Exhibit A
DECISION AND ORDER

The Commissioner of the District of Columbia Department of Insurance, Securities and Banking (the “Commissioner”) issues this Decision and Order pursuant to his authority under the Hospital and Medical Services Corporation Regulatory Act of 1996, effective April 9, 1997 (D.C. Law 11-245; D.C. Code §§ 31-3501 et seq. (2009)) (the “HMSC Regulatory Act”).

In accordance with the HMSC Regulatory Act, and upon consideration of the record in this proceeding, including timely public comments received by the Department of Insurance, Securities and Banking (the “Department”), the Commissioner orders Group Hospitalization and Medical Services, Inc. (“GHMSI”) to dedicate its excess 2011 surplus attributable to the District of Columbia (the “District”), as adjusted in accordance with this Decision and Order, to community health reinvestment by issuing rebates to current subscribers under subscriber contracts with a situs in the District, as further described in this Decision and Order. The rebates must be paid within 120 days of the date of this Decision and Order. The freeze on premium rate increases imposed by the Decision and Order on Group Hospitalization and Medical Services, Inc. Plan, Order No. 14-MIE-016 (June 14, 2016) (the “June 14, 2016 Order”) shall remain in effect until
GHMSI issues the rebates required by this Decision and Order, at which time the freeze shall be lifted.

I. BACKGROUND

A. GHMSI’s Obligation to Engage in Community Health Reinvestment

GHMSI is a nonprofit hospital and medical services corporation created in 1939 by Congressional charter. See An Act Providing for the incorporation of certain persons as Group Hospitalization, Inc., Pub. L. No. 395, 53 Stat. 1412 (1939), as amended (the “Charter”).1 The Charter declares GHMSI to be “a charitable and benevolent institution,” id. at § 8, 53 Stat. at 1414, and further states that GHMSI “shall be not be conducted for profit, but shall be conducted for the benefit of [its] certificate holders.” Id. at § 3, 53 Stat. at 1413. The Charter establishes the District as GHMSI’s legal domicile, see District of Columbia Appropriations Act, 1994, Pub. L. No. 103-127, § 138(a), 107 Stat. 1336, 1349 (Oct. 29, 1993), and provides that GHMSI “shall be licensed and regulated by the District of Columbia in accordance with the laws of the District of Columbia.” Id., § 138(b).2 GHMSI is licensed to operate in the District pursuant to the HMSC Regulatory Act.

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1 GHMSI originally was incorporated as Group Hospitalization, Inc. but later merged with Medical Services, Inc. to form Group Hospitalization and Medical Services, Inc. See An Act to amend the Act providing for the incorporation of certain persons as Group Hospitalization, Inc., Pub. L. No. 98-493, § 1, 98 Stat. 2272, 2272 (Oct. 17, 1984).
2 GHMSI is a wholly-owned subsidiary of CareFirst, Inc., a nonprofit holding company. See Health Annual Statement for the Year Ended December 31, 2015 for the Condition and Affairs of the Group Hospitalization and Medical Services, Inc. at 33. Through CareFirst, Inc., GHMSI is affiliated with CareFirst of Maryland, Inc. (“CFMI”). Id. Together, GHMSI and CFMI do business in the District, Maryland and Virginia as “CareFirst BlueCross BlueShield.” Id. Through a jointly-owned intermediate holding company, GHMSI and CFMI share ownership of CareFirst BlueChoice, a health maintenance organization doing business in the District, Maryland and certain counties in Virginia. Id.
In 2009, due to its concern over GHMSI’s commitment to its mission as a charitable and benevolent institution, the Council of the District of Columbia (the “Council”) amended the HMSC Regulatory Act by enacting the Medical Insurance Empowerment Amendment Act of 2008, effective March 25, 2009 (D.C. Law 17-369; 56 DCR 1346) (“MIEAA”). Under MIEAA, GHMSI is required to “engage in community health reinvestment to the maximum feasible extent consistent with financial soundness and efficiency.” D.C. Code § 31-3505.01. To ensure GHMSI does not neglect this obligation, MIEAA requires the Commissioner to review GHMSI’s surplus at least once every three years and authorizes the Commissioner to issue a determination regarding whether the surplus is excessive. See id. at § 31-3506(e). If the Commissioner determines that GHMSI’s surplus is excessive, he must order it to “submit a plan for dedication of the excess to community health reinvestment in a fair and equitable manner.” Id. at § 31-3506(g)(1). MIEAA further provides that if the Commissioner determines GHMSI has “failed to submit a plan [for community health reinvestment] as ordered . . . within a reasonable period . . . the Commissioner shall deny for 12 months all premium rate increases for subscriber policies written in the District sought by the corporation . . . and may issue such orders as are necessary to enforce the purposes of this chapter.” Id. § 31-3506(i).

B. Review of GHMSI’s 2011 Surplus

Following a multi-year review, pursuant to Decision and Order No. 14-MIE-012 (December 30, 2014) (the “December 30, 2014 Order”), then Acting Commissioner Chester A. McPherson (the “Acting Commissioner”) determined that GHMSI’s surplus as of December 31, 2011 was excessive under MIEAA and ordered GHMSI to submit a
plan for dedication of the excess attributable to the District—approximately $56.2 million—to community health reinvestment in a fair and equitable manner. See December 30, 2014 Order at 66. GHMSI and the D.C. Appleseed Center for Law and Justice, Inc. (“Appleseed”) both filed motions for reconsideration of the December 30, 2014 Order, which were denied.5

On March 16, 2015, GHMSI submitted a response to the December 30, 2014 Order, which it styled as a “plan.” See Plan of Group Hospitalization and Medical Services, Inc. filed with the Department of Insurance, Securities and Banking Pursuant to December 30, 2014 Order No. 14-MIE-012 (Mar. 16, 2015) (the “Plan”). In the Plan, GHMSI essentially maintained that no tangible plan for reinvestment of the excess 2011 surplus was needed. GHMSI based its position on several grounds. First, GHMSI argued that it had no excess surplus. See id. at 3. Second, and alternatively, GHMSI

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3 The precise amount of excess 2011 surplus attributable to the District is $56,213,088.72. The figure $56.2 million is used for ease of reference.

4 Appleseed is a nonprofit public interest center located in Washington, D.C. and has long been involved as an interested person in these proceedings.

5 In January 2015, GHMSI and Appleseed filed motions with the Department for reconsideration of the December 30, 2014 Order. See D.C. Appleseed’s Motion for Reconsideration (Jan. 9, 2015); GHMSI’s, Motion for Reconsideration and Coordinated Proceedings with Maryland and Virginia (Jan. 22, 2015). The Acting Commissioner denied those motions. See Order on Appleseed’s Motion for Reconsideration and GHMSI’s Request for Briefing Schedule on Reconsideration, Order No. 14-MIE-013 (Jan. 15, 2015); Order on GHMSI’s Motion for Reconsideration and Coordinated Proceedings with Maryland and Virginia, and on D.C. Appleseed’s Request for Briefing Schedule, Order No. 14-MIE-014 (Jan. 28, 2015).

Also, on January 29, 2015, GHMSI and Appleseed filed petitions for review of the December 30, 2014 Order with the District of Columbia Court of Appeals (the “Court of Appeals”). GHMSI also petitioned for review of the Order denying its motion for reconsideration. In light of these appeals, GHMSI requested a stay of all further proceedings in this matter – including the filing of a plan – until after the appeals’ resolution. The Acting Commissioner denied GHMSI’s motion for a stay. See Order on GHMSI’s Motion to Stay Further Proceedings and Appleseed’s Request for Briefing Schedule, Order No. 14-MIE-015 (Mar. 2, 2015). The Court of Appeals dismissed the petitions filed by GHMSI and Appleseed as having been taken from a non-final and non-appealable order, reasoning that the Acting Commissioner had not yet reviewed GHMSI’s plan, and thus the “administrative process [was] not yet complete, and no specific, enforceable obligations regarding the excess assets ha[d] been imposed on GHMSI.” Order, Appeal Nos. 15-AA-108 and 15-AA-109 (D.C. Ct. App. Apr. 28, 2015).
maintained that in the years since 2011, it had spent more than $56.2 million on community health reinvestment, in addition to incurring underwriting losses and experiencing a decline in surplus, and therefore had fulfilled its obligations under MIEAA. See id. at 4-6. GHMSI further argued, among other things, that the Department had not sufficiently coordinated with Maryland and Virginia before issuing the December 30, 2014 Order. See id. at 6-8.

C. Decision and Order Regarding GHMSI’s Plan

On June 14, 2016, the Commissioner issued a Decision and Order on Group Hospitalization and Medical Services, Inc. Plan, Order No. 14-MIE-016 (June 14, 2016) (the “June 14, 2016 Order”). Under the June 14, 2016 Order, the Commissioner determined that GHMSI had failed to submit a plan as required by the December 30, 2014 Order and ordered as follows:

1. Effective as of the date of the June 14, 2016 Order, all requests for premium rate increases for subscriber policies written by GHMSI in the District were denied for 12 months or until the Commissioner develops and approves a plan for reinvestment of the 2011 excess surplus, whichever occurs first;

2. Pursuant to his authority to issue such orders as are necessary to enforce the purposes of MIEAA, the Commissioner would develop and approve a plan for GHMSI to dedicate the excess 2011 surplus attributable to the District to community health reinvestment in a fair and equitable manner;

3. There would be a 30-day period beginning on the date of the June 14, 2016 Order for the public to comment on the plan to be developed by the Commissioner; and
4. The Commissioner would issue and approve a plan no later than 30 days after
the expiration of the public comment period.

June 14, 2016 Order at 19-20.

**D. State and Federal Responses to the December 30, 2014 Order**

The State of Maryland, the Commonwealth of Virginia and the federal
government took various actions in response to the December 30, 2014 Order. On
February 10, 2015, the Maryland Insurance Commissioner sent a letter to GHMSI’s
President and Chief Executive Officer stating that the Maryland Insurance Administration
(“MIA”) would initiate an investigation to determine whether the December 30, 2014
Order would be harmful to the interests of Maryland residents. See Motion to Stay
Further Proceedings by Group Hospitalization and Medical Services, Inc. (Feb. 10,
2015), Exhibit B (Letter from Al Redmer, Jr., to Chet Burrell at 3 (Feb. 10, 2015)). The
letter stated that while the MIA’s investigation was ongoing, “GHMSI is prohibited from
reducing or distributing its surplus as a result of the [December 30, 2014 Order] and is
prohibited from submitting a plan to the D.C. Commissioner for dedication of its excess
of 2011 surplus attributable to D.C. until submitted, reviewed, and approved by the
MIA.” Id. On June 10, 2015, following a proceeding to consider the effect of the
December 30, 2014 Order on Virginia residents, the Virginia State Corporation
Commission (“VA SCC”) issued an order stating that GHMSI should not distribute or
reduce any portion of its surplus without approval of the VA SCC. See Order, Case No.
INS-2015-00007, Commonwealth of Virginia, State Corporation Commission (June 10,
2015).
In addition, both Maryland and Virginia enacted legislation in the first months of 2015, the intended effect of which is to prohibit GHMSI from distributing or reducing its surplus in response to an order by the Commissioner to enforce MIEAA without the approval of Maryland and Virginia state insurance regulators. See Md. Code, Ins. § 14-124(a)(3), (6); Va. Code § 38.2-4229.2(D). The Maryland legislation was enacted on April 14, 2015. The Virginia legislation was enacted on March 23, 2015.

In December 2015, Congress amended GHMSI’s federal charter to provide that GHMSI may not divide, attribute, reduce or distribute its surplus pursuant to any law or order of any jurisdiction without the express agreement of the District, Maryland, and Virginia. See Financial Services and General Government Appropriations Act, 2016 § 747, enacted as part of Consolidated Appropriations Act of 2016, Pub. L. No. 114-113, 129 Stat. 2242 (Dec. 18, 2015). Congress made this requirement applicable with respect to GHMSI’s surplus for any year after 2011. Id. at § 747(b).

II. PUBLIC COMMENT

The June 14, 2016 Order requested public comment on the plan to be developed by the Commissioner to enforce the December 30, 2014 Order. The Commissioner received and considered numerous thoughtful and helpful comments. Persons submitting comments included members of the Council, GHMSI, Appleseed, GHMSI subscribers and contractholders, two coalitions of local organizations dedicated to improving public health and welfare, nonprofit groups providing community health services in the District, the Maryland Insurance Commissioner, local trade associations, and other interested persons.6 The discussion below summarizes major aspects of the comments received.

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6 All public comments are hereby incorporated as part of the record in this proceeding and can be found at http://disb.dc.gov/node/771622.
A. GHMSI’s Comments

GHMSI’s comments revisit many of the same arguments it has made before in this proceeding. See GHMSI Comments in Response to DISB’s Order of June 14, 2016 (“GHMSI Comments”). The Department has addressed these arguments in its previous decisions and orders in this proceeding.

New issues raised by GHMSI include the following: GHMSI argues that the amendment to its Charter enacted by Congress in 2015 prohibits the Commissioner from ordering reinvestment of the excess 2011 surplus without the agreement of Maryland and Virginia. See id at 2-5. In addition, GHMSI asserts that since 2011, it has made premium rate filings that resulted in a reduction to its surplus of $42.44 million, which should be credited as community health reinvestment. See id. at 10-13. Finally, GHMSI argues that the Commissioner lacks authority under MIEAA to develop and approve a plan for reinvestment of GHMSI’s excess surplus on his own initiative. See id. at 14.

B. Comments from Members of the Council

The Commissioner received comments from Councilmember At-Large Elissa Silverman and Ward 3 Councilmember Mary M. Cheh. See Letter from Councilmember At-Large Elissa Silverman to Commissioner Taylor (July 14, 2016); (“Silverman Letter”); Letter from Councilmember Mary M. Cheh to Commissioner Taylor (July 14, 2016) (“Cheh Letter”). Councilmembers Silverman and Cheh both urge the Commissioner to maintain the rate freeze on GHMSI for a full 12 months as a penalty for failing to comply with the December 30, 2014 Order. See Silverman Letter at 1-2; Cheh

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7 As it has before, GHMSI also argues that its community giving, contributions to the Healthy DC fund, and losses attributable to the District’s open enrollment program should be credited as expenditures of excess surplus for community health reinvestment. See GHMSI Comments at 13-14.
Letter at 1. The Councilmembers state that MIEAA requires this result. See Silverman Letter at 2; Cheh Letter at 1. In addition, both Councilmembers support the recommendation made by two coalitions of nonprofit organizations to establish a fund for reinvestment of the excess surplus. See Silverman Letter at 1; Cheh Letter at 1. The coalitions’ recommendations are summarized below. Finally, both Councilmembers urge the Commissioner to require reinvestment of the excess surplus in ways most likely to improve public health in the District. See Silverman Letter at 2; Cheh Letter at 2.

C. Appleseed’s Comments

Appleseed urges the Commissioner to adopt a plan similar to that suggested by the coalitions, as summarized below. Specifically, Appleseed proposes requiring GHMSI to place the excess surplus in a trust fund managed by an independent and experienced third party acting in the public interest. See D.C. Appleseed’s Comments on the Commissioner’s Plan for Holding GHMSI Accountable to the Requirements of the Medical Insurance Empowerment Amendment Act at 3-5 (July 14, 2016) (“Appleseed Comments”). Appleseed further suggests that the Commissioner require the fund manager to invest the excess surplus in community health initiatives over a five-year period. See id. at 5. Appleseed recommends that spending by the fund be guided by independent assessments of the District’s community health needs, such as those provided in a report from the Urban Institute examining the District’s health care needs and the types of community investments that could be made with the excess surplus (the “Urban Institute Report”)

Health in April, which provides baseline information on District community health indicators (the “DOH Report”). See id.

Appleseed bases its recommendation to establish a community reinvestment fund on two grounds. First, Appleseed states that although MIEAA defines “community health reinvestment” broadly, the legislative history of MIEAA suggests that the Council was particularly interested in promoting community healthcare-related programs, which is what a community reinvestment fund would be designed to achieve. See id. at 1-2. Second, Appleseed argues that a reinvestment fund is a better option than requiring GHMSI to pay rebates because rebates would likely not be “fair and equitable,” as required by MIEAA. See id. at 8. Appleseed offers several reasons for this view, most of which center on the view that the rebate received by each subscriber should be directly proportional to the subscriber’s contribution to the excess 2011 surplus, and it would be difficult to ensure that this goal is achieved. See id. at 8-9. Appleseed also argues that the payment of rebates would not advance MIEAA’s purpose of promoting and safeguarding the public health. See id. at 9-10.

Appleseed urges the Commissioner not to credit GHMSI for any reductions in surplus it has made since 2011 as community health reinvestment. Appleseed maintains that any such reductions must be intentional to qualify as community health reinvestment. See id. at 10. According to Appleseed, there are several reasons why GHMSI cannot show the requisite intent. See id. First, Appleseed states that GHMSI has consistently maintained it has no excess surplus and therefore cannot now argue that it intentionally

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sought to reduce its surplus for purposes of community health reinvestment. See id. at 10-11. Second, Appleseed asserts that, until now, GHMSI has never indicated that it intended to reduce its surplus for the purpose of engaging in community health reinvestment. See id. at 11. In addition, Appleseed states that, although it found three rate filings by GHMSI effective after 2011 in which GHMSI intentionally sought to reduce its surplus, none of these filings identifies community health reinvestment as the purpose of the reduction and none is distinguishable from rate changes made for competitive reasons. See id.

Finally, Appleseed argues that because the Commissioner has determined GHMSI failed to submit a timely plan for community health reinvestment, he is required by MIEAA to deny rate increases by GHMSI for a full 12 months and has no discretion to lift the freeze on rates until the 12-month period has ended. See id. at 12-14.

D. Comments from GHMSI Contractholders and Subscribers

The Commissioner received comments from a number of GHMSI contractholders and subscribers. These comments generally urge the Commissioner to devote the excess surplus to the payment of rebates or rate reductions.

E. Comments from Coalitions

The Commissioner received comments from two coalitions of local organizations whose missions include improving the health and welfare of District residents.10 The

10 The comments of the first coalition were submitted on the letterhead of the Community Foundation for the National Capital Region, which was joined as a signatory by the following organizations: The Morris & Gwendolyn Cafritz Foundation; The Moriah Fund; Eugene and Agnes Meyer Foundation; The Washington Area Women’s Foundation; and The Consumer Health Foundation. The comments of the second coalition were signed the following organizations: Bread for the City; Children’s Law Center; DC Fiscal Policy Institute; Families USA; Family and Medical Counseling Service, Inc.; Family Voices of the District of Columbia, Inc.; Greater Washington Society for Clinical Social Work; Legal Aid Society of the District of Columbia; Miriam’s Kitchen; National MS Society, Greater DC-Maryland Chapter; ONE DC; University Legal Services; and Washington Interfaith Network.
comments from both coalitions are very similar. Each coalition recommends dedicating the $56.2 million in excess surplus to a fund from which grants would be made over no more than a five-year period to support community health initiatives in the District. See Letter from the Community Foundation for the National Capital Region to Commissioner Taylor at 2 (July 14, 2016) (“Community Foundation Letter”); Letter from Bread for the City, et al., to Commissioner Taylor at 1 (July 14, 2016) (“Bread for the City Letter”). Although their recommendations differ in some details, both coalitions envision that the fund would be administered by one or more private foundations with oversight by the Commissioner. See Community Foundation Letter at 4-8; Bread for the City Letter at 1. Both coalitions also suggest that priorities for grant-making could be guided by the Urban Institute Report. See Community Foundation Letter at 2; Bread for the City Letter at 2. In addition, one coalition identifies the DOH Report as a guidepost that could be used to track the effectiveness of the fund over the course of its operations. See Community Foundation Letter at 2.

F. Comments from Community Health and Welfare Service Providers

The Commissioner received comments from a number of District-based organizations that provide community health and welfare services in the District.11 These comments generally provide recommendations regarding specific programs that should receive funds for community health reinvestment.

Whitman-Walker Health makes the more general suggestion that the Commissioner either order GHMSI to reinvest the excess surplus using GHMSI’s

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11 The following health and welfare service providers submitted comments: Walker Whitman Health; District of Columbia Primary Care Association; Miriam’s Kitchen; Capital Area Food Bank; ONE DC; Amerihealth Caritas DC; Food & Friends; DC Campaign to Prevent Teen Pregnancy.
existing grant-making procedures or require GHMSI to contribute the excess to a fund dedicated to providing financial support to individuals and families insured by GHMSI. See Letter from Donald Blanchon, Chief Executive Officer, Whitman-Walker Health to Commissioner Taylor at 2 (July 14, 2016).

G. Comments from Trade Associations

The Commissioner received comments from three District trade associations representing the insurance industry and the business community at large. Each expressed concern over the effect a distribution or reduction of excess surplus might have on GHMSI’s financial position.

H. Comments from Maryland Insurance Commissioner

The Commissioner also received comments from Maryland Insurance Commissioner Al Redmer, Jr. Commissioner Redmer states that, under the 2015 amendment to GHMSI’s federal Charter, any order by the Commissioner that will cause GHMSI’s present or future surplus to be distributed or reduced requires the agreement of the District, Maryland and Virginia. See Statement of Al Redmer, Jr., Maryland Insurance Commissioner at 1-2 (July 11, 2016) (“Redmer Comment”). Commissioner Redmer further states that any such order would conflict with a consent order issued in 2012 by former Maryland Insurance Commissioner Therese M. Goldsmith as well as with Commissioner Redmer’s own assessment of the appropriate target level for GHMSI’s surplus and the 2015 amendment to Maryland law requiring the consent of the Maryland Insurance Commissioner before GHMSI may distribute or reduce its surplus in

12 District of Columbia Association of Health Plans; DC Chamber of Commerce; District of Columbia Insurance Federation.
response to a law or order from another jurisdiction. See id. at 2-3. Commissioner Redmer also asserts that coordination among the District, Maryland and Virginia should precede any such order. See id. at 3-4.

