of stock markets, actually identify the maximum level of surplus for GHMSI under MIEAA. The only—and highly instructive—point here is that the size of the difference strongly supports the conservatism of Rector's finding of 600% using the Milliman model.

The peer reviews conducted by ARM and Invotex of other non-profit Blues further indicate the conservatism of Rector's finding of 600%.[103] Rector describes the results of the ARM and Invotex peer reviews, noting that "[w]e do not disagree with those selections."[104] While DC Appleseed agrees with Invotex's observation that there are "nuances" among Blues plans that can reduce comparability, and that peer review serves only as a "diagnostic tool,"[105]

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100 GHMSI Supplemental Submission, at 10.

101 Even if a holding company were legally able to transfer funds to an operating insurance subsidiary, it would be loathe to do so where, as is typically the case, there are regulatory constraints on payback by the subsidiary. There is nothing in the record to suggest that, in a given year, such transfers are anything but rare. GHMSI fails to address other possible types of constraints, such as: limits on the frequency with which inter company transfers may occur; limits on the amounts that may be or in practice are supplied; limitations on the purposes of funding; requirements for corporate board approvals; payback terms and periods (which over the full cycle of transfer and payback may not reduce revenue requirements at all); and reciprocity arrangements (which can increase risks for operating subsidiaries).

102 *Id.* These potential uncertainties only underscore the insufficiency of GHMSI's blank-check suggestion with respect to for-profits. Milliman tries to have it both ways. It fails to acknowledge that there can be uncertainties regarding intercompany transfers from for-profit holding companies, GHMSI Supplemental Submission, at 10, but, at the same time, it uses what it sees as uncertainties in the Intercompany Agreement as a rationale for ignoring the Agreement completely in its assessment of GHMSI. Invotex, at 49-50. No reason is given why for-profit companies would be more casual than non-profits with respect to intercompany transfers, or why for-profits and non-profits would differ, other things being equal, in their ability to secure regulatory approval.

103 We discuss ARM's findings because its peer analysis depended on publicly available information to which its access was the same as Rector's and Invotex's.

104 Rector Report, at 12.

105 Invotex, at 37.

these peer reviews all point to a maximum permitted surplus that is way below GHMSI's RBC-ACL of 845%—far below the 750% that is the lower end of Milliman's and Lewin's "ranges," let alone their upper ends of 1050% and 1000%. The differences are so great that they provide serious reason by themselves to question the reliability of the Milliman and Lewin analyses.

ARM and Invotex reached the same results with respect to the four Blues that were included in both of their respective peer reviews.[106] Among those four Blues examined in common, the average was 625% RBC-ACL.[107] Invotex found an average of 678% among all of the Blues in its comparison, far below either GHMSI's actual 845% or the low end of the "ranges" that Milliman and Lewin reported.[108] ARM found an average of 572% RBC-ACL among all seven of the Blues that it considered appropriate for peer review, with a median for the group of 551%.[109]

The final peer group that provides an illuminating comparison is GHMSI's own competitors. It is telling that GHMSI's surplus in 2008 was "very high compared with the vast majority of insurers in the National Capital Area."[110] Kaiser Foundation Health Plan, "GHMSI's largest competitor and also a nonprofit company, held 632 percent of ACL."[111] Only United, "a relatively small company" in the area, "held more surplus."[112] In addition, GHMSI has yet to explain how CFMI, with the same competitors, held a surplus of 503% at the end of 2008,[113] satisfying the Maryland standard for surplus (which is simply the general standard that it not be "unreasonably large"),[114] while GHMSI, with a surplus that was two-thirds greater, did not exceed what is allowed under MIEAA's much more rigorous standard.

These data all point to a single conclusion: *companies that are GHMSI's peers hold surplus that more closely approximates Rector's 600% RBC result —not the 845% that GHMSI held at the end of 2008 or the 902% that it held at the end of 2009.* We will now show that Rector's 600% result using the Milliman model was the product of a number of choices that render that 600% figure conservative. Taken together, the peer review and the corrected

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106 Rector Report, at 11, 12.

107 Rector Report, at 12.

108 Invotex at 43.

109 Actuarial Risk Management, Excessive Surplus Assessment Report of GHMSI Surplus Position, at 33 (App. B) (Aug. 31, 2009) *available at* http://disb.dc.gov/disr/frames.asp?doc=/disr/lib/disr/pdf/dcac_filing_exhibit_b_8_31_09.pdf ("ARM First Review"). If the one for-profit Blue in ARM's review is omitted (BlueCross BlueShield of Georgia), the remaining average is 569%.

110 D.C. Appleseed Pre-hearing Report, Ex. C, Statement of Deborah Chollet, Ph.D., Senior Fellow Mathematica Policy Research, Inc., prepared for DC Appleseed, at 7 (Aug. 31, 2009) ("Chollet Aug. 2009").

111 *Id.*

112 *Id.*

113 ARM First Review, at 33 (App. B).

114 Invotex, at 62-66 (citing Md. Code Ann., Ins § 14-117(e)(1)).

Milliman model confirm the proposition that 600% RBC-ACL should be the maximum surplus approved by the Commissioner.

2. *Rector's Adjustments to the Milliman Model Do Not Support a Surplus In Excess of 600% RBC-ACL.*

a) Confidence level.

Rector assumed that a 99% confidence level for remaining above 200% RBC-ACL was proper under MIEAA. Under a statute that requires community health reinvestment to the "maximum feasible" extent, this level—which is beyond what would already bring near-certainty—is arguably too high. For example, without even taking MIEAA into account, Milliman used a lower requirement of 98% and did not consider occurrences above the 98th percentile because it considered them too "remote."[115] Lewin, again without even considering MIEAA, chose a 95% probability of remaining above 200%."[116] Only Rector chose a 99% confidence level. To suggest that Rector's 99% confidence level is too high is not to criticize its actuarial analysis. The choice of a confidence level must reflect MIEAA's intent and we believe Milliman's 98% figure fully satisfies that intent. As a result, Rector's 600% RBC-ACL may be too high, further underscoring that it is the maximum figure the Commissioner should approve.

b) Premium growth.

Rector increased the upper end of Milliman's premium growth assumptions, to an annual growth of 16% (with a lower end of 10%).[117] Because premium growth increases ACL-RBC, this has the actuarial effect of increasing surplus requirements at any confidence level.[118] Under MIEAA, which allows only what is "consistent with" GHMSI's financial soundness and efficiency, Rector's assumption is conservative—raising the amount of surplus that Rector estimated GHMSI would need. In contrast, Milliman's estimates assume an upper end of 14%, "based on GHMSI's own internal financial forecasting,"[119] and reflecting "actual recent experience."[120] Indeed, Milliman's assumptions were "agreed upon by Milliman and GHMSI."[121] ARM found it questionable whether premiums would grow at all during a loss

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115 Milliman Report, at 48.

116 Lewin Group, *Recommended Surplus Range for GHMSI: Approach and Considerations for Determining the Appropriate Range of Surplus*, at 20, 23 (Oct. 29, 2009) *available at* http://disb.dc.gov/disr/frames.asp?doc=/disr/lib/disr/pdf/posthearing/attachment_3_-_lewin_ghmsi_surplus_final_report.pdf ("Lewin Oct. 29, 2009"). Invotex did not provide its assumptions, a point confirmed by Rector. Rector Report, at 4.

117 Rector Report, at 4.

118 *Id.* at 7; *see also* ARM First Review, at 13 ("[B]ecause premiums are such a significant component of the RBC formula, a huge amount of the projected RBC needed in a Pro Forma analysis is directly a result of the projected growth in premiums").

119 Hearing Sept. 10, at 62: 5-6 (Dobson).

120 Milliman (Nov. 2, 2009), at 5.

121 Invotex, at 68.

period,[122] as did Lewin (stating that, because of economic conditions in the DC area, "it expect[s] *flat* commercial enrollment growth [for GHMSI] for the next three years").[123]

The conservatism of increasing the premium growth assumption is further underscored by Mr. Burrell's own testimony concerning the "unprecedented . . . movement towards high deductible health plans."[124] He stated that group subscribers "all over the country" are choosing such plans in order to avoid "the rate increase that they would have had otherwise,"[125] and that shift "has had an effect on the growth of the company's revenue for sure."[126]

c) Consecutive-year losses.

Rector used a three-year underwriting cycle, and not the four-year cycle that Milliman assumed.[127] Rector did so in order to be "conservative," because the fourth year "generates an additional year of underwriting *gains*."[128] However, assuming a three-year underwriting cycle is conservative for a more fundamental reason: the probability that GHMSI would sustain *any* consecutive underwriting-loss years, let alone three straight years of losses, is extremely low, as shown by its many consecutive years of underwriting gains. Moreover, not only underwriting results matter in gauging surplus needs; net income, which includes income and gains from investments, is also important, and the probability of consecutive year losses in net income also is remote.

Rector found that, for "the past 10 years, GHMSI has consistently produced positive results" from the combination of "its underwriting operations and its investment holdings."[129] To take underwriting first, "GHMSI has produced average annual underwriting profits of $35 million from 1999 through 2008."[130] However, it does not appear that Rector developed the statistical significance of that recent history for its assumed loss cycles. We therefore believe that ARM's work is helpful on this point. Starting from the same 10 consecutive years of underwriting gains, ARM demonstrated with respect to underwriting results that the "likelihood of having *any* losses in consecutive years is only about 2%, the likelihood of any losses in three consecutive years is only about 0.3%, and finally the likelihood of having any underwriting loss

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122 ARM First Review Report, at 13-14.

123 Lewin Oct. 29, 2009, at 10 (emphasis added).

124 Hearing Sept. 10, at 244: 16-44 (Testimony of Mr. Burrell).

125 *Id.* at 244: 20-21, 245: 6.

126 *Id.* at 245: 1-2. Mr. Burrell also stated that "we have consistently in recent years produced less revenue than our rating formulas would indicate because employer groups buy down their benefits." *Id.* at 243. Results that are "consistent" from year to year are the opposite of any reason to increase surplus. Further, the consistent errors in the formulas may indicate that GHMSI needs to change its formulas and is in that respect not efficiently managing – again, hardly a reason to increase surplus.

127 Rector Report, at 9.

128 *Id.* (emphasis added).

129 *Id.* at 14.

130 *Id.*

in four consecutive years is approximately 0.04%."[131] We believe this analysis is useful to the Commissioner given that, unlike the ranges computed by the other experts using the Milliman model, this ARM analysis was based solely on publicly available historical data. If, as apparently is the case, Rector assumed greater probabilities than ARM's analysis calculated for underwriting losses in consecutive years, that assumption would further confirm that Rector's result of 600% is conservative.

The point is the same when looking at net income, which measures the company's overall ability to meet its obligations in the event of unexpected developments affecting costs or revenues and correlates much more strongly with surplus than do underwriting results.[132] Rector found that, "[o]verall, GHMSI has generated consistent net profits [in every year] since 1999, averaging $55 million per year."[133] Rector also pointed out that GHMSI had actual net income in 2008 of $26.2 million in 2008, "positive results in a very difficult economic environment."[134] Thus, despite the numerous unexpected economic downturns in that year, "GHMSI only missed its targeted RBC ratio of 855% by 10 points."[135]

Again using standard statistical methods applied to publicly available information, ARM derived the statistical import of GHMSI's successful earnings history for the surplus analysis. Using an overlapping but even longer period (1995 through 2008), ARM found that "the **probability** of GHMSI incurring *any* after-tax adjusted net income **loss in a given year is less than 1.0%** and the **possibility** of GHMSI having after-tax adjusted net income **losses in consecutive years to be less than 0.01%.**"[136]

As with the statistical significance of the 10 consecutive years of underwriting gains, this statistical analysis of GHMSI's years of positive net income is based on consideration of publicly available data (unlike the application of the Milliman model) and therefore should be considered. If Rector did not consider the possibility of net income losses in consecutive years to be as remote as ARM found them to be, that, too, would confirm the conservatism of Rector's 600% finding. These results also rebut Milliman's insistence that that the "loss cycle is going to occur."[137] Furthermore, GHMSI's consistent earnings success underscores the hedge provided by GHMSI's operations in three different jurisdictions that exhibit different results, and the low risk

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131 Actuarial Risk Management, *Rebuttal of CareFirst's Position on the Appropriateness of GHMSI's Surplus - An Independent Assessment of the Excess Surplus*, at 13 (Nov. 2, 2009) *available at* http://disb.dc.gov/disr/frames.asp?doc=/disr/lib/disr/pdf/appendix_b_arm_rebuttal_11_2_09.pdf ("ARM Subsequent Assessment Report") (emphasis added).

132 ARM Subsequent Assessment Report, at 9-11. "Net income" for this purpose included net income as traditionally determined, plus unrealized gains and losses from GHMSI's assets.

133 Rector Report, at 14.

134 *Id.* at 15.

135 *Id.*

136 ARM Subsequent Assessment Report, at 11 (italicized emphasis added; bolded emphasis in original).

137 Hearing Sept. 10, at 239: 17.

associated with its FEP business, despite GHMSI's claim that it lacks the protection of diversity.[138]

One further indication that 600% RBC-ACL would easily meet the proper definition of allowable surplus under MIEAA is ARM's analysis of what GHMSI's position would have been if its surplus had been at 500% of RBC for the years 1995 through 2008.[139] ARM used GHMSI's actual, publicly reported results, but assumed that its surplus would have been only 500% RBC-ACL. It found that **"the probability of GHMSI incurring any after-tax adjusted net income loss in a given year is less than 1.2% and the possibility of GHMSI having after tax adjusted net income losses in consecutive years [is] less than .015%."**[140] This analysis provides further strong confirmation that 600% would be a conservative measure of allowed surplus under MIEAA.

d) Trend miss.

Trend miss is the assumed amount of time that it takes management to "identify and address rating fluctuations."[141] Milliman considered it to be an estimate of the elapsed time "between the initial development of adverse experience and the point at which management corrections would be realized in rates."[142]

Rector chose the longer of Milliman's alternative trend miss durations, 2.5 years.[143] This was a conservative choice: a longer assumed trend miss would increase surplus requirements. As we have just shown, the probability of underwriting losses in consecutive years is remote. In fact, rate increases are realized sooner than 2.5 years. And whether or not rate increases are realized sooner, other changes (resulting from management interventions, competitive success, changes in utilization, or other factors) correct the situation. Whatever the cause, the record indicates that assuming a 2.5-year trend miss is highly conservative.