III. DISCUSSION

The discussion below addresses the major comments received in response to the June 14, 2016 Order, especially as they relate to the Commissioner’s authority under MIEAA and the actions necessary to enforce MIEAA’s purposes.

A. Commissioner’s Authority Under MIEAA

The Commissioner construes MIEAA to authorize him to enforce the December 30, 2014 Order by directing GHMSI to issue rebates and by lifting the freeze on rate increases imposed by the June 14, 2016 Order at such time as GHMSI complies with the directive to issue rebates.

1. Authority to Lift Rate Freeze

Appleseed and Councilmembers Cheh and Silverman urge the Commissioner not to lift the freeze on rate increases imposed by the June 14, 2016 Order under any circumstances. They assert that MIEAA requires the freeze to remain in place for 12 months as a punitive measure.

MIEAA provides that if the Commissioner determines that a hospital or medical service corporation has failed to submit a plan for community health reinvestment within a reasonable period following an order to do so, “the Commissioner shall deny for 12 months all premium rate increases for subscriber policies written in the District sought by
the corporation . . . and may issue such orders as are necessary to enforce the purposes of this chapter.” D.C. Code § 31-3506(i) (emphasis added). The Commissioner interprets the authority under this provision to issue such orders as are necessary to enforce the purposes of MIEAA to permit him to lift the freeze on GHMSI’s rates if he reasonably determines that doing so is necessary to enforce the purposes of MIEAA.13

MIEAA was enacted “to ensure that nonprofit hospital and medical service corporations pursue their public health mission.” D.C. Appleseed Ctr. for Law & Justice, Inc. v. D.C. Dep’t of Ins., Sec. & Banking, 54 A.3d 1188, 1201 (D.C. 2012) (quoting D.C. Council, Report on Bill 17-934, the “Medical Insurance Empowerment and Amendment Act of 2008” at 2 (Oct. 17, 2008)). In specific, the Council’s twin objectives were “(1) obligating GHMSI to reinvest in community health ‘to the maximum feasible extent,’ (2) without undermining GHMSI’s ‘financial soundness and efficiency.’” D.C. Appleseed, 54 A.3d at 1214. These objectives are explicitly stated in Section 2(c) of MIEAA, which is codified at D.C. Code § 31-3505.01. In addition, if the Commissioner determines that GHMSI’s surplus is excessive, MIEAA requires dedication of the excess attributable to the District to community health reinvestment. See D.C. Code § 31-3506(g)(1).

For several reasons, the Commissioner believes a continued freeze on rate increases after GHMSI complies with this Decision and Order would be contrary to the purposes of MIEAA. First, so long as GHMSI complies with the Commissioner’s order to issue rebates, it will have engaged in community reinvestment to the maximum

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13 The Department’s regulations provide that if GHMSI fails to submit a plan as ordered, “the Commissioner shall deny all premium rate increases for subscriber policies written in the District until the company complies with the order or the Commissioner may issue any other order as necessary to enforce the purposes of the Act.” D.C. Mun. Regs. tit. 26-A, § 4603.3. The Commissioner also construes this provision to permit him to lift the freeze on GHMSI’s rates if he reasonably deems it necessary to enforce the purposes of MIEAA.
feasible extent, as determined by the December 30, 2014 Order—*i.e.*, GHMSI will have reinvested all of the excess 2011 surplus attributable to the District. Thus, a continued freeze on rate increases will not be necessary or consistent with the purposes of MIEAA.

Second, a freeze on rates following the distribution of the excess 2011 surplus attributable to the District would likely cause a further reduction in GHMSI’s surplus to the extent that GHMSI seeks rate increases during the freeze period to maintain rates that are adequate to meet claims costs and expenses. Any such reduction would reduce the surplus attributable to the District in excess of the amount determined in the December 30, 2014 Order.

Finally, the Commissioner is concerned that a continued freeze on rates could have an adverse effect on GHMSI’s financial efficiency, which also would be contrary to MIEAA’s purposes. The record in this proceeding documents the disruption to the health insurance marketplace resulting from, and uncertainty surrounding, the reforms mandated by the Affordable Care Act (“ACA”) and District law implementing the ACA. *See, e.g.*, December 30, 2014 Order at 32-49 (citing Rector & Associates, Inc., *Report to the D.C. Department of Insurance, Securities and Banking – Group Hospitalization and Medical Services, Inc.* (Dec. 9, 2013). This disruption includes uncertainty regarding the expense of insuring, and appropriate premium rates for, new entrants to the health insurance pool, who may be less healthy than existing participants and in need of more costly services. *See id.* The Commissioner is mindful of the fact that a lengthy freeze on rates could require GHMSI to increase rates in the future by a larger amount than would otherwise be the case. In this case, larger-than-expected rate increases could be detrimental to GHMSI’s contractholders and subscribers, especially individuals and small businesses,
who may not have the resources to manage unplanned-for increases in the cost of health
insurance. Accordingly, the Commissioner concludes that lifting the rate freeze after
GHMSI’s compliance with this Decision and Order is necessary to ensure that GHMSI
engages in community health reinvestment, but only to the extent consistent with the
purposes of MIEAA.

2. Authority to Order Implementation of a Plan

GHMSI disputes the Commissioner’s authority to develop and approve a plan for
dedication of its excess 2011 surplus to community health reinvestment. According to
GHMSI, MIEAA provides only two remedies following a determination that its surplus is
excessive: (1) that GHMSI submit, and the Department approve, a plan for reinvestment
of the excess attributable to the District or (2) that the Commissioner deny premium rate
increases for 12 months if GHMSI fails to submit a satisfactory plan when required by
MIEAA. See GHMSI Comments at 14. GHMSI therefore argues that the Commissioner
has no authority under MIEAA to approve and issue a plan for the reinvestment of the
excess surplus on his own initiative as stated in the June 14, 2016 Order. See id. at 15.

GHMSI’s argument ignores the Commissioner’s statutory authority to “issue such
orders as are necessary to enforce the purposes of [MIEAA].” D.C. Code § 31-3506(i).
This broad grant of authority allows the Commissioner to issue such orders as he
reasonably determines are necessary to enforce MIEAA’s purposes. See Wisconsin-
(“[W]e will accord deference to an agency’s interpretation of the statute which it is
responsible for administering if it is reasonable and not plainly wrong or inconsistent
with its legislative purpose.”) (internal quotation omitted); Smith v. D.C. Dep’t of Emp’t
Servs., 548 A.2d 95, 97 (D.C. 1988) (“Where an administrative agency is delegated broad authority to administer a statutory scheme . . . we defer to a reasonable construction of the statute made by the agency.”) (citations omitted).

To accept GHMSI’s formulation of MIEAA’s remedies would render the public policies embodied in MIEAA unenforceable and simply ignores the authority conferred upon the Commissioner to issue such orders as are necessary to enforce the purposes of the law. As discussed above, the central purpose of MIEAA is to require GHMSI to engage in community health reinvestment to the maximum extent feasible consistent with financial soundness and efficiency. The development and approval of a plan for reinvestment of excess surplus, and not just a rate freeze, clearly is necessary to enforce this purpose. Without such a plan, GHMSI would be free to ignore its full obligations under MIEAA as determined by the December 30, 2014 Order. Accordingly, the Commissioner concludes that he has discretion to develop, approve and order GHMSI to implement a plan for community health reinvestment. ¹⁴

B. GHMSI’s 2015 Charter Amendment

On December 18, 2015, Congress passed and the President signed into law the Financial Services and General Government Appropriations Act, 2016 (the “Appropriations Act”), which was enacted as part of the Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, 129 Stat. 2242. Section 747 of the Appropriations Act states:

Sec. 747. (a) The Act entitled “An Act providing for the incorporation of certain persons as Group Hospitalization and Medical Services, Inc.”, approved August 11, 1939 (53 Stat. 1412), is amended—

¹⁴ Moreover, it is immaterial whether the Commissioner’s orders under this Decision and Order are characterized as a “plan” or otherwise. Regardless of how they are characterized, they are orders necessary to enforce the purposes of MIEAA and therefore squarely within the Commissioner’s authority.
by redesignating section 11 as section 12; and
inserting after section 10 the following:

Sec. 11. The surplus of the corporation is for the benefit and protection of all of its certificate holders and shall be available for the satisfaction of all obligations of the corporation regardless of the jurisdiction in which such surplus originated or such obligations arise. The corporation shall not divide, attribute, distribute, or reduce its surplus pursuant to any statute, regulation, or order of any jurisdiction without the express agreement of the District of Columbia, Maryland, and Virginia—

(1) that the entire surplus of the corporation is excessive; and
(2) to any plan for reduction or distribution of surplus.

The amendments made by subsection (a) shall apply with respect to the surplus of Group Hospitalization and Medical Services, Inc. for any year after 2011.

GHMSI contends that under Section 747, the Commissioner must obtain the approval of Maryland and Virginia before he may order GHMSI to distribute or reduce its excess 2011 surplus or impose a freeze on rates for policies issued in the District. See Letter from Chet Burrell, President and C.E.O., CareFirst, to Commissioner Taylor at 5 (July 14, 2016); GHMSI Comments at 2. According to GHMSI, because any order to dedicate the excess 2011 surplus to community health reinvestment necessarily would affect GHMSI’s present or future surplus, the Commissioner may not take such action without the agreement of Maryland and Virginia. See id. at 3. Thus, GHMSI concludes that in amending the Charter, Congress chose not to interfere with the Commissioner’s review of GHMSI’s 2011 surplus but intended to require that any decision by the Commissioner requiring a reduction in GHMSI’s present or future surplus would require the agreement of Maryland and Virginia. Id. at 4.

GHMSI’s argument regarding the effect of the Charter amendment ignores the plain language of the Appropriations Act and contravenes established principles of statutory construction. The Charter amendment under Section 747(a) provides that
GHMSI “shall not divide, attribute, distribute, or reduce its surplus pursuant to any statute, regulation, or order of any jurisdiction without the express agreement of the District of Columbia, Maryland, and Virginia—(1) that the entire surplus of the corporation is excessive; and (2) to any plan for reduction or distribution of surplus.” Section 747(b) provides that this requirement “shall apply with respect to the surplus of [GHMSI] for any year after 2011.” It is very clear from this language that the required agreement among jurisdictions regarding whether surplus is excessive and as to any plan for reduction or distribution of surplus applies only to surplus for any year after 2011. In other words, by the plain language of the statute, GHMSI may divide, attribute, distribute or reduce its surplus as to any year through 2011 pursuant to a law or order of the District without the express agreement of all three jurisdictions in which it operates.

GHMSI argues that any such action will affect its present or future surplus—i.e., its surplus after 2011—and therefore is prohibited by the Charter amendment. This argument makes nonsense of the savings clause found in Section 747(b). MIEAA requires the Commissioner to review GHMSI’s surplus and, if it is determined to be excessive, permits him to order dedication of the excess to community health reinvestment. By practical and logical necessity, any such order must affect GHMSI’s present or future surplus. In other words, it must affect the surplus after the reference date used to determine whether the surplus is excessive. In this proceeding, that date is December 31, 2011.

Congress was clearly aware of this fact when it enacted the Charter amendment. GHMSI itself acknowledges that Congress was “well aware of the [December 30, 2014 Order] and the changes in law enacted in Maryland and Virginia . . .” and was acting in
response to those developments when it amended the charter. *CareFirst, Inc. v. Taylor*, Case No. 1:16-cv-02656-CCB (D. Md. July 22, 2016), Complaint, ¶ 32. Moreover, under accepted principles of statutory construction, Congress is presumed to be aware of such circumstances when it enacts legislation. *See Mississippi ex rel. Hood v. AU Optronics Corp.*, 134 S. Ct. 736, 742, 187 L. Ed. 2d 654 (2014) (“[W]e presume that ‘Congress is aware of existing law when it passes legislation.’”) (quoting *Hall v. United States*, 132 S.Ct. 1882, 1889 (2012)); *United States v. Wilson*, 290 F.3d 347, 354 (D.C. Cir. 2002) (interpreting statutory amendment by presuming that Congress considered the broader context of the amendment, including “the contextual background against which Congress was legislating, including relevant practices . . . which presumably informed Congress’s decision, prior legislative acts, and historical events”).

Therefore, in enacting the savings provision under Section 747(b), Congress could only have intended to preserve the Commissioner’s authority to order a distribution or reduction with respect to GHMSI’s excess 2011 surplus pursuant to the December 30, 2014 Order. To construe the savings clause otherwise would render it entirely superfluous and meaningless, as there would be no surplus to which it could apply. A basic principle of statutory interpretation is that statutes should be construed “so as to avoid rendering superfluous” any statutory language. *Astoria Fed. Savings & Loan Ass’n v. Solimino*, 501 U.S. 104, 112 (1991). GHMSI’s suggested interpretation would render the savings clause a nullity and stands in direct conflict with basic principles of statutory construction.

GHMSI further argues that, in enacting the Charter amendment, Congress intended not to interfere with the Commissioner’s review of GHMSI’s 2011 surplus, but
to prohibit any decision by the Commissioner to order a distribution or reduction of excess 2011 surplus. This argument again renders the savings clause entirely superfluous. Creating an exception to the Charter amendment solely for the review of GHMSI’s 2011 Surplus would be meaningless given that the review was completed under the December 30, 2014 Order nearly a year prior to when Congress amended GHMSI’s charter on December 18, 2015.\textsuperscript{15} As stated above, Congress was clearly aware of these facts and is presumed by law to have been aware of them. Thus, Congress cannot reasonably be said to have intended to create an exception for a review that had already occurred. The only reasonable interpretation of the savings clause is that it was intended to allow enforcement of MIEAA with respect to GHMSI’s excess 2011 surplus.\textsuperscript{16}

A statement released by Congresswoman Eleanor Holmes Norton just after the Charter amendment was passed indicates that the saving clause was intended to permit the Commissioner to enforce MIEAA with respect to GHMSI’s excess 2011 surplus. According to Congresswoman Norton, she “did succeed in allowing any of the jurisdictions to order such a disposition without the consent of the other jurisdictions for any surplus before 2012, thereby allowing D.C. to enforce, if it so chooses, the D.C. Insurance Commissioner’s order that GHMSI reinvest $56 million from its 2011 surplus.” Press Release, Congresswoman Eleanor Holmes Norton, \textit{Norton Gets Record Funding for DCTAG and Other D.C. Priorities, Prevents New Social Riders, Despite

\textsuperscript{15} Indeed, the two petitions for reconsideration of the review were received by the Department in early 2015 and denied many months before Congress acted. \textit{See supra} note 5.

\textsuperscript{16} If Congress had intended the Charter amendment to prohibit enforcement of the December 30, 2014 Order, there was no need for the Congress to enact Section 747(b) as the language in section 747(a) would prohibit the District from enforcing the December 30, 2014 Order without consent from Maryland and Virginia.
First Republican Controlled Congress in Eight Years (Dec. 16, 2015). Accordingly, the only reasonable interpretation of the savings clause is to permit enforcement of the December 30, 2014 Order.

C. Coordination with Maryland and Virginia

MIEAA requires any review of GHMSI’s surplus by the Commissioner to determine whether it is excessive to be “undertaken in coordination with the other jurisdictions in which the corporation conducts business.” D.C. Code § 31-3506(e). At various points in this proceeding, GHMSI has argued that the Department did not coordinate sufficiently with Maryland and Virginia. See, e.g., Plan at 6-7. The Maryland Insurance Commissioner also asserts that the Department has not sufficiently coordinated with his state, citing the conflict between Maryland law and the December 30, 2014 and June 14, 2016 Orders. See Redmer Comment at 3.

As a threshold matter, the Commissioner notes that MIEAA requires coordination with Maryland and Virginia only as to any review to determine whether GHMSI’s surplus is excessive. See D.C. Code § 31-3506(e). Once such a determination is made, MIEAA does not contemplate coordination with other jurisdictions with respect to ordering a plan to dedicate excess surplus attributable to the District to community health reinvestment, the imposition of a rate freeze if timely plan is not provided, or the issuance of other orders necessary to enforce the purposes of the statute. See id. §§ 31-3506(h), (i). Thus, to the extent that GHMSI or the Maryland Insurance Commissioner contends that the Commissioner is required by MIEAA to coordinate with other jurisdictions with respect to these aspects of the statute, their assertions are incorrect.
As to the determination under the December 30, 2014 Order that GHMSI’s 2011 surplus was excessive, the fact remains that the Department fully coordinated with Maryland and Virginia in reaching that determination. As explained in the December 30, 2014 and June 14, 2016 Orders, during the review of GHMSI’s 2011 surplus, the Department actively coordinated with Maryland and Virginia by communicating with the state insurance commissioners and their staff, advising them of the review, soliciting their participation, carefully considering their comments, and responding to their inquiries. See June 14, 2016 Order at 16. Indeed, Virginia regulators reported not that the Department failed to coordinate with them, but rather that they did not take full advantage of the opportunities presented by the Department to coordinate and intend to participate more fully in future surplus reviews. See Commonwealth of Virginia State Corporation Commission Bureau of Insurance, Bureau Report Regarding the Impact of the Distribution of GHMSI’s Excess Surplus on Virginia Residents at 7 (Apr. 15, 2015).

As the Department also has explained previously, see June 14, 2016 Order at 16, at its root, GHMSI’s assertion that the Department failed to coordinate with Maryland and Virginia rests on the erroneous assumption that MIEAA’s requirement for coordination requires agreement among the affected jurisdictions. This conclusion is directly contrary to the plain language of MIEAA. Nothing in MIEAA suggests that the Commissioner must come to agreement with regulators in Maryland and Virginia in determining whether GHMSI’s surplus is excessive or, as explained above, issuing orders to enforce the purposes of MIEAA once such a determination is made. To the contrary, MIEAA vests sole authority in the Commissioner in this respect. See D.C. Code §§ 31-3506(e)-(i).
D. Reductions in Surplus After 2011

In its comments to the Commissioner, GHMSI repeats many of the arguments it has made in the past concerning expenditures, costs, underwriting losses and changes in surplus it asserts should be credited as community health reinvestment with respect to the excess 2011 surplus. See GHMSI Comments at 5-14. The Department reviewed and addressed these arguments, see June 14, 2016 Order at 6-15, and will not revisit them here, except to reiterate the following: As stated in the June 14, 2016 Order, it is important to recognize that the analysis the Acting Commissioner conducted of GHMSI’s 2011 surplus to determine whether it was excessive was based on reasonable projections of GHMSI’s post-2011 performance, including the possibility of underwriting losses and fluctuations in surplus. See, e.g., December 30, 2014 Order at 30, 39 (discussing modeling generally and the rating adequacy and fluctuation risk factor in particular). In other words, the fact that GHMSI has experienced some underwriting losses and has undergone modest fluctuations in surplus does not change the determination that the 2011 surplus was excessive. In this regard, the Commissioner notes that GHMSI’s surplus as of June 30, 2016 was $982 million, which is above its level of $964 million on December 31, 2011.

GHMSI also argues that expenditures such as its annual community giving should be credited as community health reinvestment of the excess 2011 surplus. See GHMSI Comments at 9-10. As the Commissioner explained in the June 14, 2016 Order, the determination that the 2011 surplus was excessive took into account anticipated, programmatic expenditures by GHMSI for community giving as well as open enrollment subsidies and contributions to the District’s Healthcare Alliance. See June 14, 2016
Order at 9. In other words, the excess 2011 surplus identified by the December 30, 2014 Order is in excess of amounts needed by GHMSI to satisfy these obligations.

In addition, GHMSI argues that, beginning in 2011, it took steps to reduce its rates in order to reduce surplus, which should be credited as expenditures of the excess 2011 surplus for community health reinvestment. See GHMSI Comments at 10-13. As explained in the June 14, 2016 Order, the Commissioner believes rate filings that reduced or moderated premium rates can reasonably be characterized as dedication of excess surplus to community health reinvestment if they demonstrably were intended by GHMSI as a deliberate effort to reduce surplus to benefit subscribers. See June 14, 2016 Order at 10. Such rate filings are distinguishable from reductions merely aimed at bringing rates in line with experience or made purely for competitive reasons and are not intended to reduce surplus. See id. at 9-10.

On this basis, the Commissioner concludes that six rate filings made by GHMSI that affected premium rates after December 31, 2011, set forth in Table 1 below, should be credited as community health reinvestment of excess 2011 surplus. Each of these filings identifies an express negative Contribution to Reserves (“CTR”) resulting from the filed rates. These filings are distinguishable from other rate filings for which GHMSI claims credit for community health reinvestment in that they can reasonably be characterized as intended to reduce surplus for the benefit of subscribers.

GHMSI claims that certain other rate filings also should be credited as community health reinvestment because they identify two rates—a “proposed rate” for which approval was requested and higher “required rate” for which

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17 CTR is the portion of premium that is intended to impact the surplus of GHMSI. A negative CTR equates to a reduction in surplus.
sought approval but did not. GHMSI Comments at 11 n.5. None of these filings expressly identifies a negative CTR. On the contrary, all of them expressly identify either zero or a positive CTR. GHMSI’s argument appears to be that by not charging the unfiled, hypothetical higher rates, it was foregoing what would have been a greater CTR and therefore should be credited with the difference between the estimated higher contribution that would have resulted from the “higher rate” and the estimated contribution that was identified for the filed rate for which Department approval was actually sought and obtained. The Commissioner cannot agree with this argument. No documentation was provided by GHMSI at the time of the filings to show that the higher rates were appropriate, and there is nothing to suggest that the Department would have approved the higher rates if they had been presented for review. Thus, there is no credible basis for GHMSI’s assertion that these filings were intended to expend excess surplus for community health reinvestment.

Table 1 below identifies the six filings which the Commissioner will credit as expenditures of excess surplus for community health reinvestment and explains the Commissioner’s calculation of their effect on surplus.

The Commissioner concludes that the rate filings identified in Table 1 resulted in an aggregate reduction in surplus of $4,887,618. Applying the aggregate reduction in surplus attributable to these filings to the total excess 2011 surplus attributable to the District of $56,213,088.72 yields a revised excess 2011 surplus attributable to the District of $51,325,470.72.
Table 1: GHMSI Rate Filings Credited as Community Health Reinvestment of Excess 2011 Surplus

<table>
<thead>
<tr>
<th>SERFF Tracking #</th>
<th>Effective Period</th>
<th>CTR</th>
<th>Annualized $ Impact 18</th>
<th>Effective $ Impact 19</th>
<th>Effective $ Impact after 12/31/2011 21</th>
</tr>
</thead>
<tbody>
<tr>
<td>CFAP-127350283</td>
<td>Nov. 1 - Dec. 31, 2011</td>
<td>-6.10%</td>
<td>(12,296,447)</td>
<td>(2,112,187)</td>
<td>(1,848,164)</td>
</tr>
<tr>
<td>CFAP-127159629</td>
<td>Oct. 1 - Dec. 31, 2011</td>
<td>-8.00%</td>
<td>(1,780,699)</td>
<td>(443,331)</td>
<td>(369,443)</td>
</tr>
<tr>
<td>CFAP-127159563</td>
<td>Oct. 1 - Dec. 31, 2011</td>
<td>-8.00%</td>
<td>(945,266)</td>
<td>(219,016)</td>
<td>(219,016)</td>
</tr>
<tr>
<td>CFAP-127360767</td>
<td>Jan. 1 - Mar. 31, 2012</td>
<td>-4.00%</td>
<td>(945,266)</td>
<td>(219,016)</td>
<td>(219,016)</td>
</tr>
<tr>
<td>CFAP-127360790</td>
<td>Jan. 1 - Mar. 31, 2012</td>
<td>-4.00%</td>
<td>(945,266)</td>
<td>(219,016)</td>
<td>(219,016)</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td>(4,887,618)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

E. Dedication of Excess 2011 Surplus to Community Health Reinvestment

The public comments submitted in response to the June 14, 2016 Order provide a range of suggestions for the reinvestment of the 2011 excess surplus, including establishing a fund for community reinvestment administered by one or more private foundations, requiring GHMSI to pay rebates to its subscribers or engage in rate reductions, ordering GHMSI to reinvest the excess using its existing procedures for making community grants, or ordering GHMSI to contribute the excess to a fund that would provide financial support for individuals and families insured by GHMSI.

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18 “CTR” is Contribution to Reserves and is the portion of premium that is intended to impact the surplus of GHMSI.
19 “Annualized $ Impact” represents the total dollar impact on surplus of the CTR factor as stated by GHMSI in the Actuarial Memorandum provided with the rate filing.
20 “Effective $ Impact” represents the Department’s estimated dollar impact on surplus. This amount is calculated by applying the CTR factor to the premium for the experience period as stated in the Actuarial Memorandum for the filing, as adjusted based on the effective period of the filing (e.g., if the effective period spans one calendar quarter, or three months, then the CTR factor is applied to one quarter of the premium for the experience period).
21 “Effective $ Impact after 12/31/2011” represents the estimated amount of the dollar impact that was realized after December 31, 2011, the closing date of the surplus review. For example, for a rate filing effective between 8/1/2011 and 10/31/2011, there are three possible renewal dates for the affected policies (8/1/2012, 9/1/2012, and 10/1/2012). Of the aggregate 36 months during which the rates for these policies could possibly be in effect (8/1/2011 - 7/31/2012, 9/1/2011 - 8/31/2012, 10/1/2011 - 9/30/2012), the rates are effective for 7, 8, or 9 months in 2012, respectively. Therefore, the effective dollar impact of the CTR factor applies to (7 + 8 + 9) = 24 out of 36 aggregate months for the effective rates in the filing, and the "Effective $ Impact after 12/31/2011" would be (24/36) x the “Effective $ Impact.”
As discussed above, the expressly stated purpose of MIEAA, as affirmed by the Court of Appeals, is to obligate GHMSI to reinvest in community health to the maximum feasible extent but without undermining GHMSI’s financial soundness and efficiency. 

See D.C. Appleseed, 54 A.3d at 1214; D.C. Code § 31-3505.01 (“A corporation shall engage in community health reinvestment to the maximum feasible extent consistent with financial soundness and efficiency.”). MIEAA defines “community health reinvestment” as “expenditures that promote and safeguard the public health or that benefit current or future subscribers, including premium rate reductions.” D.C. Code § 31-3501(1A).

MIEAA further states that a plan for community health reinvestment must be “fair and equitable,” id. § 31-3506(g)(1), and “may consist entirely of expenditures for the benefit of current subscribers of the corporation.” Id. § 31-3506(g)(2).

The Commissioner has carefully considered the comments received and the record in this proceeding and concludes that the purposes of MIEAA are best served by requiring GHMSI to issue rebates for current subscribers. Appleseed argues that the payment of rebates to current subscribers of GHMSI would likely not be fair and equitable because the rebates would benefit many current subscribers, who may not have contributed premium dollars to the surplus build-up that resulted in the 2011 excess. See Appleseed Comments at 9. This argument ignores MIEAA’s definition of community health reinvestment, which includes “expenditures that . . . benefit current or future subscribers . . . .” D.C. Code § 31-3501(1A) (emphasis added). Moreover, Appleseed

22 The Commissioner is very appreciative of the innovative concepts advanced by the foundation coalitions, the Members of the Council, and Appleseed that could promote and safeguard public health in the District. However, the Commissioner could not find the authority in the MIEAA to establish a trust as contemplated by the foundations, or the regulations and procedures required to administer such a trust. Additionally, MIEAA does not provide authority for the Commissioner to oversee and regulate a private trust. In the absence of that necessary authority, the Commissioner cannot implement such a plan.
ignores the fact that the type of expenditures it advocates would benefit persons who may not have contributed any amount to the excess 2011 surplus. That such expenditures are authorized by MIEAA further confirms there is no requirement that a plan benefit only persons who contributed to the excess 2011 Surplus.

The dedication of the excess surplus to rebates will have three beneficial effects, all of which directly advance the purposes of MIEAA to promote and safeguard the public health and benefit subscribers. First, it will ensure that the funds are distributed now, to the immediate benefit of GHMSI’s subscribers and in an administratively efficient manner. Second, it will promote and safeguard public health by reducing the cost of health insurance for subscribers, including not only the costs associated with the payment of insurance premiums and contributions, but also deductibles, co-pays, coinsurance and other out-of-pocket costs. Finally, the payment of rebates for the benefit of all subscribers provides for a dedication of the excess surplus in the most fair and equitable manner.

Consistent with the method by which a portion of GHMSI’s excess 2011 surplus was attributed to the District under the December 30, 2014 Order, see December 30, 2014 Order at 50-58, the Commissioner focuses primarily on the location or “situs” of GHMSI’s subscriber contracts to determine the eligibility of subscribers for rebates. Only subscribers insured under subscriber contracts with a situs in the District—i.e., subscriber contracts issued in the District—will be eligible to receive a rebate. In addition, consistent with the surplus attribution methodology used in the December 30,
2014 Order, only Federal Employee Program (“FEP”) subscribers who reside in the District will be eligible for rebates.23

Because MIEAA defines community health reinvestment to include expenditures that “benefit current or future subscribers,” see D.C. Code § 31-3501(1A), without reference to contractholders, the Commissioner intends that rebates will be paid only to subscribers, and not to contractholders who are not also subscribers. A subscriber is “any person entitled to benefits under the terms and conditions of a subscriber contract.” D.C. Code § 31-3501(8). A contractholder is any “person entering into a subscriber contract with a [hospital or medical services] corporation.” Id. § 31-3501(1B). In the case of an individual contract, the contractholder also is a subscriber. In the case of a group contract, the contractholder, which may be an employer or other entity, may not be a subscriber. Thus, for example, in the case of employer group contracts, the employer contractholder will not be eligible for a rebate unless the employer is a natural person and a subscriber under the contract.

Finally, for practical reasons, the Commissioner intends that rebates will be paid to the primary insured subscriber under any group or individual contract, and not to spouses, domestic partners or dependents who also may be covered under the contract.

IV. ORDER

Based on the foregoing, the Commissioner hereby ORDERS:

1. The denial of requests for premium rate increases for subscriber contracts issued by GHMSI in the District, as established by the June 14, 2016 Order, shall remain

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23 Under the method used to attribute excess surplus to the District, the Department followed the allocation of premiums by jurisdiction reported on Schedule T of the 2011 Annual Statements for GHMSI and CareFirst BlueChoice. See December 30, 2014 Order at 54. On the 2011 Annual Statements, only premiums for FEP subscribers who resided in the District were reported as allocated to the District.
in effect until GHMSI certifies in writing to the Commissioner that all rebates required by
this Decision and Order have been issued.

2. No later than 120 days following the date of this Decision and Order, GHMSI shall pay rebates in the total amount of its revised excess 2011 surplus attributable to the District. The rebates shall be paid only to Eligible Subscribers, which are individuals who are GHMSI subscribers as of the date of this Decision and Order, who are the primary insured under the subscriber contract, and who meet one or more of the following criteria:

   a. Subscribers with an individual in-force major medical contract issued in the District;

   b. Subscribers with a policy or certificate from an in-force group major medical contract, excluding FEP business, issued in the District;

   c. Subscribers with a certificate from the FEP who reside in the District;

   d. Subscribers with a policy or certificate from an in-force group dental or vision contract issued in the District;

   e. Subscribers with an in-force Medicare Supplement contract issued in the District;

   f. Subscribers with any other type of in-force contract not listed above issued in the District.

3. The amount of each Eligible Subscriber’s rebate shall be calculated in proportion to the Eligible Subscriber’s current annual premium for health insurance as follows: A rebate percentage shall be calculated as the ratio of the total rebate amount
($51,325,470.72) to the sum of the annual premium (12 times the current monthly
premium) as of the date of this Decision and Order for all Eligible Subscribers identified
above. Each Eligible Subscriber’s rebate will be the rebate percentage times the Eligible
Subscriber’s annual premium and then rounded to the nearest dollar. If an individual is
an Eligible Subscriber under more than one contract—for example, a major medical
contract and a dental or vision contract—all such contracts shall be taken into account in
calculating the rebate.

4. The cost of calculating, preparing and distributing the rebates shall be
borne by GHMSI.

5. As of the date that GHMSI certifies in writing to the Commissioner that
all rebates required by this Decision and Order have been issued, the denial of requests
for premium rate increases for subscriber contracts issued by GHMSI in the District, as
established by the June 14, 2016 Order, shall be lifted.

Dated: August 30, 2016

Stephen C. Taylor
Commissioner
Department of Insurance, Securities and Banking

[Seal]
Exhibit B
GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF INSURANCE, SECURITIES AND BANKING

IN THE MATTER OF

Surplus Review and Determination for Group Hospitalization and Medical Services, Inc.

Order No.: 14-MIE-012

DECISION AND ORDER

This Decision and Order sets forth the factual findings and legal conclusions of the Acting Commissioner of the District of Columbia Department of Insurance, Securities and Banking (“Commissioner”) regarding whether the 2011 surplus of Group Hospitalization and Medical Services, Inc. (“GHMSI”) attributable to the District of Columbia is “excessive,” as defined by applicable law.

Throughout these proceedings, the Commissioner has stressed that this surplus review requires thoughtful analysis of complex facts and laws. The opinion below reflects the factual findings and legal conclusions reached after hearing testimony from over a dozen witnesses and reviewing hundreds of pages of submissions by GHMSI, various experts, other regulators, and other interested persons. As detailed further below, the Commissioner concludes:

- GHMSI’s surplus as of December 31, 2011 was 998% RBC-ACL (approximately $963.5 million);
- the appropriate level for GHMSI’s surplus was 721% RBC-ACL (approximately $695.9 million) and because GHMSI’s surplus exceeded 721% RBC-ACL, it was excessive;
- 21% of GHMSI’s surplus is attributable to the District of Columbia; and
- GHMSI must submit a plan to the Commissioner for dedication of its excess 2011 surplus attributable to the District of Columbia to community health reinvestment in a fair and equitable manner.
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I. JURISDICTION

The Commissioner has the authority to decide whether GHMSI’s surplus attributable to
the District of Columbia is excessive pursuant to D.C. Official Code § 31-3506(e) (2012 Repl.),
which codifies Section 7(e) of the Hospital and Medical Services Corporation Regulatory Act of
1996, effective April 9, 1997 (D.C. Law 11-245; D.C. Official Code § 31- 3501 et seq.), as
amended by the Medical Insurance Empowerment Amendment Act of 2008, effective March 25,
2009 (D.C. Law 17-369) (the “MIEAA”) (in this Decision and Order, “the Act” refers to the Hospital and Medical Services Corporation Regulatory Act of 1996 as amended by the MIEAA). The Commissioner’s determination also is governed by the regulations implementing the Act, 26A DCMR §§ 4600.1 to 4699.4.

II. PROCEDURAL HISTORY

A. Brief Description of GHMSI and Surplus Review

GHMSI is a nonprofit hospital and medical services corporation domiciled in the District of Columbia (the “District”) and regulated by the Commissioner under the Act. See D.C. Official Code § 31-3501 (2012 Repl.). As a nonprofit hospital and medical services corporation, GHMSI is required by the Act to “engage in community health reinvestment to the maximum feasible extent consistent with financial soundness and efficiency.” Id. at § 31-3505.01. The Act further provides that the Commissioner must review GHMSI’s surplus at least once every three years and may issue a determination regarding whether the surplus is excessive. Id. at § 31-3506(e). GHMSI’s surplus may be considered excessive only if it exceeds certain risk-based capital standards and is determined by the Commissioner to be unreasonably large and inconsistent with GHMSI’s obligation under the Act to engage in community health reinvestment. Id. All of these provisions of the Act were added by the MIEAA, which became effective March 25, 2009. Under regulations implementing the MIEAA, GHMSI must file an annual report with the Commissioner detailing its surplus and examining whether it is excessive. 26A DCMR § 4601.1.

1 GHMSI was organized and operates under a federal charter as a “charitable and benevolent institution.” An Act providing for the incorporation of certain persons as Group Hospitalization and Medical Services, Inc., approved Aug. 11, 1939 (Pub. L. No. 76-395, § 8; 53 Stat. 1412, 1414), as amended (the “Charter”). The Charter requires that GHMSI be operated as a nonprofit entity for the benefit of its certificate holders and further provides that it is to be legally domiciled in the District of Columbia and licensed and regulated by the District in accordance with the District’s laws and regulations. Charter at §§ 1, 3, 5.
B. Review of GHMSI 2008 Surplus

Following the MIEAA’s enactment and applying its new standards, during 2009-2010 the Department of Insurance, Securities and Banking (“DISB” or the “Department”) performed a comprehensive review of GHMSI’s surplus as of December 31, 2008. In a Final Decision and Order issued on October 29, 2010, then-Commissioner Gennet Purcell determined that GHMSI’s 2008 surplus of 845% RBC-ACL (approximately $687 million) was not excessive. DISB, Final Decision and Order, In the Matter of: Surplus Review and Determination Regarding Group Hospitalization and Medical Services, Inc., Order No. 09-MIE-007 (Oct. 29, 2010) (the “2010 Order”). (See Section IV.B., below, for an explanation of RBC-ACL.)

In the 2010 Order, Commissioner Purcell noted that by the end of 2009 GHMSI’s surplus had increased to 902% RBC-ACL (approximately $761 million), and that this amount would be considered excessive “if all of the assumptions underlying this review were to remain the same.” Id. at 12. Commissioner Purcell did not deem the 2009 surplus to be excessive, however. Id. Instead, she concluded that it would be necessary to conduct a de novo review of GHMSI’s surplus for any year after 2008 because changes in GHMSI’s regulatory and financial environment – particularly those brought by implementation of the Patient Protection and Affordable Care Act (the “ACA”) and related health care reform legislation – could affect the company’s surplus needs. Id. at 12-13. Accordingly, consistent with the Act’s requirement that GHMSI’s surplus be reviewed at least once every three years, Commissioner Purcell ordered a subsequent review to occur by July 31, 2012. Id. at 14.

On November 24, 2010, the D.C. Appleseed Center for Law and Justice, Inc. (“Appleseed”) filed a petition with the District Columbia Court of Appeals challenging the 2010 Order on the grounds that Commissioner Purcell had: (1) incorrectly interpreted the Act, (2)
failed to provide adequate reasons to support her determination that GHMSI’s 2008 surplus was not excessive, and (3) abused her discretion in failing to order an immediate review of GHMSI’s 2009 and 2010 surpluses. *D.C. Appleseed Center for Law and Justice, Inc. v. District of Columbia Department of Insurance, Securities and Banking*, 54 A.3d 1188, 1192, 1198 (D.C. App. 2012) (“Appleseed Appeal”).

On September 13, 2012, the D.C. Court of Appeals issued a decision affirming in part and reversing in part the 2010 Order. *Appleseed Appeal*, 54 A.3d at 1220. The Court affirmed Commissioner Purcell’s decision to not order an immediate review of GHMSI’s 2009 and 2010 surpluses, holding that “in light of the changing conditions identified in the order[,]” she had not abused her discretion by deferring further review until July 31, 2012. *Id.* at 1220. The Court reversed Commissioner Purcell’s decision on the 2008 surplus, ruling that she had not correctly interpreted the Act in determining whether GHMSI’s surplus was excessive and had not provided sufficient explanation for her determination. *Id.* at 1219.

Based on these holdings, the Court remanded the matter to DISB for further proceedings consistent with its opinion, including (1) a more complete explanation of the reasoning in support of the surplus determination and (2) an interpretation of the Act, “as guided by the Department’s discretion and expertise, that follows the framework we have set out in this opinion….” *Id.* at 1220-21. As discussed in Section IV.A.2., below, the Court’s “framework” consists of guidance on how the Act should be construed in light of GHMSI’s statutory obligation to engage in community health reinvestment to the “maximum feasible extent consistent with financial soundness and efficiency.” *See id.* at 1218-20.
C. **Review of GHMSI 2011 Surplus**

Before the D.C. Court of Appeals issued its decision, DISB already had begun to solicit input from interested persons regarding the appropriate standards for, and scope of, the next surplus review. On June 1, 2012, GHMSI filed the report required by 26A DCMR § 4601.1 for its surplus as of December 31, 2011. See CareFirst BlueCross BlueShield, Report on GHMSI Surplus [for 2011], 1 (June 1, 2012) (“2011 Surplus Report”).

When the Court remanded the 2008 surplus review to DISB in September 2012, then-Commissioner William P. White determined that further review of the 2008 surplus would be moot. Commissioner White concluded that the review instead should focus on GHMSI’s surplus as of December 31, 2011, which was the surplus for which the most recent information was available at the time. Commissioner White further concluded that a review of the 2011 surplus would satisfy the statutory mandate to review GHMSI’s surplus review at least once every three years. See D.C. Official Code § 31-3506(e) (2012 Repl.).

DISB retained Rector & Associates, Inc. (“Rector”), an insurance regulatory and financial analysis firm, and NovaRest, Inc., an actuarial firm, to assist in the surplus review. See D.C. Official Code § 31-3506(h) (2012 Repl.) (authorizing retention of consultants to assist with a surplus review). Rector in turn retained FTI Consulting, Inc., to assist it with actuarial analysis. (“Rector,” in this Decision and Order, refers to Rector and FTI Consulting together.)

At the outset of its engagement, Rector met at least twice with key staff from GHMSI and its consulting expert, Milliman, Inc., as well as with Appleseed and its consultant, United Health Actuarial Services, Inc. (“UHAS”), to discuss the structure of Rector’s work, the actuarial model used by Milliman to assist GHMSI in determining its surplus needs (the “Milliman Model”), and the standards to be used by DISB in the analysis of GHMSI’s surplus. Transcript, Group
During those meetings, GHMSI, Milliman, Appleseed, and UHAS all provided input into the appropriate structure and standards to be used for the examination. *Id.* Following the meetings, Rector requested and received additional information from Milliman and GHMSI regarding GHMSI’s surplus and the Milliman Model. *Id.*

On December 9, 2013, Rector issued a report with its findings and recommendations concerning GHMSI’s 2011 surplus. Rector & Associates, Inc., Report to the D.C. Department of Insurance, Securities and Banking – Group Hospitalization and Medical Services, Inc. (Dec. 9, 2013) (the “Rector Report”). In brief, the Rector Report concluded that GHMSI should strive for a target of 958% RBC and that GHMSI’s surplus should be measured against a benchmark range of 875% to 1040% RBC. Rector Report at 13. (Sections IV.C. and IV.E., below, discuss the Rector Report in greater detail.)