Furthermore, there is no reason to suppose that consecutive-year underwriting losses are becoming more likely. To the contrary, as ARM points out, insurers are using "more accurate

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138 *See* Chollet Aug. 2009 at 5. Based on GHMSI's own publicly available information, ARM found the year-to-year variance in GHMSI's net income, and, therefore, the uncertainty, to be "relatively small." ARM Subsequent Assessment Report, at 11. Small uncertainty reduces the need for surplus. Consistent results tend to confirm the ability of GHMSI's management to take corrective actions in order to avoid substantial reductions in surplus.

139 ARM Subsequent Assessment Report, at 20-22.

140 *Id.* at 21 (bold emphasis in original).

141 Aug. 6 Decision, at 12.

142 GHMSI (Sept. 2, 2010), Att. C, Milliman Response to Rector, at 6.

143 Rector Report, at 9. Rector accepted Milliman's assumption concerning rating adequacy and fluctuations. Rector Report, at 6. The NAIC has characterized this as the "predominant risk" of a health insurer. NAIC, *Risk-Based Capital General Overview,* at 3 (7/15/09), *available at* http://www.naic.org/documents/committees_e_capad_RBCoverview.pdf ("NAIC Risk-Based Capital"). So have Milliman and Lewin. Milliman Report, at 46 ("primary independent risk category"); Lewin Oct. 29, 2009, at 7.

and timely data feedback . . . on utilization and other cost trends" than in the past.[144] "Today, well-run companies conduct experience reviews and revise financial projections on at least a monthly basis."[145] If GHMSI is not performing at this level, that is not a reason to allow it to increase surplus.[146]

Finally, we note that the District of Columbia recently received a substantial federal grant to enhance its rate review procedures; this will allow development of statutory and regulatory changes to reflect best practices, and more sophisticated technology to support rate reviews.[147] These enhancements should reduce the time required for regulatory approvals. Consequently, any trend miss should be reduced, and certainly is unlikely to increase.

3. Rector's Pension Plan-Related Calculations Do Not Warrant Surplus Greater than 600% RBC-ACL.

Rector made an upward adjustment to Milliman's loss curve of 1.75% (at the 99% confidence level) for pension plan charges.[148] However, Milliman now claims that it "implicitly recognized them in our other assumptions," referring to its discussion of Catastrophic Events.[149] Thus, Rector's upward adjustment seems to double-count risk factors, making the total size of the adjustment greater than either Rector or Milliman intended. The record does not suggest the magnitude of the double-count. It is not remedied by Rector's downward adjustment for catastrophes.

4. Certain Items that Rector Evaluated Need Not Be Considered in Surplus Evaluation.

Rector also considered additional risk factors that it deemed only doubtfully appropriate for inclusion at all in the analysis, such as charges for catastrophic events and growth and

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144 ARM Subsequent Assessment Report, at 12.

145 *Id.*

146 GHMSI seemed reluctant to acknowledge the efficacy of management interventions. For example, when Rector's Mr. Toole questioned Mr. Burrell concerning management's ability to delay infrastructure investments, Mr. Burrell avoided an answer, and referred instead to the small share of total costs that is represented by "administration"— which is a different category of costs. Hearing Sept. 10, at 240-42. The issue highlights the cautionary point that GHMSI may wish to argue for increased surplus requirements based on its own inefficiency. It has done so in the past. *See* Chollet Aug. 2009, at 4 ("Including [in Milliman's historical analysis] 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. In effect, GHMSI appears to be pointing to its own earlier mismanagement to justify the accumulation of high surplus now.").

147 HHS News Release.

148 Rector Report, at 7, 24.

149 Milliman Response to Rector Report, at 5 (Sept. 1, 2010), attachment C to GHMSI Supplemental Submission ("Milliman Response")

development.[150] The inclusion of these risk factors increased Rector's measure of needed surplus, again reinforcing the conservatism of its 600% result.

There is one final point that does not necessarily go to Rector's conservatism but that provides strong, broad support for the net effects of its adjustments to Milliman and for using the 600% as the maximum amount for GHMSI's allowed surplus. Rector observed that "it seems highly improbable that GHMSI's actual results could have been generated using the Milliman approach, *a critical test for the validity of any modeling approach.*"[151]

Validation of a model is a straightforward exercise. The analyst applies the model to the past to determine if it would have predicted the actual results. Thus, the model might have been applied to each of the years in a past period (for example, the years since the National Association of Insurance Commissioners (NAIC) adopted the RBC approach for health insurers) to determine whether it would have predicted the actual results that ensued in the following years.

But Milliman does not say that is what it did—and for that reason alone, it fails to rebut Rector's point. Milliman attempts to respond to Rector by noting that its "baseline pro forma assumptions" included GHMSI's "operating environment and policies (*looking forward*)."[152] It also incorporated not only "assumptions that were consistent with [GHMSI's] history" but assumptions that "reflected future expectations *which varied somewhat from recent history.*"[153] Further, its assumptions concerning unexpected events included "*anticipated*" low rates of investment income, and it claims to have integrated events that might occur only once in 50 years.[154] The logic by which Milliman then claims that its assumptions "are consistent with GHMSI's history of results, including the 13-year historical period cited by Rector,"[155] appears to be that, by changing history, Milliman somehow validates its model against history. One thing is clear: Milliman did not do the straightforward, correct thing—test its model by applying it to history as it happened and, therefore, its model fails the "critical test for the validity of any modeling approach."[156]

In summary, with a surplus ratio of 600% on December 31, 2008, GHMSI would have remained with near-certainty above 200% while maintaining financial soundness and efficiency. These peer review analyses confirm the correctness of this result. Taken together, Rector's two analyses point to the maximum measure of permissible surplus under MIEAA. The BCBSA reporting standard of 375%, to which we now turn, does not change this measure.

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150 *See* Rector Report at 6-7.

151 Rector Report, at 5 (emphasis added). ARM made the same finding, which could not possibly be rebutted by any of GHMSI's confidential information. *See* ARM Subsequent Assessment Report, at 14-15.

152 Milliman Response at 2.

153 *Id.* (emphasis added).

154 *Id.* at 3.

155 *Id.*

156 Rector Report, at 5.

C. The Proper Ceiling for Surplus Under MIEAA Should not be Determined by the BCBSA Reporting Standard.

Rector finds a substantial difference between (a) the surplus that, on December 31, 2008, would have provided a 99% assurance of remaining above the regulatory standard of 200% RBC-ACL[157] and (b) the surplus that would have provided a 95% likelihood of remaining above the BCBSA standard of 375% RBC-ACL for additional reporting and monitoring (the "reporting standard"). The difference in dollar terms is $205 million over the $488 million that would have been required at the 600% level.[158] Notably, Rector does not contend that the Commissioner should adopt the 850% figure produced by the 375% standard; it merely provides the figure for the Commissioner's use.