Following release of the Rector Report, DISB hosted a series of conference calls among DISB staff, Rector, GHMSI, Appleseed, and their consultants to discuss Appleseed’s comments and questions on the report’s findings, methodologies, and underlying data. During this time, Appleseed submitted four lengthy sets of questions and data requests to DISB. DISB replied to each of these requests with detailed written responses and disclosures of data which were added to the Record. See Section II.D., below, and the attached Exhibit 1 for a complete description of materials in the Record and where they may be located.2

2 The Commissioner acknowledges and appreciates Appleseed’s efforts in enhancing the record and contributing its analyses of GHMSI’s surplus. Although the Commissioner denied Appleseed’s request for formal party status, the Commissioner granted Appleseed expansive rights of participation. See DISB, Order on DC Appleseed Participation, In the Matter of: Surplus Review and Determination Regarding Group Hospitalization and Medical Services, Inc., Order No. 14-MIE-004 (June 10, 2014) (“Participation Order”). These rights included extensive engagement with DISB, its consultants and GHMSI; more than tripling the applicable page limit for a pre-hearing brief; and permitting Appleseed to make a lengthy oral presentation as well as a closing statement at the (continued on next page)
The Commissioner initially scheduled a hearing for the surplus review to take place in March 2014 but ultimately rescheduled the hearing for June 25, 2014, to ensure that Appleseed and any other interested persons would have sufficient time to review and respond to information provided by DISB in response to Appleseed’s questions and data requests. The Commissioner sent hearing notices directly to Maryland and Virginia Insurance Commissioners.

Prior to the hearing, GHMSI and Appleseed submitted pre-hearing briefs for the Commissioner’s consideration. Appleseed also submitted an extensive analysis of GHMSI’s surplus prepared by Mark Shaw of UHAS. In addition, the Commissioner received written statements from numerous other persons, including the Maryland Insurance Commissioner, the Blue Cross Blue Shield Association (“BCBSA”), and recipients of GHMSI’s charitable giving.

At the hearing on June 25, 2014, the Commissioner heard testimony from Rector, GHMSI, Appleseed, Milliman, and UHAS, each followed by lengthy question and answer sessions with the Commissioner and Associate Commissioner for Insurance Philip Barlow. The Commissioner also heard testimony from a number of other interested persons. The hearing concluded with closing statements by Appleseed and GHMSI and final remarks by the Commissioner.

After the hearing, the Commissioner issued a series of orders (1) requesting additional information from Rector, GHMSI, and Appleseed; (2) establishing a schedule for the submission of responses to these requests; and (3) setting a deadline of November 7, 2014, for the filing of hearing. See id. The Commissioner granted these enhanced rights in light of Appleseed’s longstanding involvement with and special interest in the MIEAA. See id.

3 The final hearing notice is available on DISB’s website and is part of the hearing record, as described in Section II.D., below. See also D.C. Register, Vol. 61- No. 19 at 4385-4386 (May 2, 2014). Prior hearing notices are available in D.C. Register, Vol. 61- No. 3 at 384 (Jan. 17, 2014) and D.C. Register, Vol. 61-No. 11 at 2093-2094 (Mar. 14, 2014).
final rebuttal statements. *See, e.g.*, DISB, Third Scheduling Order, *In the Matter of: Surplus Review and Determination Regarding Group Hospitalization and Medical Services, Inc.*, Order No. 14-MIE-005 (Aug. 7, 2014); Order with Supplemental Information Requests, Order No. 14-MIE-008 (Oct. 3, 2014). The Commissioner received submissions from Rector, GHMSI and Appleseed in September and October 2014, in response to his requests. After the hearing, the Commissioner also received a Statement of the Virginia State Corporation Commission’s Bureau of Insurance, and a Statement from Therese M. Goldsmith, the Maryland Insurance Commissioner, addressing surplus allocation. *See Section II.D.; Exhibit 1. See also Section IV.F.*, below, for a discussion of communications with Maryland and Virginia.

In the post-hearing period, the Commissioner denied, on two grounds, a request from Appleseed for certain confidential and proprietary information submitted to DISB by GHMSI. First, the Commissioner determined that much of the information requested by Appleseed was not relevant to the review of GHMSI’s surplus, would not be relied upon by the Commissioner in reaching a final determination, and therefore was not needed by Appleseed. Second, the Commissioner concluded that Appleseed already had received extensive information concerning GHMSI’s operations and the analysis performed by Rector, as evidenced by the fact that it had provided the Commissioner with detailed analyses of GHMSI’s surplus, and therefore did not need additional confidential and proprietary information to contribute to the Commissioner’s final determination. *Order on DC Appleseed Request for Disclosure of Confidential and Proprietary Information, Order No. 14-MIE-010 (Oct. 24, 2014).*

GHMSI and Appleseed submitted final rebuttal statements on November 7, 2014. On November 24, 2014, Appleseed submitted a letter acknowledging that the rebuttal period had closed, but requesting leave to respond to information in GHMSI’s rebuttal statement. Because
the rebuttal period had closed, the Commissioner denied this request and confirmed the closing of the record in this proceeding. Order Closing Record, Order No. 14-MIE-011 (Nov. 26, 2014).

D. The Record

At the June 25, 2014 hearing, the Commissioner gave notice that “the surplus-related material posted on DISB’s website will be the official record for this proceeding.” Tr.11:9-11. All non-confidential materials related to the review of GHMSI’s surplus are publicly available on various webpages on DISB’s website at www.disb.dc.gov. See also Exhibit 1 – Hearing Record Index for 2011 Surplus Review. The Record materials include the reports by GHMSI pursuant to 26A DCMR § 4601.1; GHMSI annual statements; the Rector Report; Appleseed’s information requests and responses to those requests; pre-hearing briefs; written testimony and other statements prepared for the hearing; the hearing transcript; DISB requests for supplemental information and responses to those requests; and the final rebuttal statements. Excluding GHMSI’s regulatory filings, there are over 2,000 pages of surplus-related materials on DISB’s website which the Commissioner considered in reaching this Decision. See id.

III. FACTUAL BACKGROUND

GHMSI is a wholly owned subsidiary of CareFirst, Inc., a nonprofit holding company. It is affiliated with CareFirst of Maryland, Inc. (“CFMI”), which is also a wholly owned subsidiary of CareFirst, Inc. See Health Annual Statement for the year ended December 31, 2011 of the condition and affairs of Group Hospitalization and Medical Services, Inc., 25.9 (“2011 Annual Statement”). CFMI and GHMSI share ownership of CareFirst Holdings, LLC. (“CFH”), which in turn owns 100% of CareFirst BlueChoice, a health maintenance organization operating in the District, Maryland and certain counties in Virginia. See id. GHMSI owns approximately 50% of
CFH, the vast majority of which consists of CareFirst BlueChoice.\(^4\) *See id.* For purposes of this review, “GHMSI” means the combination of 100% of the business of GHMSI itself and GHMSI’s approximately 50% ownership of CFH.

GHMSI does business in the District as CareFirst BlueCross BlueShield. It uses the BlueCross and BlueShield names and logos subject to certain requirements established under licensing agreements it maintains with the BCBSA. *See Group Hospitalization and Medical Services, Inc.’s Responses to Questions in the Third Scheduling Order, 7 (Sep. 5, 2014)* (“GHMSI Resp. Third Sched. Order”).

GHMSI plays a significant role in providing health insurance in the District. CareFirst’s CEO, Chet Burrell, testified that, in the District, CareFirst provides 76% of commercial health insurance coverage for individuals under age 65; provides 72% of small group coverage; and covers 80% of the U.S. Congress. Tr.90:16-20. CareFirst also serves many larger employer groups. *Id.* at 89:25, 90:1. As of December 31, 2011, GHMSI had nearly 288,000 policies\(^5\) in force and contracted with over 59,000 network providers throughout the District, Maryland and Virginia. Response of Group Hospitalization and Medical Services, Inc. to Supplemental Information Request 1(d) in DISB Order No. 14-MIE-08 (October 3, 2014) (Oct. 31, 2014) (“GHMSI 1(d) Resp.”). During 2011, GHMSI wrote approximately $4.4 billion in premiums and paid nearly $3.7 billion in claims. *Id.*

As of year-end 2011, GHMSI’s surplus stood at 998% RBC-ACL, or $963,581,310. 2011 Surplus Report at 1; 2011 Annual Statement at 28, line 4. GHMSI describes the 2011

\(^{4}\) CFH also owns certain other subsidiaries that are much smaller than BlueChoice and which do not significantly affect the analysis here.

\(^{5}\) This figure includes policies issued to individuals and to employers/groups. Thus, the number of individuals covered by GHMSI policies is significantly higher.

IV. ANALYSIS OF GHMSI SURPLUS

A. Applicable Law

1. District of Columbia Statutes and Regulations

Two separate but interrelated provisions of the Act define the scope of the Commissioner’s surplus review: (1) under section 31-3505.01, GHMSI must “engage in community health reinvestment to the maximum feasible extent consistent with financial soundness and efficiency,” and (2) under section 31-3506(e), the Commissioner must periodically review the portion of GHMSI’s surplus attributable to the District to determine whether it is “excessive.” D.C. Official Code §§ 31-3505.01, 31-3506(e) (2012 Repl.). Section 31-3506(e) further provides that GHMSI’s surplus may be considered excessive only if:

(1) The surplus is greater than the appropriate risk-based capital requirements as determined by the Commissioner for the immediately preceding calendar year; and

(2) After a hearing, the Commissioner determines that the surplus is unreasonably large and inconsistent with the corporation's obligation [to engage in community health reinvestment] under § 31-3505.01.

6 As noted in Section I, above, the “Act” refers to the Hospital and Medical Services Corporation Regulatory Act of 1996, effective April 9, 1997 (D.C. Law 11-245; D.C. Official Code § 31-3501 et seq.), as amended by the Medical Insurance Empowerment Amendment Act of 2008, effective March 25, 2009 (D.C. Law 17-369) (the “MIEAA”).
Id. at §31-3506(e). The Act defines community health reinvestment as “expenditures that promote and safeguard public health or that benefit current or future subscribers, including premium rate reductions.” Id. at § 31-3501(1A).

DISB regulations clarify that if the Commissioner makes a preliminary determination that GHMSI’s surplus is excessive because it exceeds applicable risk-based capital requirements, then the Commissioner must schedule a public hearing to make a final determination regarding whether the surplus is “excessive and unreasonably large.” 26A DCMR § 4601.5.7

In determining whether GHMSI’s surplus is excessive, the Commissioner must “take into account all of the corporation’s financial obligations arising in connection with the conduct of the corporation’s insurance business, including premium tax paid and the corporation’s contribution to the open enrollment program required by § 31-3514 and payments and expenditures pursuant to a public-private partnership.” D.C. Official Code § 31-3506(f) (2012 Repl.). Also, “the Commissioner shall consider the interests and needs of the jurisdictions in the corporation’s service area.” Id. at § 31-3506.01(b).8

To facilitate the surplus review, DISB regulations require GHMSI to file an annual report with the Commissioner concerning the company’s surplus and whether it is excessive under the Act. 26A DCMR § 4601.1. Under the Act, the Commissioner must review the portion of

7 The regulations define an “unreasonably large surplus” as a surplus that is greater than the sum of “(a) The appropriate NAIC [National Association of Insurance Commissioners] risk-based capital level requirements determined by the Commissioner and the Blue Cross/Blue Shield Association capital requirements based on the company’s surplus from the immediately preceding year” and “(b) The amount of surplus needed by the corporation to meet its expected and unanticipated contingencies.” 26A DCMR § 4699.4.

8 DISB regulations provide further guidance for assessing whether the surplus is excessive. The regulations mandate consideration of (1) the risk-based capital requirements for health insurers developed by the NAIC as implemented by District law in D.C. Official Code § 31-3851.01 et seq. (2012 Repl.) and (2) the capital requirements established by the BlueCross BlueShield Association. 26A DCMR § 4601.4. The regulations permit consideration of (a) “actuarially determined risk exposures as well as the expected and unanticipated contingencies of the company” and (b) “the anticipated cost of the corporation’s contribution to the open enrollment program required by section 15 of the Act.” Id. at § 4601.8.
GHMSI’s surplus that is attributable to the District no less often than once every three years and may issue a determination as to whether the surplus is excessive. D.C. Official Code § 31-3506(e) (2012 Repl.). The surplus review required by the Act must be “undertaken in coordination with the other jurisdictions in which the corporation conducts business.” Id. DISB therefore must coordinate with both Maryland and Virginia, where GHMSI also conducts business. Maryland itself reviews GHMSI’s surplus in separate proceedings. See, e.g., Statement of Therese M. Goldsmith, Maryland Insurance Commissioner (June 25, 2014) (“Maryland Pre-Hearing Statement”); Maryland Insurance Administration, Consent Order, In re Targeted Surplus Ranges for CareFirst of Maryland Inc. and Group Hospitalization and Medical Services, Inc., Case No. MIA-2012-09-006 (Sept. 14, 2012) (“Maryland Consent Order”).

The Act further states:

(1) If the Commissioner determines that the surplus of the corporation is excessive, the Commissioner shall order the corporation to submit a plan for dedication of the excess to community health reinvestment in a fair and equitable manner.

(2) A plan submitted pursuant to paragraph (1) . . . may consist entirely of expenditures for the benefit of current subscribers of the corporation.

D.C. Official Code § 31-3506(g) (2012 Repl.)

In reviewing the Commissioner’s 2010 Order, the D.C. Court of Appeals provided guidance as to how the Act should be interpreted and applied, as discussed below.

2. Court of Appeals Framework

In its 2012 decision, the D.C. Court of Appeals reviewed the standards for evaluating GHMSI’s surplus in light of the Act’s structure and legislative history. Appleseed Appeal, 54 A.3d at 1213-15. The Court noted the interrelationship between section 31-3505.01, which mandates that GHMSI engage in community health reinvestment to the maximum feasible extent
consistent with financial soundness and efficiency, and section 31-3506(e)(2), which requires the Commissioner to determine whether GHMSI’s surplus is unreasonably large and inconsistent with GHMSI’s community reinvestment obligation under section 31-3505.01. *Appleseed Appeal*, 54 A.3d at 1213-14. Both sections, the Court noted, were added to the Act by the MIEAA. *Id.* at 1214. Reviewing the MIEAA’s legislative history, the Court took note of “the Council’s twin objectives in amending the statute: (1) obligating GHMSI to reinvest in community health ‘to the maximum feasible extent,’ (2) without undermining GHMSI’s ‘financial soundness and efficiency.’” *Id.* at 1214. In the Court’s judgment, “A harmonious interpretation of the statute’s language, viewed in its entirety, requires that a surplus determination . . . keep both these objectives in mind.” *Id.*

Accordingly, the Court held that “the two determinations required by § 31-3506(e)(2)—whether GHMSI’s surplus is ‘unreasonably large’ and whether the surplus is inconsistent with GHMSI’s community health reinvestment obligations under §31-3505.1—must be made in tandem, not *seriatim*, to give full effect to the statute.” *Appleseed Appeal*, 54 A.3d at 1215. Having reached this conclusion, the Court acknowledged that “there remain details as to how such a determination is to be made. As to the specification of how surplus and community reinvestment are to be calculated and balanced, we defer to the agency’s reasonable discretion in light of its expertise in this subject matter.” *Id.*

Applying the D.C. Court of Appeal’s guidance, the Commissioner interprets section 31-3506(e)(2) as requiring him to determine the level of surplus that maximizes GHMSI’s community health reinvestment without undermining GHMSI’s financial soundness and efficiency. Stated differently, the Act requires the Commissioner to determine the amount of surplus that is large enough to be consistent with financial soundness and efficiency, but no
larger. A surplus in excess of this amount would be unreasonably large and inconsistent with GHMSI’s community reinvestment obligations. The Commissioner concludes that this approach fully encompasses the objectives of the Act and provides the tandem analysis envisioned by the Court.

**B. GHMSI Surplus is Greater than the Appropriate RBC Standards**

As noted above, the Act has a two-step process for determining whether GHMSI’s surplus is excessive: (1) determining whether the surplus is greater than “the appropriate risk-based capital standards” established by the Commissioner, and (2) deciding, after a hearing, whether the surplus is unreasonably large and inconsistent with GHMSI’s community health reinvestment obligations. D.C. Official Code § 31-3506(e) (2012 Repl.).

For the first step, DISB regulations state that, in determining the appropriate risk-based capital standards, the Commissioner must consider the NAIC risk-based capital standards for health insurers adopted under District law and the capital requirements established by the BCBSA for its licensees. 26A DCMR § 4601.4.

Risk-based capital (“RBC”) is a method developed by the NAIC to determine the minimum amount of capital an insurer should hold to support its business operations in consideration of its size and risk profile. NAIC, Risk-Based Capital (Nov. 25, 2014) (available at www.naic.org/cipr_topics/topic_risk_based_capital.htm) (“RBC Website”). See also NAIC, Risk-Based Capital Forecasting & Instructions - Health (2013), available through www.naic.org (“NAIC RBC Instructions”). The RBC standards require an insurer with greater risk to hold a higher amount of capital to protect against insolvency. See RBC Website. RBC focuses on the material risks typically faced by insurers but does not necessarily encompass every risk an insurer may encounter. Id. RBC is intended as an early warning system for U.S. insurance regulators to identify insurers at risk of insolvency and take appropriate action to address
financial problems with a company. *Id.* The RBC framework thus “operates as a tripwire system that gives regulators clear legal authority to intervene in the business affairs of an insurer that triggers one of the action levels specified in the RBC law. . . . [and] alerts regulators to undercapitalized companies while there is still time for the regulators to react quickly and effectively to minimize the overall costs associated with insolvency.” *Id.*

Insurers calculate their RBC using a mathematical formula developed by the NAIC that incorporates various standards for quantifying risks. *Id.* District law requires every domestic insurer, including GHMSI, to file an annual “RBC report” that discloses its RBC ratio, as calculated using instructions published by the NAIC. D.C. Official Code § 31-3851.02 (2012 Repl.).

District law identifies various RBC action levels at which company or regulatory action is required to address an insurer’s financial deficiencies. *See* D.C. Official Code §§ 31-3851.03 to 31-3851.06 (2012 Repl.). Each action level is a multiple of a reference level of RBC known as the insurer’s RBC Authorized Control Level (“RBC-ACL”). *Id.* If a health insurer’s surplus falls below 200% RBC-ACL, it must submit a plan to the Commissioner for corrective action to bring its surplus up to a safer level. *Id.* at § 31-3851.03. District law authorizes and requires additional actions if an insurer’s surplus drops to lower RBC-ACL levels. *See id.* at §§ 31-3851.04 – 31.3851.06.

In addition to the RBC standards established under District law, GHMSI is subject to certain capital standards established by the BCBSA for its licensees. GHMSI Resp. Third Sched. Order at 7. As discussed in greater detail below, these standards include a requirement that a licensee take corrective action to improve its financial position if its surplus falls below 375% RBC-ACL. GHMSI Resp. Third Sched. Order at 8; *see also* Section IV.C.3.a., below.
Under D.C. Official Code § 31-3506(e)(1), the Commissioner must determine the “appropriate risk-based capital standards” and whether GHMSI’s surplus exceeds those standards as a first step in his review. Prior to the surplus review hearing, the Commissioner determined that the appropriate RBC standards for purpose of section 31-3506(e)(1) are 200% RBC-ACL and 375% RBC-ACL, which are the thresholds at which GHMSI must take corrective action to improve its financial position under, respectively, the NAIC RBC standards for health insurers adopted under District law and the BCBSA’s capital standards. The Commissioner further concluded that GHMSI’s surplus was greater than the appropriate RBC standards under section 31-3506(e)(1) because its 2011 surplus of 998% RBC-ACL exceeded both the 200% RBC-ACL and the 375% RBC-ACL thresholds.⁹

C. **GHMSI’s Surplus is Unreasonably Large and Inconsistent with its Community Health Reinvestment Obligations**

1. **Defining Financial Soundness and Efficiency**

The second step of the review requires that the Commissioner determine whether GHMSI’s surplus is unreasonably large and inconsistent with its statutory obligation to engage in community health reinvestment to the maximum feasible extent consistent with financial soundness and efficiency. D.C. Official Code § 31-3506(e)(2) (2012 Repl.). In accordance with *Appleseed Appeal*, this step of the analysis requires the Commissioner to determine the level of surplus that will maximize GHMSI’s community health reinvestment (*i.e.*, ensure the greatest quantity or highest degree attainable for community health reinvestment that the company is

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⁹ This finding also triggered the public hearing requirement under D.C. Official Code § 31-3506(e)(2) and 26A DCMR §§ 4601.4 and 4061.5.
capable of making) without undermining its financial soundness and efficiency.\textsuperscript{10} To make this
determination, the Commissioner must consider (1) what constitutes “surplus,” (2) what it means
for surplus to be consistent with financial soundness, and (3) what it means for surplus to be
consistent with efficiency. \textit{See} D.C. Official Code § 31-3506(e)(2) (2012 Repl.); \textit{Appleseed
Appeal}, 54 A.3d 1188.

The Act defines “surplus” as “the amount by which all admitted assets of the corporation
exceeds its liabilities, inclusive of reserves” that the corporation is required to establish by
District law. D.C. Official Code §§ 31-3501(11), 31-3509 (2012 Repl.). In other words, an
insurer’s surplus is the value of its admitted assets\textsuperscript{11} above and beyond its reserves. Reserves, in
turn, are amounts an insurer sets aside to pay claims, cover the cost of administering claims and
cover other liabilities reported in its statutory financial statement. \textit{Id.} at § 31-3509. Reserves
alone, however, are not enough to ensure an insurer’s financial stability. As the Act implicitly
recognizes, an insurer needs assets above and beyond reserves—\textit{i.e.}, surplus—to protect against
a variety of risks and provide for various contingencies to ensure that its operations are
financially sound and efficient. \textit{See id.} at § 31-3501(11). \textit{See also} GHMSI Pre-Hearing Brief at

\textsuperscript{10} The Commissioner has broad discretion in interpreting the phrase, “maximum feasible extent.” \textit{see}
\textit{Younger v. Turnage}, 677 F. Supp. 16 (D.D.C. 1988) (“Younger”) (In the absence of specific statutory standards,
court deferred to agency discretion in fulfilling obligation to provide services “to the maximum feasible extent” or
(D.D.C. Mar. 11, 2005) (relying on \textit{Younger}, interpreting “‘to the maximum extent possible’ as hortatory and not as
a legally binding standard by which to review the Secretary’s judgment.”). At least one court, in a non-binding
decision, concluded that “maximum” means the “greatest in quantity or highest degree attainable.” \textit{Burke v.
\textit{Webster’s Third New International Dictionary} 1396 (1993)). The U.S. Supreme Court itself has affirmed the plain
meaning of “feasible” as “capable of being done, executed, or effected.” \textit{Amer. Textile Mfg. Inst., Inc. v. Donovan},

\textsuperscript{11} “Admitted assets” are defined as “assets having economic value which can be used to fulfill policy
obligations and are permitted, as allowed in the . . . [NAIC] Accounting Practices and Procedures Manual, to be
reported as admitted assets on the statutory financial statement of the insurer . . . , but excluding assets of separate
3 (“An insurance company must retain surplus in order to protect against future risks and contingencies that could impair the company’s ability to service its policyholders.”).

The Act does not define what it means for surplus to be consistent with financial soundness. Based on the Act’s purpose, the Commissioner concludes that a surplus is consistent with financial soundness if it is sufficient to address all reasonable risks and contingencies faced by the insurer in excess of the risks for which reserves are established. (These risks and contingencies are discussed in detail in Section IV.C.3.c., below.)

The Act also does not define what it means for surplus to be consistent with efficiency. The dictionary definition of “efficient” is “capable of producing desired results without wasting materials, time, or energy.” Merriam-Webster Online Dictionary at http://www.merriam-webster.com. Based on this common understanding of “efficiency,” the Commissioner concludes that a surplus is consistent with efficiency only if it is no greater than—and no less than—the level required to meet the reasonable risks and contingencies for which surplus is required. In other words, the surplus must be neither so high as to be wasteful of the

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12 The Commissioner does not agree with Appleseed’s argument that the surplus calculus should be adjusted for alleged “administrative inefficiency.” See D.C. Appleseed Report to the D.C. Department of Insurance, Securities and Banking: Surplus Review of Group Hospitalization and Medical Services, Inc. (“GHMSI”), 41-42 (June 10, 2014) (“Appleseed Pre-Hearing Brief”). Although the Commissioner expects GHMSI to be efficient in its operations, he does not agree that the company’s administrative expenses are relevant to determining whether, under the Act, its surplus is excessive. GHMSI correctly points out that it would make no sense for the Act to refer to operating efficiencies because GHMSI’s administrative expenses are recovered in annual rate filings and neither contribute to nor draw from surplus. Group Hospitalization and Medical Services, Inc., Post-Hearing Brief – DISB Review of GHMSI Surplus Pursuant to the Medical Insurance Empowerment Act of 2008, D.C. Code § 31-3501, et seq., 23 (Nov. 7, 2014) (“GHMSI Post-Hearing Brief”); see also Testimony of Phyllis Doran, F.S.A., M.A.A.A., District of Columbia Department of Insurance, Securities and Banking Public Hearing to Review the Surplus and Community Health Re-Investment of GHMSI, 8 (June 25, 2014) (“Doran Testimony”). Moreover, even if the Act could be interpreted as Appleseed suggests, Appleseed has presented no clear evidence that GHMSI’s operations are inefficient. Appleseed’s analysis relies upon a comparison of GHMSI with a limited selection of “peer” plans without any explanation as to how the comparison plans were selected or why they were deemed to be peers (other than the fact that they all make use of the BlueCross or BlueShield trademarks) and fails to give any consideration to operational differences among the selected plans. See Mark E. Shaw, United Health Actuarial Services, Inc., Report to the D.C. Department of Insurance, Securities and Banking Group Hospitalization and Medical Services, Inc. MIEAA Surplus Review, 33-38 (June 10, 2014) (“Shaw Pre-Hearing Report”).
company’s resources nor so low as to render GHMSI unable to respond efficiently to reasonable risks and contingencies if they occur. For example, one of the risks for which surplus is necessary is the risk that the insurer will underestimate future increases in health care costs when setting premium rates, making rates inadequate to cover claims and the cost of adjusting claims. A surplus level would be inefficient if it were so low that a reasonable risk of rating inadequacy, if realized, would require GHMSI to request a large, “catch-up” rate increase, which would be disruptive to subscribers and harmful to the company.

To determine whether GHMSI’s surplus is excessive, the Commissioner evaluates GHMSI’s surplus needs to determine an appropriate level of surplus and then compares the company’s actual surplus to this target level. In conducting this analysis, the Commissioner ensures that the target surplus level is consistent with the Act’s standards, including financial soundness, efficiency, and maximizing community reinvestment, by considering only reasonable risks and contingencies faced by GHMSI. In other words, the analysis does not consider highly attenuated risks. Rather, it applies reasonable, “middle-of-the-fairway” projections of surplus needs to arrive at a target surplus that is large enough to be consistent with financial soundness and efficiency, but no larger.

2. Estimating Surplus Needs

Having defined the applicable standards, the next step is to apply those standards to determine a target surplus level that maximizes GHMSI’s community health reinvestment without undermining its financial soundness and efficiency. To assist with this determination, the Commissioner retained Rector to conduct an analysis of the various risks and contingencies

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13 As discussed in greater detail below, the analysis of risks involves evaluating both the probability and severity of the risk. In other words, a risk such as a catastrophic event might have a low probability but may be considered in the analysis if it also has a high severity.
for which GHMSI must maintain surplus. To understand how the Commissioner reached his determination, it is helpful to understand how Rector conducted its analysis.

Rector’s analysis relied in part on the Milliman Model, which is an actuarial model developed by Milliman and used by GHMSI to forecast its long-term surplus needs over a three-year projection period. Rector Report at 9. Rector did not rely upon the Milliman Model as originally presented. Rather, after an extensive review, Rector modified numerous aspects of the Milliman Model to bring it in line with the Act’s standards. (This Decision and Order refers to the Milliman Model, as modified by Rector, as the “Modified Milliman Model.”)

The purpose of Rector’s review and modifications was to ensure that the conceptual approach taken by Milliman was reasonable and that each individual assumption underlying the model was a reasonable, “middle-of-the-fairway” assumption. Tr. 74:14-75:16; see Rector Report at 18 et seq. To this end, Rector performed validation testing of the assumptions in both a bottom-up fashion (validating the selections made relative to each assumption against company, industry or other relevant experience) and a top-down fashion (comparing the assumptions selected, as a group, to GHMSI’s historical operating results). Rector Report at 34; Tr.20-22; Rector & Associates, Inc., Questions for/ Information Requested from Rector [in Response to Third Scheduling Order], 10-11 (Aug. 27, 2014) (“Rector Resp. Third. Sched. Order”). In addition, Rector evaluated each conceptual approach adopted by Milliman and made certain modifications where appropriate. Rector Report at 11, 18-20. The modifications made by Rector to the Milliman Model and how Rector arrived at those modifications are discussed in detail below.

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14 Rector’s review included analysis of a Milliman report prepared for GHMSI on the development of an optimal surplus target range; evaluation of supplemental materials provided by Milliman and GHMSI; consideration of related materials provided by Appleseed and UHAS; and discussions, both in person and by telephone conference, with Milliman, Appleseed, and UHAS. Rector Report at 10.
The Commissioner has reviewed Rector’s work and concludes that Rector’s modifications are reasonable and appropriate and, except for the assumptions adopted by Rector regarding premium growth, produced reasonable, “middle-of-the-fairway” assumptions for the analysis of GHMSI surplus needs. With respect to premium growth, after further review and in consultation with NovaRest, the Commissioner concluded that the assumptions for this factor should reflect a lower projected level of premium growth than was assumed by Rector.

The Commissioner concludes that the Modified Milliman Model, with the modifications made by Rector and the additional revisions he requested, is an appropriate tool to use in determining a target surplus level for GHMSI under the Act. The Commissioner concurs with Rector’s conclusion that, in using the Milliman Model (as modified), neither he nor Rector were being deferential to Milliman or to GHMSI or that GHMSI was being advantaged. Projection models [like the Milliman Model] are essentially calculators and should produce similar results if similar assumptions are used. If a given model is properly constructed, it ultimately isn’t all that important whose model you use. Rather, the important decisions pertain to the numbers put into the calculator. In other words, the assumptions selected for the model to run.

Tr. 20:15-24.

3. Model Assumptions and Operation

The discussion below reviews each step of the modeling process. It includes a discussion of the analysis conducted by Rector to evaluate the assumptions and conceptual approaches used in the modeling, the modifications made by Rector to arrive at the Modified Milliman Model, and the further revisions made by the Commissioner. Unless otherwise stated, the Commissioner concurs with Rector’s analysis and conclusions.

a) Benchmark RBC Levels and Corresponding Confidence Levels

The modeling used to determine whether GHMSI surplus is excessive is a multi-step process. It begins by selecting two benchmark levels of RBC against which to measure
GHMSI’s surplus. The selected benchmarks—200% and 375% RBC-ACL—are the same as those adopted for determining whether the surplus is greater than appropriate risk-based capital requirements under D.C. Official Code § 31-3506(e)(1) (2012 Repl.). See Section IV.B., above. The Commissioner concludes that these benchmark levels are similarly appropriate for use in the modeling process.  

Next, confidence levels are selected to determine an amount of surplus that will provide an appropriate level of confidence that GHMSI’s surplus will not fall below the benchmark RBC thresholds during a three-year review period. As with other aspects of this review, in selecting appropriate confidence levels the Commissioner seeks to calibrate the selection so as to maximize community health reinvestment without undermining financial soundness and efficiency.

(1) 95% Confidence Level for 200% RBC-ACL Benchmark

Given the potentially severe consequences to GHMSI and the District’s health insurance market if GHMSI’s surplus were to fall below 200% RBC-ACL and the difficulty GHMSI would have rebuilding surplus from such a low level, the Commissioner concludes that a confidence level of 95% with respect to the 200% RBC-ACL benchmark is appropriate.

As discussed in Section IV.B. above, 200% RBC-ACL is the level at which an insurer’s surplus is considered to be deficient, requiring the insurer to submit a plan for corrective action to the Commissioner. U.S. insurance regulators, including DISB, consider a 200% RBC-ACL level to be a significant indicator of very real problems with an insurer’s financial and operational strength. Rector Report at 15.

15 They also are the same benchmarks the Commissioner used to evaluate GHMSI’s 2008 surplus. See 2010 Order at 10. The D.C. Court of Appeals found no error in the Commissioner’s use of these standards in the previous review. Appleseed Appeal, 54 F.3d at 1217-18.
Moreover, the consequences to GHMSI under its licensing agreement with BCBSA if its surplus falls below 200% RBC-ACL are potentially severe. If this occurred, the BCBSA could revoke GHMSI’s licenses to use the Blue Cross and Blue Shield names and trademarks. GHMSI Resp. Third Sched. Order at 9. Loss of the licenses would mean that BCBSA could appoint another BCBSA licensee to do business in GHMSI’s Blue service area. *Id.* BCBSA also would assign GHMSI’s approximately 365,000 Federal Employee Program (“FEP”) members – representing 33% of GHMSI’s total enrollment – to another BCBSA licensee. *Id.* at 9-10. In addition, most of GHMSI’s National Account business – approximately 290,000 members, representing 29% of its total enrollment – would be transferred to the other BCBSA licensees. *Id.* at 10. Finally, if the BCBSA were to revoke GHMSI’s licenses, all of GHMSI’s members would lose full access to providers participating in the Blue Cross and Blue Shield networks. *Id.*

Having a surplus near or below 200% RBC-ACL also would likely cause significant concern among GHMSI’s policyholders and other customers, possibly leading them to seek another, more stable insurer or administrator, which would further weaken the company. Tr.128:5-18. The Commissioner concurs with Rector’s estimation that having GHMSI’s surplus drop to 200% RBC-ACL would cause “extreme distress” in the District’s health insurance market, and given GHMSI’s dominance in the District market, be far more troubling and disruptive than if such a loss were sustained by a similarly sized health insurer with a more modest share of the market. Tr.39:20 - 40:3.

The adverse consequences of having GHMSI’s surplus fall below 200% RBC-ACL are compounded by the company’s status as a nonprofit insurer, which makes it difficult for the company to rebuild surplus. Unlike for-profit insurance companies, GHMSI does not have the ability obtain funds from the capital markets if needed. Tr.40:5-8. Nor does GHMSI have a
parent company that might have cash available to contribute if GHMSI were under financial stress. Tr.40:8-10.

The ACA’s medical loss ratio ("MLR") also limits GHMSI’s ability to rebuild surplus. The MLR rules, which were first implemented in 2011, limit how quickly a health insurer may build surplus by raising rates. Under the MLR rules, an insurer must pay rebates to its policyholders if its non-medical costs exceed 15% of premiums in the large group market or 20% in the small group or individual markets. See D.C. Official Code § 31-3311.02 (2012 Repl.); 45 C.F.R. § 158.210. This requirement limits the amount of surplus an insurer can generate in any one year because any funds that would go to surplus must come out of the 15% to 20% of premiums allocated for non-medical costs, which include employee salaries, broker commissions, equipment, and administrative costs and other such expenses. 45 C.F.R. § 158.221(b).16

In light of the adverse consequences and challenges outlined above, the Commissioner concludes a 95% confidence level is appropriate for the 200% RBC-ACL benchmark and that it is the confidence level most consistent with the requirements of the Act. This level provides a very high degree of confidence that GHMSI’s surplus will not fall below 200% RBC-ACL and therefore is consistent with financial soundness and efficiency. At the same time, a 95% confidence level maximizes GHMSI’s community reinvestment by not allowing GHMSI to accumulate surplus at a level that is inefficient or unnecessary for financial soundness.

16 Federal regulations implementing the ACA permit the Secretary of Health and Human Services to defer the payment of rebates if the payment would cause an insurer’s surplus to fall below 200% RBC-ACL. 45 C.F.R. § 158.270. There is no guarantee, however, that the Secretary would grant such relief or would grant it in a timely manner. Moreover, because a deferral can be granted only if the payment of rebates would cause the insurer’s surplus to fall below 200% RBC-ACL, the availability of this relief appears to be limited to circumstances where surplus already may be dangerously low.
(2) Alternate Confidence Levels for 200% RBC-ACL Benchmark

In reaching the conclusion that the 95% confidence level for the 200% RBC-ACL threshold is appropriate here, the Commissioner carefully considered – but ultimately rejected – the alternate levels proposed by Appleseed, GHMSI, and Rector.

The Commissioner disagrees with Appleseed’s proposed 90% confidence level for the 200% RBC-ACL benchmark. The Commissioner concludes that this level of confidence—a one-in-ten chance of surplus falling below 200% RBC-ACL—would pose too great a risk to the solvency of GHMSI given the potential for severe adverse consequences if the company’s surplus drops to this level. The Commissioner agrees with Appleseed that the confidence level chosen for this review must be calibrated to the Act’s standards. But under the Act any such calibration must be made only to a point consistent with financial soundness and efficiency. A 90% confidence level goes beyond what is efficient and could jeopardize the company’s financial soundness.

Nor does the Commissioner agree with GHMSI’s proposal to adopt a 98% confidence level. In support of its position, GHMSI points to confidence levels in the range of 98% and above used by GHMSI’s consultants at various times, the A.M. Best rating agency, and the European Union under its Solvency II standards. GHMSI Post-Hearing Brief at 14-15. None of the standards cited by GHMSI are appropriate for this review. There is no evidence that GHMSI’s consultants took into account the requirements of the Act in the selection of their confidence levels. Moreover, the Commissioner notes that one GHMSI consultant—Lewin—employed a 95% confidence level with respect to the 200% RBC-ACL benchmark. See, e.g., The Lewin Group, Recommended Surplus Range for GHMSI: Approach and Considerations for Determining the Appropriate Range of Surplus in 2011, 19-20 (May 20, 2011) (the “Lewin Report”). The confidence levels cited by GHMSI that are used by A.M. Best and by the
European Union are designed for different purposes than those that apply to this review and do not take into account the requirements of the Act.

Finally, although Rector also recommended a 98% confidence level for the 200% RBC-ACL benchmark, Rector took pains to state that the selection of an appropriate confidence level is a matter of judgment. Tr.40:25-41:1. As the D.C. Court of Appeals emphasized, in selecting a confidence level, consideration must be given to calibrating the level in accordance with the requirements of the Act. Appleseed Appeal, 54 A.3d at 1218-1219. This determination ultimately is entrusted to the Commissioner’s reasonable discretion. Id. at 1215.

After consideration of all the facts in the record, the Commissioner concludes that a confidence level of 95% for the 200% RBC-ACL benchmark is most consistent with the Act’s standards.

(3) 85% Confidence Level for 375% RBC-ACL Benchmark

The Commissioner concludes that an 85% confidence level is appropriate for the 375% RBC-ACL benchmark. The adverse consequences of falling to 375% RBC-ACL are real and justify establishing a reasonably high level of confidence that GHMSI’s surplus will not fall below that benchmark. But because the consequences are less severe than those at the 200% RBC-ACL benchmark level, the confidence level in turn may be lower.

There are good reasons to avoid a surplus level below 375% RBC-ACL. As stated above, 375% RBC-ACL is the BCBSA “Early Warning” threshold. GHMSI Resp. Third Sched. Order at 8; see also Section IV.B., above. If GHMSI’s RBC falls below 375% RBC-ACL, it must submit a recovery action plan to the BCBSA outlining the steps it will take to increase its RBC. GHMSI Resp. Third Sched. Order at 8. The BCBSA also would subject GHMSI to certain enhanced reporting and monitoring requirements and require it to disclose its financial condition to all health care providers and group and individual policyholders before entering into
contracts with them. *Id.* at 9. The BCBSA thus clearly regards a surplus below 375% RBC-ACL to be an indication of financial weakness requiring enhanced oversight of its licensee and development of a plan by the licensee to bring its surplus up to a safer level. It is reasonable to conclude that GHMSI’s policyholders and administrative services customers would view a surplus below 375% RBC-ACL in the same light, which could cause GHMSI to lose business and weaken the company. In addition, Milliman expressed concern that at 375% RBC-ACL, GHMSI would likely need to curtail long-term investments important to GHMSI’s viability, limit or suspend social mission initiatives, and limit or cease innovation in markets and products while the company focused on rebuilding its surplus. Milliman, Inc., *CareFirst Inc. – Group Hospitalization and Medical Services, Inc. – Development of Optimal Surplus Target Range*, 12 (May 31, 2011) (“Milliman Report”).

The potential adverse consequences of a 375% RBC-ACL level are substantial, but are not so dire and immediate as those at the 200% RBC-ACL level. The Commissioner therefore concludes that the confidence level for the 375% RBC-ACL threshold should remain reasonably high but be lower than that for the 200% RBC-ACL threshold. The 10 percentage point difference between the confidence levels for the two benchmarks (95% vs. 85%) is justified by the fact that the negative consequences of falling to 375% RBC-ACL, though significant, are not nearly as severe as those associated with a surplus below 200% RBC-ACL. The Commissioner concludes that a confidence level of 85% for the 375% RBC-ACL benchmark is appropriately calibrated to the standards of the Act.

**b) Modeling Risks and Contingencies**

The next portion of the analysis involves identifying the various risks and contingencies to which GHMSI is subject and estimating their potential impact on surplus. The purpose of this step is to determine how much surplus GHMSI should maintain to achieve a 95% confidence
level that its surplus will not fall below 200% RBC-ACL and an 85% confidence level that its surplus will not fall below 375% RBC-ACL during the projection period.

The modeling of risks and contingencies involves several stages. First, the relevant risks and contingencies are identified and grouped into discrete “risk factors.”17 Sarah Schroeder, Memorandum re: Overview of Milliman Modeling Methodology, 1 (May 12, 2014) (“Rector Modeling Memo”). Next, for each risk an estimate is made of the probability that the risk will occur and how severe an effect it would have on GHMSI’s surplus if it occurred. See id. at 2. In this step, each risk is assigned an array of estimated probabilities and associated severities. For example, it might be estimated that a particular risk has a 50% chance of having no impact on GHMSI’s surplus, a 25% chance of having a positive impact of a certain magnitude and a 25% chance of having a negative impact of a certain magnitude. The estimated probabilities and severities for each risk are based on relevant historical experience and reasonable projections for how future experience may deviate from historical experience. See id.