GHMSI cannot have two ceilings for its allowed surplus under MIEAA, and adopting the ceiling driven by the 375% standard would be to establish a higher ceiling than is legally permitted. It is legally incorrect for the 375% reporting threshold to drive the outcome, making the 200% regulatory standard irrelevant. For reasons developed in this section, adoption of the higher figure would be inappropriate under MIEAA.

While the BCBSA reporting standard should not drive the outcome under MIEAA, there is one highly unlikely circumstance that the Commissioner might consider in future proceedings if it were to be presented—that is, when a surplus that would provide a near certainty of remaining above the regulatory standard of 200% of RBC-ACL would nevertheless itself be below 375%.[159] In our view, MIEAA does not otherwise allow the proper ceiling to be determined—let alone dramatically increased—by reason of the BCBSA reporting standard.[160]

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[157] ACL RBC is equal to 100% of the amount of RBC required by the NAIC Instructions, as those Instructions might be amended from time to time. D.C. Code § 31-3851.01(3), (15). When RBC is 70% to 100% of ACL-RBC, the insurer is in an ACL Event, and regulatory control is authorized. When RBC is below 70%, the insurer is in a Mandatory Control Level Event, and such control is mandatory. D.C. Code §§ 31-3851.01(12)-(13); 31-3851.06(a). We will discuss below the other two categories of regulatory action levels based on RBC: Company Action Level Event (150-199%% ACL RBC) and Regulatory Action Level (100-149% ACL RBC).

[158] 850% ÷600% + 1.42. 1.42 x $488M = $693M. $693M - $488M = $205M.

[159] That is not remotely the case here: the $488 million that Rector finds would provide near-certainty of remaining above 200% is $184 million above 375% of GHMSI's actual RBC-ACL at the end of 2008, which was $81 million. GHMSI Annual Statement for 2008, 43. 375% x $81M = $304 million. $488M - $304 M = $184M.

If a surplus keyed to the 375% industry standard exceeds the surplus that provides near certainty with respect to the 200% standard (and thereby establishes a "range"), MIEAA requires that allowable surplus be set at the lower measure. The circumstance that we have noted in the text provides the one situation that can be determined in advance, categorically to warrant an increase by reason of the 375% reporting threshold. Should other circumstances arise that warrant consideration of a higher surplus (whether relating to the 375% standard or any other reason), GHMSI is always free to petition the Commissioner to initiate a surplus review (which, in any event, is mandatory every three years), and the Commissioner may initiate such review sua sponte in her discretion. In any such proceeding, all the circumstances relating to then-current surplus needs could be examined.

[160] D.C. Appleseed has previously argued with respect to Milliman's use of a 95% confidence level for the 375% reporting requirement that, "[w]hatever might be the validity for a reporting requirement to an industry (continued...)

1. *The BCBSA Reporting Standard Is Not a Measure of Whether GHMSI's Surplus is "Consistent With Financial Soundness and Efficiency."*

The BCBSA reporting standard does not increase the surplus that would be "consistent with" GHMSI's "financial soundness and efficiency." The standard changes neither the size nor the probability of GHMSI's "expected and unanticipated contingencies." Therefore, it does not change what is needed to meet them—namely, and conservatively, 600% RBC-ACL. Under MIEAA, the 375% standard provides no basis for revising upward a ceiling that is otherwise "consistent" with GHMSI's "financial soundness and efficiency."

This legal conclusion is demonstrated by: the nature and role of the BCBSA and its reporting standard; the limited consequences for a licensee of falling below BCBSA's 375% standard; the hundreds of millions of dollars that ratepayers would bear in order to provide a very high degree of assurance that GHMSI would always remain above that reporting standard, with no material benefit to ratepayers; and the great increase *above 99%* with respect to the 200% regulatory standard that would result from allowing the 375% standard to drive the permitted surplus, again without material benefit to ratepayers.

a) The BCBSA 375% reporting standard is a private, commercial decision of BCBSA licensees.

The BCBSA is a private association that manages a commercial asset—the Blues brand—and its members are Blues licensees. The Association licenses the individual companies to use the Blues marks. *The Association is controlled by its licensees*, who can change the rules for licensees through specified majorities. The adoption by the licensees of the 375% standard in the 1990s enabled licensees to argue to insurance commissioners, as GHMSI is arguing here, for surplus levels vastly higher than they would be under the 200% regulatory standard then-recently adopted by the NAIC.

There is no public body that can second-guess the licensees' decision to establish various degrees of reporting, nor should there be. BCBSA's standards for additional reporting are simply private, commercial decisions by the Association licensees acting in their own self-interest. But there is no *public* interest in taking their privately determined reporting standards as the measure of maximum permitted surplus under MIEAA. The absence of any public interest underscores the legal conclusion based on the language of MIEAA that the commercial decision of Blues licensees to set a self-imposed threshold for additional reporting should not set the standard under MIEAA.

The 375% reporting standard is in sharp contrast to the 200% regulatory standard. As Milliman has noted, 200% "is the threshold for mandatory corrective action plan notification by domestic insurers" to the D.C. Insurance Commissioner.[161] There are in fact more regulatory

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association of that degree of probability in other contexts, it is not appropriate under the 'maximum feasible . . . consistent with' standard." C&B Rebuttal Statement, at 5 n.13.

[161] Milliman Report, at 20.

consequences than that. Under the D.C. insurance statute, the NAIC standards, and the insurance statutes in most if not all states, the Company Action Level is from 150% to 200% of RBC. Surplus below 200% and in that range is deemed a Company Action Level Event. When there is a Company Action Level Event, the insurer must submit a plan with corrective actions and financial forecasts. The Commissioner may reject the insurer's mandatory plan or propose revisions to the plan. Rejection of a revised plan may trigger a hearing, after which the Commissioner may provide notification that the insurer is in a Regulatory Action Level Event.[162]

In a Regulatory Action Level Event (which ordinarily occurs when an insurer is between 100% and 150% of RBC), the Commissioner may not only propose revisions to a plan but "*shall* . . . [i]ssue a corrective order."[163] The Commissioner may retain actuaries, investment experts, and others as necessary to analyze the financial situation of the health insurer and formulate the corrective order. The costs of such experts are borne by the insurer.[164]

In short, falling below 200% has regulatory consequences, which can include corrective orders that reach deeply into an insurer's finances and operations. Unlike the 375% BCBSA reporting standard, there is a public interest, cognizable under MIEAA and consistent with its language, in avoiding that circumstance. It is appropriate under MIEAA to key the probability analysis of surplus adequacy to that regulatory standard. This public interest in avoiding the regulatory consequences exists wholly without regard to any rule of the BCBSA.

b) The consequences of falling below the BCBSA 375% reporting standard are neither regulatory nor substantial.

The legal conclusion—that surplus determinations under MIEAA should be keyed to the NAIC/DC standard for a Company Action Level Event and not to the 375% Association reporting standard—is even stronger in light of the limited consequences for a BCBSA licensee of falling below the 375% standard. The consequence of falling below the 375% standard is "intensified monitoring."[165] But quite apart from the 375% standard, BCBSA "continually monitors the operating performance and financial condition of each of its 39 Plans, which must submit quarterly financial reports and semi-annual Health Risk-Based Capital (HRBC) reports to BCBSA." Thus, continuous monitoring by BCBSA and frequent reporting by all licensees including GHMSI are not dependent on meeting the 375% standard.