The next step is to feed the probability/severity arrays, or “probability distributions,” into an automated projection calculator that produces numerous gain and loss outcomes, each of which is then ranked from worst loss outcome to best gain outcome. Rector Modeling Memo at 2. Rector used an automated calculator developed by Milliman for this purpose but built its own calculator to validate Milliman’s approach. Tr. 20:3-9. Next, a loss outcome is selected based on the desired confidence level that surplus will not decline below a threshold level. If, for

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17 Rector used the following risk factors: (1) premium growth rate, (2) equity portfolio asset values, (3) rating adequacy and fluctuation, (4) unpaid claim liabilities and other estimates, (5) change in interest/discount rate, (6) bond portfolio impairment, (7) overhead expense recovery and fee income risks-commercial business, (8) overhead expense recovery and fee income risks-FEP indemnity business, (9) overhead expense recovery and fee income risks-FEP operations center business, (10) overhead expense recovery and fee income risks-BlueCard, (11) other business risks, (12) catastrophic events, and (13) unidentified development and growth. See Rector Report; Milliman Report; Rector Modeling Memo. These factors are discussed in detail in the next section below.
example, a confidence level of 95% is desired, the loss outcome in the 95th percentile of the ranked outcomes is selected.

Finally, the selected loss outcome is incorporated into a three-year pro forma financial statement to determine what effect it would have on GHMSI’s surplus if it were to occur. In this way, the modeling produces an estimate of how much surplus GHMSI would need to able to sustain the loss outcome and still remain above a specific RBC threshold at the selected level of confidence. Rector’s analysis of the Milliman Model included an analysis of all of the assumptions used in the pro forma income statement and a comparison of GHMSI’s historic financial results to those generated using the pro forma income state to validate the financial projections. Jim Toole, FTI Consulting, Memorandum re: Milliman Pro Forma Financial Projection Model Methodology Validation (Feb. 7, 2014) (“Pro Forma Memo”); Rector Resp. Third. Sched. Order at 11-15. In validating these assumptions, Rector found them to be reasonable and did not believe it was necessary or appropriate to make any adjustments to Milliman’s baseline assumptions. Rector Resp. Third. Sched. Order at 12.18

c) Risk Factors

A key aspect of modeling is the choice of assumptions underlying each risk factor. In light of the D.C. Court of Appeals’ admonition that the Commissioner should provide a complete explanation of the reasoning supporting his determination, see Appleseed Appeal, 54 F.3d at 1219, the following discussion reviews in detail the approach Rector took to evaluate the reasonableness of the assumptions underlying each risk factor and the revisions Rector made to

18 As discussed in detail below, Rector did make adjustments to some of the assumptions used by Milliman to develop the probability/severity distributions used in the Milliman Model. Some of these adjustments flowed through to the pro forma financial statement because certain assumptions used to build the financial statement—for example investment earnings and pricing margins—also are captured in the 13 risk factors used for the risk modeling. Id.
ensure that each factor reflects reasonable, “middle-of-the-fairway” assumptions. Of the 13 risk factors used in the modeling, three—Premium Growth Rate, Equity Portfolio Asset Values, and Rating Adequacy and Fluctuation—had the most significant effect on the results of the modeling. The discussion therefore focuses most heavily on these three factors. Except as stated with respect to the premium growth factor, the Commissioner concurs with Rector’s analysis as to each of the risk factors described below.

(1) **Premium Growth Rate**

Premium growth rate is a key factor because the amount and type of premium projected to be written by a health insurer are important determinants of the insurer’s future surplus needs. Rector Report at 27.

Milliman had considered the effect of premium growth in the Milliman Model but did so in a way that Rector believed gave undue weight to the worst possible outcome for this factor. Rector Report at 20. Instead of following Milliman’s approach, Rector created a separate risk factor for premium growth to obtain a more reasonable projection of the effect it would have on surplus. *Id.* The Commissioner concurs with this approach.

The Commissioner also concurs with much of Rector’s analysis of how to develop appropriate assumptions for premium growth. Specifically, Rector and the Commissioner generally agree that this factor should take into account: (1) historical premium experience; (2) changes that might cause deviation from this historical experience, particularly due to ACA implementation, and (3) different treatment of FEP and non-FEP business. The Commissioner, like Rector, therefore first considered GHMSI’s historical premium growth rate. Rector

The Commissioner also carefully evaluated Rector’s analysis of the likely effect of factors that might change GHMSI’s future premium growth, causing it to deviate from historical growth levels. \textit{See} Rector Resp. Third Sched. Order at 16-17; Rector Report at 28; Rector Premium Growth Memo at 3. The factors considered by Rector were: (a) changes in future enrollment, including changes in enrollment due to ACA implementation; (b) rising health care costs, and (c) policyholder cost-sharing decisions. Rector Resp. Third Sched. Order at 16-17; Rector Report at 28-29; Rector Premium Growth Memo at 3.

Regarding changes in enrollees, Rector noted that the number of GHMSI’s enrollees had fluctuated up and down during the historical review period, but had declined more recently, with significant declines in 2009 and 2010. Rector believed it was reasonable to assume that this decline would not continue and that if GHMSI could maintain its market share, a slow but steady increase in enrollees could be assumed due to natural population growth in GHMSI’s service area. Rector Report at 28-29; Rector Premium Growth Memo at 3.

Regarding increases in health care costs, Rector assumed a baseline health care cost trend of 8% based on projections developed by PwC and the Health Cost Index database developed and maintained by Milliman. Rector Premium Growth Memo at 4; \textit{see also} Rector Resp. Third Sched. Order at 17; Rector Report at 29. Based on projections developed by the Society of Actuaries, Rector also believed that the implementation of ACA reforms—namely, the individual mandate and health care exchanges—would cause GHMSI’s premiums to increase

\textsuperscript{19} Rector excluded the growth rate for 2008, which was unusually low due to a one-time change in the insured population caused by a reinsurance transaction. \textit{Id.} at 2-3.
more quickly than historical averages. Rector Resp. Third Sched. Order at 17; Rector Report at 28-29; Rector Premium Growth Memo at 4.

Regarding benefit reductions and employee cost shifting, Rector noted that in recent years many insureds have opted for less coverage in exchange for reduced premiums and many employers have altered their plan design to offer fewer benefits and greater cost sharing, all of which have put downward pressure on premium growth. Rector Report at 29; Rector Premium Growth Memo at 4. Rector’s projections for premium growth assumed that insureds have reached a point of diminishing returns with respect to these strategies, which would relieve the downward pressure on premiums. Rector Resp. Third Sched. Order at 17; Rector Report at 29; Rector Premium Growth Memo at 4.

The Commissioner agrees with Rector that, in developing projections for premium growth, GHMSI’s Federal Employee Program (“FEP”) and non-FEP business should be examined separately, for several reasons. See Rector Resp. Third Sched. Order at 17; Rector Report at 29; Rector Premium Growth Memo at 5. First, although the FEP is an insured program, it is constructed in a manner that significantly reduces GHMSI’s short-term underwriting risk with respect to the program. Rector Resp. Third Sched. Order at 17; Rector Report at 29; see also Rector Premium Growth Memo at 5. Second, the NAIC RBC formula that assigns risk charges to various types of health businesses applies a significantly lower risk charge to FEP business. Rector Resp. Third Sched. Order at 17; Rector Report at 29. Finally, Rector anticipated that the increase in enrollment likely to result from the ACA would affect GHMSI’s

GHMSI supports 620,000 federal employees in this region and also supports an operations center for 5 million federal employees nationwide. Tr.139:16-20. Rector therefore recognized that “the FEP constitutes a relatively large portion of GHMSI’s business.” Rector Report at 29.
non-FEP business more significantly than its FEP business. Rector Resp. Third Sched. Order at 17; Rector Report at 29; Rector Premium Growth Memo at 5.

Based on this approach, Rector developed a probability distribution for projected FEP and non-FEP premium growth rates reflecting estimated high, mid- and low ranges of premium growth. See Rector Report at 30; Rector Premium Growth Memo at 8. Rector’s mid-points for annual premium growth with respect to FEP and non-FEP business were, respectively, 7.5% and 12.4%. Rector Report at 30; Rector Premium Growth Memo at 8.

The Commissioner concluded that Rector’s probability distribution for projected FEP premium growth rates is reasonable.

However, after reviewing GHMSI’s historical rates of premium growth and the anticipated effect of the ACA, the Commissioner, in consultation with NovaRest, concluded that Rector’s projections for non-FEP premium growth, based on a 12.4% probability distribution midpoint, were too high. The Commissioner concluded that Rector overestimated the non-FEP premium growth rate because they gave too much weight to the impact of the ACA and not enough weight to slower rates of premium growth experienced by GHMSI in 2009 through 2011. Therefore, the Commissioner, through his staff and consultants, projected lower levels of premium growth due to the ACA. Specifically, they revised the projection to reflect a lower “take up” rate, i.e., they assumed a decreased number of previously uninsured individuals would purchase insurance under the ACA. The Commissioner deemed the decrease appropriate given the levels of uninsured individuals and the problems with take-up in the first year of any new program. Accordingly, the Commissioner developed the following modified probability distribution for non-FEP premium growth with a mid-point of 8.0% annual premium growth based on historic growth and ACA growth combined:
Table 1. Commissioner’s Requested Premium Growth Probability Distributions

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<td>4.5%</td>
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<td>8.0%</td>
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<td>12.2%</td>
<td>25%</td>
<td>8.4%</td>
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Based on the advice of NovaRest and DISB’s own analysis, the Commissioner concludes that the modified probability distribution shown in Table 1 is a more reasonable assumption for premium growth than those proposed by Rector, GHMSI, or Appleseed, and therefore is more consistent with the requirements of the Act.

(2) Equity Portfolio Asset Values

The Equity Portfolio Asset Values factor assesses risks associated with GHMSI’s investment portfolio and their implications for reported surplus levels. Milliman Report at 16. Specifically, it pertains to variations in anticipated earnings from equity investments as expressed in a probability distribution. Rector Resp. Third Sched. Order at 5. The pro forma financial projections used in the Milliman Model start with an average annual investment earnings rate of 3.75% as a baseline assumption. Rector Resp. Third Sched. Order at 5. This baseline assumption reflects the anticipated return on GHMSI’s investment portfolio, which consists of a blend of equity and fixed income investments. Id. Thus, anticipated earnings from equity investments are just one part of GHMSI’s total anticipated investment earnings. Id.

The Commissioner concurs with Rector’s analysis of the reasonableness of the model’s treatment of the equity portfolio factor. In the Modified Milliman Model, Rector used the same baseline assumption for average annual investment earnings—3.75%—and the same probability distribution for equity portfolio asset values as were used in the Milliman Model. Rector Resp. Third Sched. Order at 5; Rector Report at 21. To evaluate the reasonableness of the baseline
assumption and potential deviations from the baseline, Rector reviewed Standard & Poor’s index data starting in 1957. Rector Resp. Third Sched. Order at 5. Rector found that while equity values have increased at an average rate of 7.3% over the last 50 years, there has been significant volatility around this average. Id. at 5-6. By comparing the deviations in the S&P 500 over a 50-year period, Rector was able to validate the assumptions relating to the equity portfolio asset values used in the stochastic portion of the Milliman Model and the reasonableness of the potential for deviation and variation from the equity portion of the average annual investment earnings rate assumption under the pro forma portion of the Milliman Model. Id. at 6.

(3) Rating Adequacy and Fluctuation

The rating adequacy and fluctuation factor reflects the risk that actual claims and expenses will differ from the amounts anticipated when premium rates are set, focusing on the effect of trend on the adequacy of premium rates. Milliman Report at 15; Rector Resp. Third Sched. Order at 6.

The Commissioner concurs with Rector’s analysis and treatment of the rating adequacy and fluctuation factor. Rector reviewed the various components of the standard trend deviation that Milliman used in its modeling. Id. For the secular trend component—i.e., the component that represents the trend variation based on changes in health care costs—Rector took into account the annual change in the Healthcare Cost Index for the period 1986-2010. Id. For other components of the standard trend deviation, Rector reviewed GHMSI’s historical experience and industry data to confirm the appropriateness of the assumptions used for this risk factor. Id.
Rector made several changes to the way Milliman modeled the rating adequacy and fluctuation risk factor. Milliman had applied two different trend miss\textsuperscript{21} periods (a two-year and a three-year miss period) as inputs to the modeling process. Rector Report at 22. Because Rector believed this approach overstated the likely effect of trend miss, it instead incorporated the effects of trend miss into a revised rating adequacy and fluctuation factor as variables with their own probability distribution. Id. Rector also found that the way Milliman had determined historical variability of the secular components of trend assumed that trends were independent from one year to the next. Id. Rector’s analysis demonstrated that trends occurring between time intervals are correlated to trends from prior periods. Id. In keeping with this analysis, Rector made appropriate changes to the trend variability assumptions and the manner in which trend is incorporated into the rating adequacy and fluctuation risk factor. Id.

Rector questioned several of Milliman's assumptions concerning rating adequacy and fluctuation. First, Milliman had assumed that the ACA’s MLR rebate requirements would have an effect on rating adequacy and fluctuation. Id. Although the effect assumed by Milliman was minimal, Rector demonstrated that the rebate requirement would be very unlikely to affect rating adequacy and fluctuation and therefore excluded this effect. Id. at 22-23; see also Jim Toole, FTI Consulting, Memorandum re: ACA Reform and Surplus Requirements, 2-3 (Sept. 12, 2013) (“ACA Reform Memo”).

Second, Milliman also had assumed that, as a result of the ACA, the time between rate filings and their effective date would increase and, in addition, regulators would restrict future

\textsuperscript{21}“Trend” or “health care cost trend” refers to the annual change in an insurer’s health care costs resulting from factors such as price inflation, advances in technology, changes in utilization of health care services and cost shifting by health care providers to compensate for low reimbursement rates from governmental plans. Rector Report at 19 n. 28. “Trend miss” is the projected period of time that GHMSI’s actual trend differs from its anticipated trend before GHMSI makes adjustments to its trend assumptions. Id. at 19.
requested premium rate increases. See Rector Report at 23. After discussions with regulators and Milliman, Rector agreed with Milliman that health care reform would slow the implementation of rate changes, but disagreed that regulators were likely to disapprove requested rate increases, especially in cases where GHMSI was in a financially difficult position. See id. at 23; ACA Reform Memo at 4. Therefore, Rector removed the effect of restricted premium rate increases from the rating adequacy and fluctuation risk factor. Id.

Third, Milliman originally included estimated effects on trend miss for coverage changes required by the ACA, including unlimited benefits, coverage for dependents to age 26, and the removal of pre-existing condition exclusions for children. ACA Reform Memo at 4. Because these requirements had been in effect since 2010, Rector determined that they had become a normal part of the pricing landscape and therefore no longer should have an effect on trend miss. ACA Reform Memo at 4. Therefore, Rector removed any risk components for these changes. Id.

Fourth, the Milliman Model only took into account the requirements of the ACA that were in effect at the time Milliman conducted its analysis, but Milliman increased its recommended surplus range for GHMSI based on a rough estimate of the effects of ACA requirements that would go into effect in the future. Rector determined that a more accurate way to estimate the impact of future ACA requirements would be to incorporate them directly into the modeling process. Rector Report at 23. Accordingly, Rector included in the rating adequacy and fluctuation risk factor appropriate estimated effects of the ACA arising from underwriting restrictions, policyholder behavioral changes, and the individual coverage mandate. Rector Report at 23. Regarding underwriting restrictions, Rector noted that the ACA would restrict the ability of GHMSI to rate policies based on an individual’s prior medical history or behavioral
factors or to rate group policies based on age or gender of group members. ACA Reform Memo at 5. These changes would force GHMSI to change its pricing structure and could cause it to face anti-selection, both of which could cause it to misprice its coverage. Id. With respect to behavioral changes, Rector noted that there was considerable uncertainty regarding how consumers would respond to upcoming changes in the marketplace due the ACA. Id. For example, it was unclear how newly insured policyholders would utilize healthcare and whether policyholders would seek to change coverage as premiums changed. Id. Rector also noted that the ACA underwriting restrictions and the potential for policyholder behavioral changes were interrelated. Id. In this regard, the greater the changes made to the underwriting process, the greater the uncertainty regarding changes to policyholder behavior. Id. In order to reflect the increased variability, Rector assumed the standard deviation of trends for those currently insured in the individual and small group markets would increase by 20%. Id.

Rector also took into account the likely effect of the ACA’s individual coverage mandate, which would likely introduce a new population of insureds in the individual market who would not have a history of insured experience and therefore be difficult to price. Id. at 5-6. Rector estimated that the variability of these new insured risks would be double the variability of risks in the current insured population and included an appropriate effect on the rating adequacy and fluctuation risk factor. Id. at 6.

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22 Anti-selection, also known as adverse selection, occurs whenever persons make insurance purchasing decisions based on their knowledge of their insurability or likelihood of making a claim. See NAIC, Adverse Selection Issues and Health Insurance Exchanges Under the Affordable Care Act (2011). For example, persons in better health may defer purchasing insurance or purchase insurance with fewer benefits and more cost-sharing while persons in worse health may purchase insurance sooner and purchase plans with greater benefits and less cost-sharing. If an insurer underestimates the amount of anti-selection it will encounter, its pricing will be inadequate.
(4) Unpaid Claims Liabilities and Other Estimates

The unpaid claims liability factor takes into account risks associated with nonpayment of claims and other liabilities due to reserving errors. Rector Resp. Third Sched. Order at 6. The probability distributions for this risk factor correlate with those for the rating adequacy and fluctuation factor. Id. at 6-7. In other words, the probability that rates will be inadequate correlates with the probability that reserves will be inadequate. Id. at 6-7. Therefore, Rector’s analysis and the data relied upon with respect to this risk factor were the same as those used for the rating adequacy and fluctuation risk factor. Id. The Commissioner concurs with Rector’s analysis of this factor.

(5) Change in Interest/Discount Rate

As stated above, the pro forma projections used in the model start with a baseline assumption of an average 3.75% annual investment earnings rate. This baseline assumption is based on the anticipated return for GHMSI’s investment portfolio, which consists of a blend of equity and fixed income investments. Rector Resp. Third Sched. Order at 6. The change in interest/discount risk factor relates to the potential deviation and variation from the portion of the baseline assumption relating to interest and discount rates. Id.

The Commissioner concurs with Rector’s evaluation of the change in interest/ discount rate factor. To evaluate the probability distribution for this risk factor, Rector assessed various characteristics and components of the bond market that could affect changes in interest and discount rates, including the interest rate environment, degree of volatility in the bond market, the outlook for inflation, and the characteristics of GHMSI’s bond portfolio (term of maturity, market yield, and unrealized gains and losses). Id. Based on this analysis, Rector used a probability distribution for this risk factor reflecting a 45% chance that interest rates would stay
relatively the same or decrease and a 55% chance that they would increase by a material amount. *Id.* at 8.

(6) **Bond Portfolio Impairment**

The bond portfolio impairment risk factor reflects the potential deviation and variation from the portion of the baseline assumed return on GHMSI’s investment portfolio that relates to bond investments. *Rector Resp. Third Sched. Order* at 8.

The Commissioner concurs with Rector’s validation of the bond portfolio impairment factor. To validate the probability distribution for this factor, Rector analyzed various components and characteristics of the bond market that could affect bond portfolio impairments, including the portfolio rating mix, bond market conditions, the economic environment, and characteristics of GHMSI’s bond portfolio. *Id.* In the course of its analysis, Rector also noted that there was an 83% chance that this risk factor would have little or no impact on surplus at all. *Id.*

(7) **Overhead Expense Recovery and Other Business Risks**

There are five risk factors associated with overhead expense recovery and other business risks. *Rector Resp. Third Sched. Order* at 9.\(^{23}\) These risk factors are intended to capture the risk that GHMSI could not recover all of its overhead expenses if it were to lose business. *Id.* In other words, if GHMSI were to lose business, it could cut some expenses but would likely not be able to cut all expenses proportionately to the loss of business, thereby increasing its expenses relative to the amount of business it wrote. *Id.*

\(^{23}\) The risk factors included in this category are (1) overhead expense recovery and fee income risks-commercial business, (2) overhead expense recovery and fee income risks-FEP indemnity business, (3) overhead expense recovery and fee income risks-FEP operations center business, (4) overhead expense recovery and fee income risks-BlueCard, and (5) other business risks. *See Rector Report; Milliman Report; Rector Modeling Memo.*
The Commissioner concurs with Rector’s evaluation of these business risk factors. To evaluate the appropriateness of these factors’ probability distributions, Rector analyzed various components of GHMSI’s overhead, including general and administrative expenses for each of its business segments, the correction period that would be required to eliminate the overhead expenses involved, and the likelihood that GHMSI could lose certain business segments. Id. In the course of its analysis, Rector noted that, depending on the risk factor, there was 75% to 90% probability that a risk factor in this category would have little or no effect on GHMSI’s surplus. Id.

(8) Catastrophic Events

The catastrophic events risk factor reflects the potential effect of events that are infrequent, severe, and unpredictable natural disasters (for example, pandemics, earthquakes, or hurricanes) and human activity (for example, terrorism, major litigation including large data security breach litigation, and nuclear accidents). See Rector Report at 24.