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162 D.C. Code § 31-3851.03(b)-(c).

163 D.C. Code § 31-3851.04(a)(3) (emphasis added).

164 *Id.* at § 31-3851.04(c).

165 Letter from Scott P. Serota (President and CEO of BCBSA) to the Hon. Gennet Purcell (Sept. 8, 2009), at 1 ("BCBSA Letter"); Rector Report, at 9. Invotex states that the Blue plan must provide the Association with an action plan, "cooperate with requests from BCBSA" for financial information and on-site visits, and provide its year-end balance sheet to providers and direct pay subscribers. Invotex, at 31. However, even that consequence may not always follow. If "the primary licensee has greater than 500% RBC-ACL, it could have a subsidiary or affiliate whose individual company RBC is as low as 300% RBC-ACL without triggering intensified monitoring by BCBSA." Invotex, at 31.

c) If the BCBSA reporting standard determines the surplus ceiling, it would vastly increase GHMSI's allowed surplus.

On the record in this proceeding, surpluses keyed to the BCBSA 375% reporting standard generate vastly larger surpluses than the same actuarial studies find is required to remain above the 200% regulatory standard. Milliman finds the increment due to the 375% standard to be 300 percentage points; Lewin, 250 percentage points; Invotex, 250 percentage points; and Rector, 250 percentage points. Today, a prescribed majority of BCBSA licensees could decide that the threshold for intensified monitoring should be, say, 425% instead of 375%. The effect of this private action by these commercial entities, acting in their own self-interest, would again be to support arguments for greatly increasing the allowed surplus of each licensee, if the monitoring standard were allowed to drive the surplus ceiling.

d) The increase that would result if the BCBSA 375% reporting standard drives the outcome would be incompatible with the MIEAA

As discussed in DC Appleseed's Pre-hearing Report, MIEAA explicitly weighs alternative uses of surplus dollars. It specifies as a matter of law that, once a ceiling is reached that is "consistent" with GHMSI's "financial soundness and efficiency" (thus providing GHMSI at an extremely high confidence level with what is "needed" to meet its "expected and unanticipated contingencies"), community health reinvestment is the more valuable alternative use of surplus dollars.[166]

Once that "consistent with" ceiling is reached, further accumulation of surplus in order to ensure that GHMSI is relieved of some additional reporting to its licensor is not a legally permitted use of surplus dollars under MIEAA, displacing millions of dollars of community health reinvestment. The weighing of the alternative uses that is prescribed by MIEAA is exactly the reverse. Community health reinvestment, for which the needs in the District are very great,[167] must be given priority to the "maximum extent" that is "consistent with financial soundness and efficiency."

The extent to which adoption of the 375% standard would subvert MIEAA can be easily demonstrated. If the requisites for avoiding the 375% threshold are a 95% confidence level at an assumed 2.5 year trend miss, which in Rector's analysis would increase the surplus ceiling from 600% to 850% of RBC, *then GHMSI policyholders and others in the GHMSI service area would be required to forego $205 million in community reinvestment that would otherwise alleviate pressing health needs and economic hardship*—all to ensure that GHMSI *never* be required to provide some additional information to the BCBSA.[168] That would be a clear error of law under MIEAA.

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166 C&B Rebuttal Statement, at 6.

167 Chollet Aug. 2009, at 9-10.

168 As previously shown: 850% ÷ 600% = 1.42. 1.42 x $488M = $693M. $693M- $488M = $205M.

Assuming that Rector's 600% RBC-ACL assures with 99% certainty that GHMSI will never fall to the 200% level, this is more than adequate protection of financial soundness; to hike surplus to 850% RBC-ACL for the sake of avoiding some additional reporting to the BCBSA, would be irreconcilable with the statutory standard under MIEAA. For it would mean that with no material increase in the needed protection of "financial soundness," the mandate to maximize community reinvestment would be subverted.[169] Stated another way, it would with complete certainty deprive many thousands of current and potential subscribers of much-needed premium relief.

Further, suppose that, instead of Rector's ratio of 850% RBC-ACL to accommodate the 375% reporting standard, the surplus were set at 750% of RBC, which is the lowest number in the range of supposed "overlap" among the four studies. (We demonstrate below that there is no probative "overlap," but we use the low-end number from that range to illustrate a different point here.) The conclusion that the result would be irreconcilable with MIEAA does not change. Seven hundred fifty percent is 150 percentage points above the ratio that Rector found already would provide a 99% confidence level with respect to the 200% level. It is ratepayers who would bear the additional cost, as Mr. Burrell acknowledged repeatedly at the September 2009 hearing. That additional cost would be $122 million.[170] However, ratepayers would not be better off: the increase would merely drive GHMSI's surplus beyond a point that already is consistent with its financial soundness and efficiency.

These illustrations demonstrate the statutory error in giving the 375% association reporting standard greater weight than the 200% level that is driven by regulatory considerations and the public interest. Under the four actuarial reports that the Commissioner is considering, it would be that standard and not the 200% level that would determine the outcome—driving the confidence level for 200% to far greater than 99%. In view of the limited consequences of falling below 375% versus the public interest in not falling below 200%, adopting the 375% standard would be incompatible with MIEAA and would also produce a result contrary to the peer review analyses.

e) DISB Rules 4601.4 and 4699.4 must be read consistently with the statute.

DISB Rule 4601.4 provides that, in making the preliminary determination whether GHMSI's surplus is "excessive" (which then triggers a hearing under MIEAA), the Commissioner "shall consider" the NAIC's "Risk Based Capital Requirements for health insurers," pursuant to the adoption of those requirements in D.C. law, and "the Blue Cross/Blue Shield Association capital requirements."[171]

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169 *See* PA. Surplus Decision, at 15 ("diminishing nature of the marginal reduction in probability of ruin or default from successive dollars of surplus"); *see also id.*, at 21 ("the question is: at what point is the statistical likelihood of insolvency so remote that a surplus level at or above that point would be considered inefficient?").

170 750% ÷ 600% = 1.25. 1.25 x 488M = $610M. $610M - $488M = $122M.

171 D.C. Mun. Regs Title 26, § 4601.4.

Where, as here, the Commissioner makes that preliminary finding, the hearing is to determine whether "the surplus is unreasonably large and inconsistent with" GHMSI's obligation to engage in community health reinvestment to the maximum feasible extent consistent with financial soundness and efficiency." DC Appleseed has previously shown that these two statutory elements must be read on an integrated basis, so that "unreasonably large" is not abstracted from but reflects the community reinvestment obligation.[172]

DISB Rule 4699.4 defines "unreasonably large" as a surplus that is "greater than the sum" of two elements: first, the "appropriate NAIC risk-based capital requirement determined by the Commissioner and the Blue Cross/Blue Shield Association capital requirements" and, second, "the amount of surplus needed by the corporation to meet its expected and unanticipated contingencies."[173]

Neither of the two rules—the one governing the threshold determination whether a hearing is required and the other, the final determination after a hearing—changes the conclusion that the BCBSA reporting standard cannot increase a surplus that would provide a near certainty of remaining above the regulatory standard of 200% RBC. The first rule does not relate to the present proceeding at all. It governs only the preliminary, threshold decision whether to conduct a full inquiry.

The interpretation of the second rule must be guided by what has been said so far about the weight that may properly be given under the MIEAA to the reporting standard. DISB Rule 4699.4 authorizes the Commissioner to determine what is an "appropriate" capital "requirement." The NAIC specifies multiple levels of capital for various purposes and with different consequences, and so does the BCBSA. The application of the rule therefore involves multiple steps. The Commissioner must determine which of the various specified levels of capital is a capital "requirement;" which, if a "requirement," is "appropriate" for consideration in this phase of surplus review; and, if appropriate for consideration, what weight is appropriate.

The NAIC has five specified levels of capital.[174] Each is accompanied by different specified consequences for falling below the specified level. As already discussed, these provisions have their counterparts in the governing DC statutes.[175]

The BCBSA also has multiple specified levels of capital. At 200% RBC-ACL, the Association is contractually authorized but not required to withdraw the Blues license through a

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172 C&B Rebuttal Statement, at 2 ("'Unreasonably large' must be applied hand in glove with . . . overarching obligation" to engage in community health reinvestment to the maximum feasible extent; otherwise, the surplus review, "designed by the Council to ensure compliance with" that obligation, "would instead provide an escape hatch from it."). *See generally, id.* at 2-9.

173 D.C. Mun. Regs. Title 26, § 4699.4(a)-(b).

174 *See* NAIC, Risk-Based Capital, at 3. (No Action; Company Action Level; Regulatory Action Level; Authorized Control Level; Mandatory Control Level).

175 *See* D.C. Code §§ 31-2001 through 31-2006 (RBC levels for insurers generally); *id.* §§ 31-3851.03-06 (RBC levels for Health Organizations).

vote of all licensees. Withdrawal would occur only if a super-majority of licensees votes for withdrawal. At 375% RBC-ACL, the licensee must begin additional reporting to the Association, as has already been discussed. The Association can undertake to provide additional monitoring and advice. For some licensees, including plans such as GHMSI that are part of large holding company structures, "additional monitoring procedures can be initiated when RBC falls below 500%."[176] Further, and separately from the 375% standard, the BCBSA may include a plan in intensified monitoring if its "liquidity levels fall below two months of claims and administrative expenses for two consecutive quarters."[177]

It is evident that not each and every one of these various specified levels of capital automatically qualifies as a "requirement" or, if a requirement, must be given equal weight in determining whether GHMSI's surplus is consistent with financial soundness and efficiency or inconsistent with its "maximum feasible extent" obligation or is "needed by the corporation to meet its expected and unanticipated contingencies." The Commissioner must interpret the rule by selecting among the various specified levels and assigning proper weight to the levels selected. No one is contending, for example, that the probability analysis should be keyed to the BCBSA specification of 500% RBC-ACL. And there are significant differences under the BCBSA rules themselves in the consequences of falling below 375% and falling below 200%.

The language of Rule 4699.4 must of course be read in light of the statute. The language easily bears the interpretation that, unlike the 200% requirement under either the NAIC standards or the BCBSA standards, the 375% reporting standard is not a "capital requirement" because of the nature of the consequences that may result from falling below it. And, if it is a "requirement," it is not "appropriate" to give it dispositive effect so long as the absolute level of surplus is above 375%. The consequences of falling below 375% would not affect GHMSI's financial soundness and efficiency, or its ability to cover its expected and unexpected contingencies.

2. *Even If It Were Appropriate to Use the BCBSA Reporting Standard as a Relevant Upper Bound of a Surplus "Range," the Lower End of the Range Should Govern Under MIEAA.*

Even if the upper-bound figure implied by the Milliman analysis were a relevant consideration under MIEAA (850% RBC-ACL as computed by Rector), the Commissioner still should not rely on it in these proceedings for two reasons: First, as we have previously demonstrated, because the 200% standard is sufficient to guard the soundness and efficiency of the company, that figure should be adopted in order to meet the requirement that GHMSI commit the maximum feasible amount to community reinvestment. Accordingly, even if the Commissioner preliminarily considers Rector's 600% and 850% to establish a "range" of surplus for GHMSI, MIEAA requires adoption of the lower end of the range. Second, and equally important, GHMSI itself has made clear that its surplus requirements can be met by any figure

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[176] Invotex, at 31 (citing Memorandum from Lester C. Schott, Maryland Assoc. Commissioner of Exam and Auditing, to R. Steven Orr, Jr., Commissioner, Re: GHMSI of Maryland Surplus Analysis (Feb 8, 2007), at 2.

[177] *Id.*

within the "range," including figures at the lower end. As Mr. Burrell testified at the September 2009 hearing: "The company has stayed within the bottom half of that range consistently. To my knowledge there is no one on the Board that is the least interested in having the company even go to the upper half of the range."[178] He also made clear that surplus toward the lower end of the range meet the financial soundness requirement:

> Our board chose that on the aggregate, that the company ought to be just from a sound business operation standpoint...within an optimum range, and, therefore, they sought the best possible advice as to what the optimum range ought to be, and we have been consistently, as we said, in the bottom third of it, or the bottom half of it. We would consider that to be financially sound.[179]

For all these reasons, the Commissioner should adopt the conservative 600% RBC-ACL figure, as computed by Rector and confirmed by the peer review analysis, as the surplus level for GHMSI that best accords with MIEAA.

D. There is No Probative "Overlap" Between Rector, on the One Hand, and, on the other, Milliman, Lewin, and Invotex.

In the Decision, the Commissioner states that the expert reports other than ARM "overlap" in the range of 750 to 850%.[180] The Commissioner does not draw a conclusion in the Decision from this asserted "overlap," nor should any be drawn. In our view, the "overlap" of these three analyses is of no probative value and provides no basis for rejecting the conclusion supported by Rector and the peer review analyses that surplus above 600% for GHMSI is "excessive."

First, as we have shown and as Rector has confirmed, the question under MIEAA does not concern selecting a "range." It concerns the level at which GHMSI begins to have excess surplus under MIEAA, with "excess" defined in reference to a particular, discrete threshold—in this case, 200%. Second, there is no "overlap" between Rector's conclusion regarding the amount of surplus required to avoid the 200% standard and any of the other analyses regarding that same 200% standard. And there is good reason for that: Rector showed persuasively that the other analyses were mistaken, insufficiently explained, or both. Therefore, it is not surprising that the suggested "overlap" range (750% to 850%) is empirically suspect; it is completely out of keeping with the peer review analyses.

In any case, "overlap" that can be created only by allowing the 375% reporting standard to drive the permitted surplus ceiling would itself entail a legal error. And even if there were some legally cognizable "overlap," the logical predicates for giving any conceivable weight to "overlap" are not present here. Those predicates are that: (1) each of the four analyses was keyed to the governing statute, MIEAA; (2) each of the analyses was independent of each of the

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178 Hearing Sept. 10, at 106: 16-20.

179 *Id.* at 200: 20-22, 201: 1-7 (emphasis added).