The Commissioner agrees with Rector’s analysis of, and revisions to, Milliman’s catastrophic risk factor modeling. In this regard, Milliman’s assumptions for catastrophic events included a base charge to surplus of 2.5% of non-FEP premiums in all of its modeling simulation outcomes. Id. Because catastrophic events are, by their nature, infrequent events, Rector did not believe it was appropriate to include such a charge in this risk factor and therefore removed it. Id. Milliman’s assumptions for the catastrophic event risk factor also include contingent provisions for some of its modeling outcomes. Id. Based on its analysis, Rector concluded that it was appropriate to include such contingent provisions. Id. The probability distribution employed by Rector in the Modified Milliman Model assumed a 90% chance that catastrophic events would have no impact on GHMSI’s surplus, a 7.5% chance that such events would result
in a decrease in surplus equal to 2.5% of non-FEP premium, and a 2.5% chance that such events would decrease surplus by 7.5% of non-FEP premium. Id. at 24-25. Rector found that the changes it made in the assumptions underlying the catastrophic events risk factor reduced the anticipated surplus needs produced by the modeling by a fairly significant amount. Rector Report at 25.

(9) Unidentified Growth and Development

The unidentified growth and development factor captures the risk that GHMSI would need to make extraordinary expenditures resulting from unanticipated growth or investment needs, including technology and infrastructure investments, new product development, and responses to legislative changes. Rector Report at 25. This risk factor encompasses the impact of capital investments that produce non-admitted assets, which cannot be included in surplus and therefore constitute a direct charge to surplus, as well as growth and development expenditures that exceed budgeted amounts included in GHMSI’s premium rate structure. Id. at 25, n. 32; 26. GHMSI’s growth in such non-admitted assets is a way to capture its investment in electronic data and processing equipment.

The Commissioner concurs with Rector’s evaluation of the unidentified growth and development risk factor. To evaluate the appropriateness of this risk factor’s probability distributions, Rector analyzed the average annual change in GHMSI’s non-admitted assets, excluding non-admitted assets relating to investments, taxes, and pension plan expenditures, which could obscure more general trends. Rector Resp. Third Sched. Order at 10; see also Rector Report at 27. In addition, Rector took into account the recent experience of the health insurance industry as a whole with respect to the growth of non-admitted assets, which Milliman did not do. Rector Report at 27; Rector Resp. Third Sched. Order at 10. Rector found that the
changes it made to the assumptions relating to unidentified growth and development had a fairly significant impact on the modeling results by bringing down projected surplus needs, similar to the effect of the changes Rector made to the assumptions used for the catastrophic events risk factor. Rector Report at 27.

\( d) \quad \textbf{Rector Conclusions Based on Modified Milliman Model} \)

The modifications made by Rector to the Milliman Model resulted in a significant decrease in the projected surplus needs of GHMSI from the surplus recommended by Milliman. Based on its analysis, Milliman had concluded that an appropriate target for GHMSI’s surplus fell in the range of 1050% to 1300% RBC-ACL, taking into account the impact of federal health care reforms that were in effect at the time of the initial analysis. Milliman Report at 5.\(^{24}\) After making the modifications discussed above, Rector ran the Modified Milliman Model at a 98% confidence level with respect to the 200% RBC-ACL benchmark and an 85% confidence level with respect to 375% RBC-ACL. Based on these results, Rector estimated that, as of December 31, 2011, GHMSI would need a surplus of 958% RBC-ACL to meet the first test (200% RBC-ACL at a 98% confidence level) and a surplus of 746% RBC-ACL to meet the second test (375% RBC-ACL at an 85% confidence level. Rector Report at 12, 30. Because GHMSI should meet both tests to comply with the Act’s standards, Rector concluded that in determining whether GHMSI’s surplus is excessive, the appropriate target surplus is 958% RBC-ACL. \textit{Id.} at 12, 32.

Rector then examined GHMSI’s historical RBC levels since 1999 and found that year-to-year changes in surplus had become less volatile in the period 2004 to 2012, averaging 82.5 RBC

\(^{24}\) In addition, Milliman estimated that its recommended surplus range could increase by 100% to 150%—\textit{i.e.}, to a range of 1150% to 1450% RBC-ACL—due to the impact of federal health care reforms that were not yet in effect at the time of the analysis. \textit{Id.} Milliman characterized its estimate as an indication of the directional nature of the impact of health care exchanges, rather than a precise quantification of their potential financial consequences. Rector Report at 20; \textit{see} Milliman Report at 5, 8.
percentage points. Id. at 13. Based on this data, Rector recommended a “safe harbor” range for GHMSI’s surplus of 958% RBC-ACL plus or minus approximately 82.5%—i.e., Rector recommended that the Commissioner find GHMSI’s surplus was not “excessive” if it was within the range of 875% to 1040% RBC-ACL. Id.

**e) Post-Hearing Modeling**

As discussed above, the Commissioner concluded that revisions should be made to the confidence level and the assumptions used by Rector for the premium growth rate risk factor. Milliman ran the modifications to the premium growth assumptions adopted by the Commissioner at various confidence levels requested by the Commissioner. Rector then validated the calculations. See Milliman, Inc., Letter re: Response to DISB October 3, 2014 Order with Supplemental Information Requests (Oct. 15, 2014) (“Milliman Resp. Supp. Info Req.”); Rector & Associates, Inc., Letter re: R&A Review of GHMSI and Milliman 10/15/14 Response To DISB Supplemental Information Request Order No. 14-MIE-08 (Oct. 24, 2014). The modeling requested by the Commissioner estimated that GHMSI would need a surplus of 721% RBC-ACL to ensure that its surplus would not fall below 200% RBC-ACL at a 95% confidence level and a surplus of 672% RBC-ACL to ensure that its surplus would not fall below 375% RBC-ACL at an 85% confidence level. Milliman Resp. Supp. Info Req. at 3. Because GHMSI must meet both tests to ensure that its surplus is consistent with financial soundness and efficiency, the Commissioner concludes that in determining whether GHMSI’s surplus is excessive, the appropriate target surplus is 721% RBC-ACL.

The Commissioner further concludes that a single target point, rather than a range, complies with the purpose and intent of the Act. The purpose of the surplus review required by the Act is to determine a target surplus that maximizes GHMSI’s community reinvestment
without undermining the company’s financial soundness or efficiency. The Commissioner is concerned that, by establishing a range, the upper boundary of the range would effectively become the target point for surplus, which would encourage GHMSI to hold levels of surplus in excess of a level that maximizes community reinvestment and is efficient. Thus, the Commissioner concludes that a target point more effectively accomplishes the Act’s purposes.

f) Assessing Appleseed’s Recommended Surplus Level

The Commissioner carefully considered, but ultimately rejected, Appleseed’s recommendation for a target level of surplus radically lower than 721% RBC-ACL. Appleseed recommended adoption of a surplus level between 400% and 500% RBC, or approximately $400 to $500 million. See Appleseed Pre-Hearing Brief at 45; DC Appleseed Center for Law & Justice, Rebuttal Statement – D.C. Department of Insurance, Securities & Banking: Surplus Review of Group Hospitalization and Medical Services, Inc. (“GHMSI”), 3 (Nov. 7, 2014) (“Appleseed Rebuttal Brief”).

According to Appleseed, the adjustments to the Modified Milliman Model made by its actuarial consultant, Mr. Shaw of UHAS, “show that a surplus below $400 million would be appropriate looking solely to the Modified Milliman Model and applying a properly calibrated confidence level.” Appleseed Rebuttal Brief at 3 (emphasis added). This is a remarkable assertion given that if GHMSI were to maintain a surplus level of less than $400 million, as Appleseed suggests, the company could very easily slip below 375% RBC-ACL.25

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25 The credibility and reasonableness of Mr. Shaw’s analysis are further called into question when one considers their full effect. If the Commissioner were to accept all of his recommended assumptions, GHMSI would have a surplus target of 205% RBC-ACL. Shaw Pre-Hearing Report at 58, Chart 25. In addition, if the adjustments recommended by Mr. Shaw due to alleged inefficiencies in GHMSI’s administrative expenses are considered, the target surplus for GHMSI would be approximately 55% RBC-ACL. See id. & 37. These levels of surplus are clearly unreasonably low, financially unsound, and therefore inconsistent with the standards of the Act. Appleseed itself did not endorse them, and instead advocated for a higher target between 400% to 500% RBC-ACL.
Ultimately, Appleseed recommends a higher surplus target—$400 to $500 million—than that suggested by its consultant’s report. Appleseed Rebuttal Brief at 3. In doing so, however, it does not identify which portions of UHAS’s analysis the Commissioner should adopt and which portions should be modified or discarded. Instead, Appleseed’s recommended surplus range is based on an impressionistic analysis relying on several considerations.

First, Appleseed argues that Mr. Shaw’s analysis demonstrates that $400 to $500 million is more than enough surplus to protect GHMSI from all reasonably probable contingencies. Appleseed Rebuttal Brief at 3. As discussed above, however, Mr. Shaw’s analysis does not lead to a reasonable projection of surplus needs and therefore is not a suitable benchmark for determining an appropriate level of surplus.

Second, Appleseed argues that intervention by GHMSI’s management, DISB, and the BCBSA would prevent GHMSI from becoming insolvent. According to Appleseed, there is “every reason to believe” that such intervention would be successful given GHMSI’s dominant market position, uniquely powerful brand, territorial exclusivity with respect to its brand, and breadth of its provider networks. *Id.* The Commissioner agrees that timely intervention and the other factors mentioned by Appleseed would have an important effect on the ability of GHMSI to maintain a financially sound position. Nevertheless, these considerations already are reflected in the selection of confidence levels and assumptions underlying the Commissioner’s analysis.

Appleseed also argues that historical experience—namely, the fact that GHMSI’s surplus increased during the Great Recession of 2008-2009—shows that a surplus of $400 to $500 million “is more than adequate to protect the company from significant economic risk.” *Id.* As with the likely effect of intervention and related factors, historical experience already is heavily
factored into the Commissioner’s analysis. Moreover, historical experience is not the only consideration here. The analysis necessarily considers reasonable projections for future experience as it may deviate from historical experience. Moreover, as discussed in detail above, the analysis encompasses much more than just economic risk.

Appleseed further argues that its surplus recommendation is consistent with the surplus level recommended by Rector for GHMSI’s 2008 surplus and the level recommended by Commissioner Mirel in 2005. Id. at 54. As Commissioner Purcell found in the 2010 Decision and the D.C. Court of Appeals recognized, the underlying assumptions and projections that go into an analysis of GHMSI’s surplus needs may vary greatly from year to year depending on changes in the regulatory and financial environment in which GHMSI operates. 2010 Order at 12-13; see Appleseed Appeal at 1220 (“in light of the changing conditions identified in the [2010 Order],” the Commissioner did not abuse her discretion by deferring further review of GHMSI’s surplus until 2012). Appleseed’s position on this score fails to give adequate consideration to the significant changes that have occurred since the time of those earlier reviews, not least of which is the implementation of the ACA’s market reforms.26

4. 2011 Surplus Level Conclusions

Based on the foregoing analysis, the Commissioner concludes that the appropriate level for GHMSI’s surplus as of December 11, 2011 is 721% RBC-ACL (approximately $695.9 million).

26 Although it is not possible to quantify precisely each factor that lead to a different conclusion regarding the appropriate level for GHMSI’s 2011 surplus as compared to its 2008 surplus, the most important factor is the uncertainty concerning the impact implementation of the ACA will have on GHMSI’s ability to forecast accurate premium rates in a volatile market. See Jim Toole, FTI Consulting, Memorandum re: GHMSI Benchmark Surplus Range Reconciliation, 3 (March 6, 2014) (“Benchmark Memo”). The full effect of the ACA was not considered in the analysis of GHMSI’s 2008 surplus. Id. Appleseed does not dispute that the ACA has some impact, but argues that the impact will be far less than what GHMSI, Milliman or Rector suggest. See, e.g., Appleseed Pre-Hearing Brief at 31, Shaw Pre-Hearing Report at 3; Appleseed Rebuttal Brief at 16.
To reach this determination, the Commissioner solicited, received and analyzed voluminous amounts of information from GHMSI, Maryland and Virginia insurance regulators, Appleseed, and other interested persons. The Commissioner and his advisors carefully and extensively analyzed the many technical considerations and underlying assumptions that went into the actuarial modeling used to estimate GHMSI’s surplus needs. The Commissioner acknowledges that any modeling of this sort requires numerous judgments concerning appropriate historical benchmarks and reasonable projections of future experience. Within a reasonable range, experts can, and often do, disagree about the appropriate assumptions to be employed in any such analysis. For this reason, the Commissioner not only looked at the individual components of the analysis, but also at the “big picture” impact of his final determination on GHMSI. Based on both a granular analysis and a consideration of the larger picture, the Commissioner concludes that 721% RBC-ACL is the appropriate target for GHMSI’s 2011 surplus. The Commissioner also concludes that any target below that level would not be financially sound or efficient for GHMSI and its subscribers. Conversely, establishing a target above 721% RBC-ACL would be inefficient and inconsistent with GHMSI’s statutory obligation to maximize its community health reinvestment.

D. Allocation of Surplus to the District of Columbia

To this point, the Commissioner has addressed the surplus as a whole. All participants in this proceeding implicitly have recognized that as a practical matter, in the first instance the surplus must be examined in its totality. GHMSI even urged the Commissioner to “not address the attribution of GHMSI’s surplus at this time.” Group Hospitalization and Medical Services, Inc.’s Further Response to Questions in the Third Scheduling Order and Statement Regarding Attribution, at 1 (Oct. 10, 2014) (“GHMSI Attribution Resp.”).
Surplus allocation is a difficult concept. The Maryland Insurance Commissioner, for example, argues that “the concept of attributing by geography the surplus of an active nonprofit health service plan whose service area spans multiple jurisdictions is fundamentally flawed.” Statement of Therese M. Goldsmith, Maryland Insurance Commissioner, at 2 (Oct. 10, 2014) (“Maryland Post-Hearing Statement”). Maryland’s expert similarly contends: “Apportionment of surplus attributable to a particular jurisdiction . . . is a concept that has no financial meaning, applicability, or relevance and should be reconsidered. This is because surplus is non-divisible and exists for the protection of the entire enterprise and all of its policyholders.” Invotex Group, Report on: Surplus Evaluation Consulting Services For the Maryland Insurance Administration Project #D80R92000007, at 3 (Oct. 30, 2009) (“Invotex Report”), attached as exhibit to Maryland Post-Hearing Statement.  

Nevertheless, the Act requires the Commissioner to determine whether “the portion of the surplus of the corporation that is attributable to the District” is excessive. D.C. Official Code § 31-3506(e) (2012 Repl.) (emphasis added).

The Act does not specify how the attribution of surplus to the District is to be performed. DISB’s regulations, however, state that “attributable to the District”:

shall mean the process used by the Commissioner to allocate the portion of the surplus of a hospital and medical services corporation that is derived from the company’s operations in the District of Columbia based on the following factors:

(a) The number of policies by geographic area;

27 GHMSI similarly argues that “[a]ttribution of reserves by jurisdiction is inconsistent with sound actuarial practice no matter what approach is used. Surplus simply cannot be subdivided by jurisdiction. . . . Outside of these proceedings, there is no accounting standard or requirement in the industry that would justify such separate accountings, let alone require them.” GHMSI Attribution Resp. at 1. Whether and how these criticisms and concerns should be addressed is a question for the D.C. Council, not DISB. As currently formulated, the Act’s plain terms require an allocation.
(b) The number of health care providers under contract with the company by geographic area; and

(c) Any other factor that the Commissioner deems to be relevant based on the record of a public hearing held pursuant to section 4602.

26A DCMR 4699.2. By permitting the consideration of “[a]ny other factor that the Commissioner deems to be relevant,” the regulations give the Commissioner considerable latitude in determining how to allocate the surplus.

GHMSI and Appleseed disagree on how the Commissioner should exercise his discretion in allocating the surplus attributable to the District. GHMSI contends that GHMSI’s surplus should be attributed based on GHMSI subscribers’ residence, reasoning that (1) its “Congressional Charter instructs GHMSI that it must conduct business on behalf of its subscribers, (2) GHMSI’s surplus was built from premiums paid by or on behalf of its subscribers, and (3) GHMSI’s surplus exists solely for the benefit of its subscribers.” GHMSI Attribution Resp. at 2. In contrast, Appleseed maintains that the Commissioner should allocate surplus based on the proportion of premiums that originate in each jurisdiction, arguing that (1) “the surplus is produced by the premiums paid by individuals and small-group and medium-group employers and their employees,” (2) because the individuals and employers who produced the surplus through their premium payments are supported in their activities by the resources and services of the jurisdiction where they are located, the attribution method should reflect the contribution to surplus made by those employers and individuals,” and (3) allocating surplus on the basis of the situs of the contracts that produced the surplus is also consistent with insurance practices both here and in other jurisdictions.” Appleseed Rebuttal Brief at 55.

After reviewing all submissions, the Commissioner concludes that the location or “situs” of the contract – as measured by the premiums reported and number of policies issued in each
jurisdiction – is the most relevant consideration and will accord it the most weight in allocating surplus. Focusing on policy situs – rather than on individual subscriber residency – is consistent with standard regulatory practice and authority. In this regard, the Commissioner has express statutory authority to regulate insurers “doing insurance business in the District.” D.C. Official Code § 31-202(a) (2012 Repl.). “Doing insurance business” encompasses both assuming risks and issuing insurance policies. See id. at § 31-202(b). Insurers themselves quantify the business done in the District by filing annual statements “setting forth specifically the net amount of its premium receipts, the amount of losses paid, [and] the amount of expenses incurred . . . .” Id. at § 31-205(a).

Focusing on reported premiums, in particular, is appropriate given the statutory language here. GHMSI observed that the Act requires allocation of the surplus “attributable” to the District, and that “attribute” means “due to, caused by, or generated by.” GHMSI Attribution Resp. Exh. 1 at 33 (quoting Electrolux Holdings, Inc. v. United States, 491 F.3d 1327, 1330-31 (Fed. Cir. 2007)). In other words, “[t]he question to be answered is ‘where did the money come from? The answer will ordinarily be the source to which the gain is ‘attributable.’” Id. (quoting Benedek v. Commissioner, 429 F.3d 41, 43 (2d Cir. 1970)). Both GHMSI and Appleseed agree that “GHMSI’s surplus was built from premiums paid by or on behalf of its subscribers.” GHMSI Attribution Resp. at 2; see also Appleseed Rebuttal Brief at 55 (“the surplus is produced by the premiums paid by individuals and small-group and medium-group employers and their employees.”).
The Commissioner has reviewed the data from the 2011 Annual Statement filed by GHMSI, as well as BlueChoice’s 2011 Annual Statement, and specifically their amended Schedule Ts showing “Premiums and Other Considerations Allocated by States and Territories.” When jurisdictions where GHMSI and Blue Choice reported $0 premium are excluded, the Schedule Ts show the following direct business only-premiums for accident and health premiums and FEP premiums:

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28 The Milliman model, both as originally created and as modified by Rector, reflects GHMSI’s 50% ownership of BlueChoice. Since BlueChoice was factored into the determination of whether the surplus was excessive, it similarly should be factored into the determination of what portion of the surplus is attributable to the District. The Commissioner therefore rejects GHMSI’s request to separately apportion surplus to GHMSI and to BlueChoice. See GHMSI Attribution Resp. at 5-6. Thus, as in the review of the surplus as a whole, the allocation calculus includes 100% of GHMSI’s own business and 50% of BlueChoice’s business.

29 The Commissioner informed the parties at the June 25, 2014 hearing that GHMSI’s annual statements would be part of the record for this proceeding. See Tr. 11:3. BlueChoice’s annual statement, filed with the NAIC, is a publicly available document and, as a practical matter, DISB accesses NAIC filings as it does its own records. Courts routinely take judicial notice of public records, see, e.g., Renard v. D.C. Dep’t of Emp. Services, 673 A.2d 1274, 1276 (D.C. App. 1996) (“An agency may take official notice of its own records”), as does the Commissioner here.

30 The FEP (also known as “FEHBP”) Premiums reported on the Schedule T are not the same as on Table 4: Premiums by Jurisdiction of Policyholder in GHMSI 1(d) Resp. It appears that the difference may be because, in the GHMSI 1(d) Response, “Premiums for FEP overseas certificate holders were included with reporting for the District of Columbia on the amended 2011 Annual Statement for GHMSI, but have been broken out separately here.” Id. at Table 4, n. 21. The Commissioner concludes, however, that GHMSI should be bound by its regulatory filings. Therefore, in determining the premiums generated in each jurisdiction, this decision relies upon the amounts reported in the Health Annual Statements’ Schedule T forms rather than in GHMSI’s 1(d) Response.

31 Appleseed accurately notes that GHMSI changed its reporting of FEP premiums, shifting the majority of reported premiums from the District to Maryland. See Appleseed Rebuttal Brief at 55, n. 48. But Appleseed incorrectly asserts that there is a “conventional” way to report FEP premiums. By way of example, Kaiser allocates all of its FEP premiums to the District in its Schedule T, while Aetna allocates its FEP premiums across several states. Therefore, GHMSI’s reported allocation of premium will be accepted for present purposes, just as DISB has accepted GHMSI’s reporting for other regulatory purposes.
Table 2. Summary of Schedule T Reported Premiums

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Accident &amp; Health Premiums</th>
<th>FEP Premiums</th>
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</thead>
<tbody>
<tr>
<td>DC – GHMSI</td>
<td>$473,305,211</td>
<td>$331,882,869</td>
</tr>
<tr>
<td>DC - BlueChoice</td>
<td>$231,586,264</td>
<td>$0</td>
</tr>
<tr>
<td>MD – GHMSI</td>
<td>$710,702,600</td>
<td>$733,798,465</td>
</tr>
<tr>
<td>MD - BlueChoice</td>
<td>$1,406,340,822</td>
<td>$174,470,124</td>
</tr>
<tr>
<td>VA – GHMSI</td>
<td>$516,253,778</td>
<td>$664,686,724</td>
</tr>
<tr>
<td>VA - BlueChoice</td>
<td>$233,708,673</td>
<td>$0</td>
</tr>
</tbody>
</table>

See 2011 Annual Statement, Schedule T (as amended); Health Annual Statement for the year ended December 31, 2011 of the condition and affairs of CareFirst BlueChoice, Inc., Schedule T (as amended).