180 Aug. 6 Decision, at 19, 20.

others and also independent of GHMSI; and (3) each is entitled to equal weight. A failure to satisfy any one of those predicates invalidates the notion that the "overlap" is at all probative concerning GHMSI's appropriate surplus under MIEAA. None of these predicates is demonstrably present:

- Both Milliman and GHMSI have acknowledged on the record that they took no account of MIEAA's standards.[181] Likewise, Lewin's reports contained no discussion of the governing legal standard, and analyzed the question of what it called "'appropriate'" surplus[182] as if the statute did not exist. Invotex's conclusion related to an RBC-ACL range requirement for GHMSI *under Maryland law*."[183] Only Rector (and ARM) recognized that the statutory standard matters here.

- In pervasive respects Milliman was not independent of GHMSI. As already described, Milliman relied on GHMSI's forecasting, and its assumptions were agreed to by GHMSI. The record is simply unclear about the extent to which the analyses other than Rector were independent of one another.

- The Rector Report identifies significant problems with the analyses conducted by Milliman and, as we have pointed out, Milliman has failed to rebut Rector's criticisms convincingly. The Commissioner's Decision recognized, "it is not clear what methodology or assumptions Lewin used in its analysis," and "it is not clear how the assumptions made by Invotex resulted in its range."[184]

Thus, the Commissioner should not weigh these analyses equally with Rector, as the notion of "overlap" assumes. To decide GHMSI's surplus in this case based on a perceived "overlap" in ranges produced by these experts would not only constitute an implicit rejection of Rector's careful analysis of the shortcomings of the other experts, it would also constitute a failure to offer a reasoned analysis under MIEAA of which experts should be credited and why.

For all these reasons, we urge the Commissioner to conclude on this record that under MIEAA GHMSI's surplus on December 31, 2008 should have been no more than 600% RBC-ACL.

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181 *See* D.C. Appleseed Rebuttal Statement, at 3 (citing Hearing Sept. 10, at 197, 211).

182 Lewin Oct. 29, 2009, at 4.

183 Aug. 6 Decision, at 13 (emphasis added).

184 Aug. 6 Decision, at 12-13.

III. BASED ON THE RECORD AND MIEAA, THE COMMISSIONER SHOULD DETERMINE THAT AT LEAST 60% OF GHMSI'S EXCESS SURPLUS IS ATTRIBUTABLE TO THE DISTRICT.

Introduction

MIEAA authorizes the Commissioner to "review the portion of the surplus of the corporation that is attributable to the District."[185] As previously established in submissions by D.C. Appleseed and Covington & Burling LLP,[186] surplus should be attributed based on the jurisdiction in which the insurance policy was written, in other words, where the policy holder is located. For most employer-sponsored group insurance policies, the surplus will therefore be attributed to the jurisdiction where the employer is principally located. For individual policies, the surplus will be attributed to the jurisdiction in which the insured individual resides. This approach is the standard practice in the industry, and is currently followed by the Maryland Insurance Administration and by GHMSI itself. Using the location of the policyholder as the determinative factor, the Commissioner should determine that at least 60% of GHMSI's excess surplus is attributable to the District.

A. Attribution Based on the Situs of the Contract Comports with MIEAA, GHMSI's Past Practices and Maryland Law.

In its report, Rector identified several factors that the Commissioner should consider in determining the percent of GHMSI's excess surplus attributable to the District. Among these are premiums by jurisdiction (the Schedule T approach) and claim expenses by jurisdiction of the policyholder (the location of the policyholder).[187] The Commissioner stated in her order that, applying these factors, 69 percent of GHMSI's surplus is attributable to the District.[188]

Attribution based on where the policy is issued is consistent with the scope of the Commissioner's authority to regulate rates in the District. The District regulates insurance policies issued in the District, as opposed to policies that cover residents of the District.[189] Likewise, the Maryland and Virginia insurance commissioners do not have authority to regulate health insurance rates of private employers located in the District and whose policies are issued in the District; nor can they regulate rates for FEHB subscribers even when they reside in Maryland or Virginia. Thus, it is clear that where an insurance policy is "issued or delivered" should be coterminous with the reach of the rate regulation authority of the insurance

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185 MIEAA, § 2(e); D.C. Code § 31-3506(e).

186 Testimony of D.C. Appleseed for GHMSI Surplus Hearing, at Exhibit B (Sept. 10, 2009) ("Appleseed Testimony"); D.C. Appleseed Rebuttal Submission, at App. A.

187 Rector Report, at 18.

188 Aug. 6 Decision, at 11.

189 D.C. Appleseed Rebuttal Submission, at Att. B.

commissioners of neighboring jurisdictions—in other words, attribution should be based on where the insurance policy is issued.

Attribution to the jurisdiction where the policy was issued is also consistent with industry practice. In its rebuttal submission to DISB in November of 2009, ARM explained that standard industry practice in issuing premium refunds in the event of low loss ratios or excess profits is to allocate such refunds by the jurisdiction of where the policy was issued, not by the residence of the individual subscriber.[190] Based on the level of GHMSI's business that originates in the District, ARM concluded that approximately 60 percent of GHMSI's surplus should be attributed to the District.

Attribution of surplus based on where the policy was issued is also consistent with GHMSI's past practice and with Maryland law. Specifically, this is the approach GHMSI itself used in its annual report to the Maryland Insurance Administration for purposes of the state's premium tax on all premium revenues "reasonably attributable" to insurance business in the state.[191] In that filing, GHMSI attributed premiums to Maryland and other jurisdictions, including the District, based on the number of policies issued in those jurisdictions, an approach known as the "Schedule T approach." On October 16, 2008, Maryland Insurance Commissioner Ralph Tyler determined that GHMSI's 2007 Premium Tax Exemption Report complied with Maryland law,[192] endorsing GHMSI's method of attributing premium revenue. Accordingly, for 2008, GHMSI attributed 63% of its total premiums to the District.[193]

Recent legislative activity in Maryland reinforces this attribution method. Pursuant to Maryland Act HB1534/SB1070, enacted and effective as of June 1, 2009, the Maryland Insurance Commissioner is authorized to review and evaluate the effects of any surplus evaluation conducted by another state but only with respect to "premiums charged to subscribers under policies issued or delivered" in Maryland. Although the Act does not define "issued or delivered" for purposes of attribution, insurance case law suggests that the phrase should be defined according to the subscriber's place of employment—in other words, the jurisdiction in which the policy was issued to the employer providing the coverage.[194]

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190 *Id.* This portion of the ARM analysis does not depend upon GHMSI information not provided to ARM, and there is thus no reason to disregard it.

191 Md. Code Ann., Ins. § 6-101(b).

192 *See* Md. Ins. Admin. Order (Oct. 16, 2008).

193 Rector Report, at 21.

194 By way of analogy, some cases discussing choice of law provisions for group life insurance policies rely on the Restatement (Second) of Conflicts of Laws § 192 in defining "policies issued or delivered." The Restatement explains that the rights of an insured should be determined "*not* by the local law of the state where the employee was domiciled and received his certificate but rather by the law governing the master policy . . This will usually be the state where the employer has his principal place of business." *Cf. Guardian Life Ins. Co. of America v. Insurance Comm'r of State of Md*, 446 A.2d 1140 (Md. 1982) (holding that a policy delivered to a Rhode Island trustee was not "issued or delivered" in Rhode Island but was instead issued or delivered in Maryland, the state in which the employer was located).

B. GHMSI Misreads the Plain Language of MIEAA.

GHMSI advocates for allocation based on the residence of subscribers, and Milliman's analysis is based on GHMSI's proposed allocation method. GHMSI argues that allocation in this manner is appropriate because MIEAA authorizes GHMSI to spend down any surplus found by the Commissioner to be excessive "entirely . . . for the benefit of current subscribers of the corporation."[195] GHMSI incorrectly interprets this language to mean that any spend down must benefit District residents only.[196]

These arguments are simply inconsistent with the plain language of MIEAA. MIEAA requires only that GHMSI "submit a plan for dedication of the excess to community health reinvestment in a fair and equitable manner."[197] There is no requirement that the excess surplus be spent on initiatives that benefit only District residents. The language quoted by GHMSI that any spend-down may be committed "entirely . . . for the benefit of current subscribers of the corporation" authorizes GHMSI to devote all of its community reinvestment resources to current—rather than future or potential—subscribers. It does not require GHMSI to spend its excess surplus on initiatives that benefit District subscribers exclusively. In fact, the statute actually directs that, when implementing MIEAA, "the Commissioner shall consider the interests and needs of the jurisdictions in the corporation's service area."[198] Moreover, if GHMSI spends down its excess surplus by reducing premiums for its group and individual subscribers as it has said it will do,[199] these premium reductions will provide a proportionate benefit to residents of jurisdictions other than the District, primarily Maryland and Virginia, whose health plans are sponsored by District employers.

GHMSI also argues that attribution according to subscriber residency is required because dictionaries define "attributable" as including both "belonging to" and being "caused by," and GHMSI's surplus belongs to subscribers because it is held to pay future claims by subscribers. GHMSI's surplus is neither "caused by" not does it "belong to" GHMSI's individual subscribers. Although GHMSI subscribers pay premiums that contribute to the surplus, their employers hold the master contracts with GHMSI and pay most of the premiums.

The premiums paid by these District employers are the source of GHMSI's consistently higher underwriting gain on D.C. business which in turn has contributed to surplus originating from D.C. business. If only non-FEP business is considered, more than 50% of underwriting gains originate from policies issued in the District, despite the fact that those policies account for

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[195] GHMSI Supplemental Submission, at 11, *quoting* D.C. Code, § 31-3506(g)(2).

[196] GHMSI Supplemental Submission, at 11. *See also* D.C. Code § 3501(a)(1A) (defining "community health reinvestment" as "expenditures that promote and safeguard the public health or that benefit current or future subscribers, including premium rate reductions").

[197] D.C. Code § 31-3506(g)(1).

[198] *Id.* § 31-3506.01(b)(emphasis added).

[199] Transcript of D.C. Appleseed Teleconference with GHMSI, 29.6-10 (noting that "if there were ever any excess that our plan that we would submit to DISB would be specific to taking that excess and giving it back to those subscribers that are residents of the District").

less than 30% of the non-FEP premium.[200] If FEP business also is considered, over 60% of underwriting gains originate from policies issued in the District.[201] As a result, GHMSI's surplus is in fact largely due to District business.

GHMSI finally argues that the situs approach deviates from the DISB regulation because it fails to take into account the number of health care providers under contract with GHMSI by geographic area. However, the Commissioner specifically addressed this factor in paragraph 7 of the Decision.[202] GHMSI's claim that it is inconsistent with the DISB regulation to allow subscriber residency to be "trumped by situs-based factors" is incorrect. The regulations require the Commissioner to take the situs of policies and the location of health care providers into account.

In summary, GHMSI's subscriber-based allocation is based on a misinterpretation of the plain language of MIEAA and is inconsistent with GHMSI's own past practices. The Commissioner should follow the plain language of MIEAA, as well as past industry and company practice, and attribute GHMSI's surplus based on the location of policy issuance. Accordingly, the Commissioner should determine that at least 60% of GHMSI's excess surplus is attributable to the District.

CONCLUSION

In the conclusion to its September 3 filing, GHMSI contends that it "could take some time—perhaps well into 2011 and beyond" before the impacts of FHCR will become clear. "In the meantime," GHMSI contends, "it is clear that GHMSI's surplus is not 'excessive' as defined by District law." Accordingly, GHMSI proposes "that this examination of GHMSI's surplus be concluded and a new evaluation be undertaken once the financial impacts of reform are better understood and quantifiable."

DC Appleseed agrees that it is too early to determine whether any adjustment to GHMSI's surplus might be warranted by FHCR. But we also believe that the potential upward adjustment in surplus of 100 to 200 percentage points that GHMSI's experts suggest has been neither explained nor substantiated. We therefore urge the Commissioner to leave the task of evaluating the impact of FHCR on the company for later proceedings—both in rate reviews and in subsequent surplus examinations.

Moreover, DC Appleseed strongly disagrees with the contention that GHMSI's surplus is not "excessive" under District law. That law, which none of GHMSI's experts referenced in their analyses, requires the Commissioner to determine a level of surplus that permits the company to "engage in community health reinvestment to the maximum feasible extent consistent with financial soundness and efficiency." Milliman's own model, as corrected by Rector, shows that this amount should be no higher than 600% RBC-ACL. And the peer review

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200 D.C. Appleseed Rebuttal Submission, at Att. B.

201 *Id.*

202 Aug. 6 Decision, at 11.

analyses done by Rector, Invotex, and ARM confirm this 600% measure—a measure that is much lower than the 845% GHMSI had accumulated by the end of 2008 and the even higher 902% it accumulated by the end of 2009. Nothing in this record explains or justifies the significantly higher surplus that GHMSI continues to hold compared with its peers. In our view, the difference between the amount of surplus needed for 600% RBC-ACL and the much higher amount GHMSI continues to hold is excessive under District law.

For reasons Mr. Burrell himself has quite rightly stated, it is important that the Commissioner rule promptly concerning the amount of GHMSI's excessive surplus and order GHMSI to file a plan to spend it down. As Mr. Burrell said, GHMSI's surplus comes from its subscribers—primarily individuals and small and medium-sized groups—and if there is excess surplus it is because the company overcharged those subscribers.

We believe that GHMSI has overcharged its subscribers and thereby produced excessive surplus. With subscribers facing growing hardship to pay ever-increasing premiums, there has never been a more important time in the history of this company that it be ordered to spend down that surplus. At the company's option and if consistent with the statutory provisions governing the spend-down plan, the spend-down could take the form of much-needed premium relief to hundreds of thousands of people in the national capital area. We urge the Commissioner to issue an order finding that GHMSI's surplus ratio should have been 600%, and requiring GHMSI to submit an appropriate spend-down plan.

Glossary

GHMSI Surplus Review Proceeding Submissions:

Public Hearing on Surplus and Review of GHMSI Before the D.C. Dept. of Ins., Sec. and Banking ("DISB"), Sept. 10, 2009 ("Hearing Sept. 10")

Public Hearing on Surplus and Review of GHMSI Before the D.C. DISB, Sept. 11, 2009 ("Hearing Sept. 11")

DISB Decision and Order, Aug. 6, 2010, *available at* http://disb.dc.gov/disr/frames.asp?doc=/disr/lib/disr/pdf/Surplus_Review_and_Determination_Regarding_Group_Hospitalization_and_Medical_Services_Inc_Decision_and_Order.PDF ("Aug. 6 Decision")

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