Thus, the combined reported premiums for GHMSI (100%) and BlueChoice (50%, as per note 29) are as follows:

Table 3. Combined 100% GHMSI + 50% Blue Choice Schedule T Reported Premiums

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Accident &amp; Health Premiums ($)</th>
<th>Accident &amp; Health Premiums (%)</th>
<th>FEP Premiums ($)</th>
<th>FEP Premiums (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DC</td>
<td>$589,098,343</td>
<td>22%</td>
<td>$331,882,869</td>
<td>18%</td>
</tr>
<tr>
<td>MD</td>
<td>$1,413,873,011</td>
<td>54%</td>
<td>$821,033,527</td>
<td>45%</td>
</tr>
<tr>
<td>VA</td>
<td>$633,108,115</td>
<td>24%</td>
<td>$664,686,724</td>
<td>37%</td>
</tr>
<tr>
<td>Total</td>
<td>$2,636,079,469</td>
<td>100%</td>
<td>$1,817,603,120</td>
<td>100%</td>
</tr>
</tbody>
</table>

Rather than simply add all Accident & Health Premiums to the FEP Premiums and use the resulting percentage allocation, the Commissioner took a more nuanced approach. As a general rule, FEP business is less risky, and therefore less profitable and less likely to contribute to surplus. See NAIC RBC Instructions, supra, at 19 (recognizing “the reduced risk associated with safeguards built into the federal employees health benefit program . . . .”). The NAIC’s underwriting risk factor for FEP business therefore is substantially lower (0.02) than the underwriting risk factor for the top tier of non-FEP business (0.09), reflecting relative weights of 18%:82% for the two lines of business. See id. at 17, 19. Similarly, the surplus allocation for
FEP business should be substantially lower than that for non-FEP business. The Commissioner therefore applied a weighted ratio of 18% to 82% for the FEP and non-FEP premiums, using the NAIC RBC Instructions as a guideline. Using these weighted averages, the premiums allocable to the District are 21%, as shown on Table 4.\(^{32}\)

**Table 4. Weighted Premium Percentages**

<table>
<thead>
<tr>
<th></th>
<th>% from Table 3</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>District Share of Combined Total Accident &amp; Health Premiums</td>
<td>22%</td>
<td>82%</td>
</tr>
<tr>
<td>District Share of Combined Total FEP Premiums</td>
<td>18%</td>
<td>18%</td>
</tr>
<tr>
<td><strong>Weighted Average for District Share of All Premiums</strong></td>
<td><strong>21%</strong></td>
<td></td>
</tr>
</tbody>
</table>

The applicable regulations also require consideration of the number of policies by jurisdiction. *See* 26A DCMR 4699.2. GHMSI reports that the policies by jurisdiction of policyholder are as follows:

**Table 5. Summary of Policies by Jurisdiction of Policyholder**

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>GHMSI and BlueChoice Policies</th>
</tr>
</thead>
<tbody>
<tr>
<td>DC</td>
<td>54,484 (19%)</td>
</tr>
<tr>
<td>MD</td>
<td>130,207 (45%)</td>
</tr>
<tr>
<td>VA</td>
<td>86,209 (31%)</td>
</tr>
<tr>
<td>Other</td>
<td>17,081 (6%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>287,981 (100%)</strong></td>
</tr>
</tbody>
</table>

*See* GHMSI 1(d) Resp., Table 1.

The Commissioner concludes that the number of policies by jurisdiction should be given less weight than premiums in determining how much of GHMSI’s surplus is attributable to the District. First, as explained above, the amount of surplus accumulated by GHMSI is largely a

\(^{32}\) Even if the Commissioner had simply added the premiums together without any premium weighting, he would have reached the same 21% allocation: the combined Accident & Health and FEP premiums for the District total $920,981,212, which is 21% of the combined totals of $4,453,682,589 for the District, Maryland, and Virginia.
function of the premiums it earns. Policy counts bear only a tenuous relationship to premiums, and therefore to surplus, because the amount of premiums generated by a policy varies greatly. Second, the Commissioner finds that the “Policies by Jurisdiction of Policyholder” data provided by GHMSI is problematic for allocation purposes. Most importantly, GHMSI’s table lumps together individual policyholders, group plans, self-insured plans, and FEP plan certificate holders. See GHMSI 1(d) Resp., Table 1 n.1. In terms of surplus contribution and allocation, the Commissioner does not believe that a single, individual policyholder necessarily should be accorded the same weight as a group plan policyholder with thousands of members. Also, self-insured plans contribute less to surplus than do individual and group plans. The Commissioner therefore concludes that the policyholder data from GHMSI should be given significantly less weight in the allocation calculation.

Finally, the regulations require consideration of the number of providers by jurisdiction. See 26A DCMR 4699.2. GHMSI reports the following numbers of providers by jurisdiction:

Table 6. Summary of Network Providers by Jurisdiction

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>GHMSI and BlueChoice Policies</th>
</tr>
</thead>
<tbody>
<tr>
<td>DC</td>
<td>8,856 (15%)</td>
</tr>
<tr>
<td>MD</td>
<td>39,240 (66%)</td>
</tr>
<tr>
<td>VA</td>
<td>11,436 (19%)</td>
</tr>
<tr>
<td>Total</td>
<td>59,531 (100%)</td>
</tr>
</tbody>
</table>

See GHMSI 1(d) Resp., Table 3.

The Commissioner finds that inclusion of the network provider data in the allocation calculus is also problematic. First, the Commissioner sees no relationship between the location of providers and accumulation of surplus. In addition, it is unclear to what extent GHMSI’s response may double-count doctors by including doctors who participate in both GHMSI’s RPN
Network, and BlueChoice’s HMO Network. The Commissioner therefore concludes that the network provider data should be given less weight in the allocation.

In making the determination of the surplus attributable to the District, the Commissioner has evaluated the three factors above – premiums, number of policies, and providers – weighing the first factor the most heavily. As discussed above, the Commissioner accords the most weight to policy situs, and uses the premium amounts as the best measure for situs. As detailed above, the Commissioner finds GHMSI’s data on the number of policies by jurisdiction to be problematic. Even more problematic is the use of network provider distribution by jurisdiction, particularly since providers have little if any effect on surplus generation. In his discretion, the Commissioner therefore has determined that a reasonable weighting of these three factors is as follows:

<table>
<thead>
<tr>
<th>Factor</th>
<th>% Allocated to District</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reported Premiums (Table 4)</td>
<td>21%</td>
<td>90%</td>
</tr>
<tr>
<td>Policies by Policyholder Jurisdiction (Table 5)</td>
<td>19%</td>
<td>5%</td>
</tr>
<tr>
<td>Providers (Table 6)</td>
<td>15%</td>
<td>5%</td>
</tr>
</tbody>
</table>

Under this weighted average, 21% of GHMSI’s surplus is attributable to the District.

E. **GHMSI’s Community Health Reinvestment**

The Act defines “community health reinvestment” as “expenditures that promote and safeguard the public health or that benefit current or future subscribers, including premium rate reductions.” D.C. Official Code § 31-3501(1A) (2012 Repl.). For GHMSI’s guidance, the Commissioner provides the following analysis of what types of expenditures he deems to constitute community health reinvestment. The guidance addresses the five main categories into which GHMSI divided its past expenditures: (1) corporate giving, (2) open enrollment subsidies,
(3) D.C. Healthcare Alliance Program funding, (4) premium rate reductions, and (5) premium taxes. Rector Report at 35.

1. **Corporate Giving**

GHMSI categorizes its corporate giving to include: (1) catalytic giving, which is defined as support for programs and initiatives that stimulate improvements in health care systems over the long term (*e.g.*, Mary’s Center Patient Centered Medical Chronic Care Initiative), (2) targeted health-related giving through others, which is defined as support to organizations that provide direct care or related services for underserved populations (*e.g.*, Community of Hope South Capital Health and Resource Center), (3) programmatic initiatives, meaning support for programs targeting a specific population or addressing a major health care issue with specific measures for success (*e.g.*, the District of Columbia Department of Health Maternal and Child Case Management Program), and (4) corporate memberships and community sponsorships/memberships with business and civic organizations (*e.g.*, sponsorship of events hosted by the Boys and Girls Clubs of Greater Washington D.C.). Rector Report at 35.

The Commissioner concludes that expenditures in the first three categories of corporate giving clearly qualify as community health reinvestment because they promote and safeguard the public health. Whether expenditures in the last category—corporate memberships and community sponsorships—qualify as community health reinvestment is a closer question, but the Commissioner ultimately concludes that they also qualify. On the one hand, these types of expenditures have a marketing component because they enhance GHMSI’s image in the community by providing it with public recognition and goodwill. On the other hand, these expenditures – particularly corporate sponsorships – support the District’s business community and organizations that provide health care resources to the District, which indirectly promotes
and safeguards public health and benefits current and future subscribers of GHMSI residing in the District. *Id.* at 35-36.\(^3\)

2. **Open Enrollment Subsidies**

Under D.C. Official Code § 31-3541 (2012 Repl.), GHMSI is required to provide an open enrollment program for District residents to ensure access to health coverage. Although open enrollment subsidies clearly qualified as community health reinvestment, they will not be part of any future GHMSI spending. The open enrollment program was discontinued in 2014 with the advent of market-wide open enrollment through the District’s Health Benefit Exchange.

3. **Public-Private Partnerships**

The Commissioner concludes that expenditures supporting public-private partnerships are community health reinvestment. The Act specifically requires GHMSI’s participation in a public-private partnership program, including a $5 million annual payment to the Healthy DC Fund (or successor fund) to expand health insurance coverage for low-income District residents, for at least five years beginning in 2009. *See D.C. Official Code § 31-3501(7A)(A) (2012 Repl.); see also* Rector Report at 36. The statute permits extension of the program past the 5-year period, i.e., past 2009, upon the mutual written agreement of the District Council and GHMSI. *D.C Official Code § 31-3501(7A)(A)(iii) (2012 Repl.).*

4. **Premium Rate Reductions**

The statutory definition of community health reinvestment expressly includes premium rate reductions, D.C. Official Code § 31-3501(1A) (2012 Repl.), and there is no doubt that premium rate reductions benefit subscribers. Moreover, any rate reduction, whether it is an

\(^3\) Corporate memberships in business and civic organizations comprise a very small part of total expenditures in the category of corporate memberships and sponsorships. For example, in 2011 corporate memberships accounted for $81,650 in expenditures. GHMSI Response to Third Scheduling Order, Attachment E.
outright reduction in rates or a decision to moderate or forego a rate increase, obviously has a direct effect on GHMSI’s surplus.

Nevertheless, the Commissioner sees no practical way to quantify past rate reductions or their benefit to subscribers, especially in cases where GHMSI asserts that a rate reduction consists of establishing a rate that is lower than the company’s estimate of health care cost trend. In addition, the Commissioner sees no practical way to distinguish between a rate reduction made for competitive purposes versus one made to benefit subscribers. Reductions for competitive purposes arguably do not benefit subscribers to the extent that subscribers may obtain similar rates elsewhere in the market. Thus, although rate reductions may benefit subscribers, the Commissioner makes no attempt to quantify them and therefore does not endorse GHMSI’s self-identified $27 million in premium rate reductions in the District market between 2010 and 2012. Rector Report at 35.

This is not to say, however, that the Commissioner takes no account of rate reductions in this review. The rates GHMSI chooses to charge obviously have a direct effect on its surplus. Thus, the Commissioner indirectly takes into account GHMSI’s decisions concerning rates in reviewing the company’s surplus to determine whether it is excessive.

5. **Premium Taxes**

GHMSI provided information about premium taxes paid to the District in response to a request from Rector for information about community health reinvestment expenditures. GHMSI Resp. Third Sched. Order at 23. Although GHMSI’s liability for premium taxes was considered in developing the *pro forma* projections used to model its surplus needs, the Commissioner does not consider premium taxes to constitute community health reinvestment.
a post-hearing filing, GHMSI agreed that premium taxes do not constitute community health
reinvestment. *Id.*

6. **2011 Community Health Reinvestment Expenditures**

The Commissioner concludes that GHMSI’s quantifiable community health reinvestment
expenditures for 2011 were as follows:

<table>
<thead>
<tr>
<th>Table 8. GHMSI’s Quantifiable Community Health Reinvestment in 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corporate giving</td>
</tr>
<tr>
<td>Open enrollment subsidies</td>
</tr>
<tr>
<td>D.C. Healthcare Alliance funding</td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
</tbody>
</table>

F. **Coordination with Other Jurisdictions**

The Act requires that the review of GHMSI’s surplus be “undertaken in coordination
with the other jurisdictions in which the corporation conducts business”—namely, Maryland and
Virginia. D.C. Official Code § 31-3506(e) (2012 Repl.). In addition, the Act provides that “the
Commissioner shall consider the interests and needs of the jurisdictions in the corporation’s
service area.” *Id.* at § 31-3506.01(b).

Throughout this proceeding, the Commissioner has taken reasonable steps to coordinate
with GHMSI’s regulators in Maryland and Virginia and take into account the interests and needs
of those jurisdictions. In addition to publishing hearing notices in the D.C. Register and posting
notices on DISB’s website, Department staff emailed notice of and invitations directly to the
Maryland and Virginia Insurance Commissioners. The Maryland and Virginia Commissioners
deprecated to testify, but, as noted above, the Maryland Commissioner submitted a pre-hearing
written statement. In response to the Commissioner’s post-hearing invitation to comment on the
question of allocating GHMSI’s surplus, both the Maryland Insurance Commissioner and the
Virginia State Corporation Commission’s Bureau of Insurance (the “Virginia Bureau”) submitted written statements.

The Maryland Insurance Commissioner’s pre-hearing statement underscored that “Maryland and the District of Columbia share a common interest in ensuring that GHMSI’s surplus is neither excessive nor inadequate for the protection of its policyholders.” Maryland Pre-Hearing Statement at 1. The statement described Maryland’s interest in GHMSI and its own surplus review process; discussed the Act and its application to GHMSI; and asserted that, in the event DISB determined GHMSI’s surplus attributable to the District is excessive, “[i]t is [the Maryland Insurance Administration’s] . . . position that distribution of any excess surplus to GHMSI policyholders, including, for example, in the form of a premium subsidy or other rate relief, is the only ‘fair and equitable manner’ of distribution.” Id. at 4. The Commissioner will take Maryland’s position into consideration in evaluating GHMSI’s plan for dedicating its excess surplus attributable to the District to community health reinvestment.

The Maryland Insurance Commissioner also submitted a post-hearing statement specifically addressing surplus allocation. See Maryland Post-Hearing Statement; see also Section IV.D., above. As noted above, the Maryland Insurance Commissioner argued that the concept of attributing GHMSI’s surplus by geography was “fundamentally flawed.” Maryland Post-Hearing Statement at 2. She also emphasized that “a substantial portion of GHMSI’s admitted assets are illiquid and not readily available for payment of claims or other obligations.” Id. at 2. The Commissioner concluded that “the Maryland Insurance Administration stands ready to work together with the District of Columbia Department of Insurance, Securities and Banking and the Virginia State Corporation Commission’s Bureau of Insurance in the best
interests of GHMSI and its members and policyholders in all of our respective jurisdictions.” *Id.* at 3.

The Virginia Bureau also addressed the question of surplus allocation. Its post-hearing statement explained that, under Virginia law, “if DISB requires [GHMSI] . . . to provide a program or benefit for the residents of the District of Columbia or Maryland, the [Virginia Bureau] . . . may be directed to conduct an examination of [GHMSI] . . . focusing on the impact on surplus, premium rates for residents of Virginia, and solvency. Statement of the Virginia State Corporation Commission’s Bureau of Insurance, 1 (Sept. 29, 2014) (“Virginia Post-Hearing Statement”). If the Virginia Bureau’s examination concluded that the impact on GHMSI was harmful to Virginia residents, it would issue an order to protect Virginia residents. *Id.* at 2. The Virginia Bureau concluded by observing that, under Virginia law, “the determination of premiums charged to Virginia residents and the determination of surplus attributable to Virginia residents must be based on the number of residents in Virginia compared with the number of residents in other states covered by” GHMSI. *Id.*

The Commissioner carefully reviewed and considered all of the materials submitted by the Maryland and Virginia Commissioners and has taken their submissions into account in reaching his conclusions in this review. In making his determination, he has sought to balance the interests and needs of Maryland and Virginia, as articulated by the regulators in those states, with the interests and needs of the District and the requirements of the Act. In this regard, he notes that although each jurisdiction has its own interests and needs, the District, Maryland, and Virginia share the common goal of ensuring that GHMSI remains financially sound and efficient so that it may continue to fulfill its statutory obligations and commitments to its subscribers.
After careful review and analysis, the Commissioner believes that his decision is consistent with this common goal.

The Commissioner acknowledges that his conclusion that a surplus above 721% RBC-ACL is excessive conflicts with the Maryland Commissioner’s conclusion that GHMSI should maintain a surplus in the range of 1,000-1,300% RBC-ACL. See Maryland Consent Order (Sept. 14, 2012). The Commissioner will directly inform the Maryland and Virginia Commissioners of this decision.

G. Requirements for GHMSI Plan

Given the determination that GHMSI’s surplus attributable to the District is excessive, the next step is for GHMSI to “submit a plan for dedication of the excess to community health reinvestment in a fair and equitable manner.” D.C. Official Code § 31-3506(g)(1) (2012 Repl.). The plan “may consist entirely of expenditures for the benefit of current subscribers of the corporation.” Id. at § 31-3506(g)(2). The Commissioner shall approve the plan if it is fair and equitable. 26A DCMR § 4603.2.
V. ORDER

GHMSI's surplus attributable to the District as of December 31, 2011 was "excessive" as defined by the Act. Specifically, GHMSI's surplus as of December 31, 2011 was 998% RBC-ACL, whereas the appropriate level was 721% RBC-ACL. The percentage of GHMSI's 2011 surplus attributable to the District was 21%.

It is therefore ORDERED that, within forty-five (45) calendar days, GHMSI shall submit to the Commissioner a plan for dedication of the excess surplus attributable to the District to community health reinvestment in a fair and equitable manner, in accordance with D.C. Official Code § 31-3506(g) and 26A DCMR § 4603.

Dated: December 30, 2014

Chester A. McPherson, Acting Commissioner

SEAL
Exhibit 1 – Hearing Record Index for
GHMSI 2011 Surplus Review

“the surplus-related material posted on DISB’s website will be the official record for this proceeding.”

Transcript, District of Columbia Department of Insurance, Securities and Banking – Group Hospitalization and Medical Services, Inc. Surplus Review Hearing at 11 (June 25, 2014).

The GHMSI surplus-related materials that constitute the hearing record on DISB’s website, www.disb.dc.gov, are listed on 7 separate webpages: 3 “main” webpages (Review of CareFirst’s 2011 Surplus, Review of CareFirst’s 2008 Surplus, and CareFirst Surplus Report Filings) and four “subsidiary” webpages (GHMSI Financial Statements, MIA Hearing Information, CareFirst Hearing – GHMSI Documents, and GHMSI Rates Filings), as shown:


CareFirst Hearing – GHMSI Documents, http://disb.dc.gov/node/333022

GHMSI Rate Filings, http://disb.dc.gov/publications-list?after[value][date]=&before[value][date]=&keys=GHMSIRF&type=79&sort_by=field_date_value&sort_order=DESC

GHMSI Financial Statements [see “Review of CareFirst’s 2011 Surplus” for link]

CareFirst Surplus Report Filings, http://disb.dc.gov/node/315992

In reaching his Decision, the Commissioner considered the record in its entirety.

For ease of reference, the following lists documents cited in the Decision and Order and lists specific webpage “nodes” where they may be located:

<table>
<thead>
<tr>
<th>Short Reference</th>
<th>Full Description</th>
<th>Website Location</th>
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<tr>
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</tr>
<tr>
<td></td>
<td></td>
<td>Also: <a href="http://www.naic.org">www.naic.org</a></td>
</tr>
<tr>
<td>ACA Reform Memo</td>
<td>Jim Toole, FTI Consulting, Memorandum re: ACA Reform and Surplus Requirements (Sept. 12, 2013)</td>
<td>Review of CareFirst’s 2011 Surplus <a href="http://disb.dc.gov/node/817782">http://disb.dc.gov/node/817782</a></td>
</tr>
<tr>
<td>Appleseed Pre-Hearing</td>
<td>D.C. Appleseed Report to the D.C. Department of Insurance, Securities and Banking: Surplus Review of Group Hospitalization and Medical Services, Inc. (“GHMSI”) (June 10, 2014)</td>
<td>Review of CareFirst’s 2011 Surplus <a href="http://disb.dc.gov/node/844192">http://disb.dc.gov/node/844192</a></td>
</tr>
<tr>
<td>Brief</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brief</td>
<td>Jim Toole, FTI Consulting, Memorandum re: GHMSI Benchmark Surplus Range Reconciliation (March 6, 2014)</td>
<td>Review of CareFirst’s 2011 Surplus <a href="http://disb.dc.gov/node/797112">http://disb.dc.gov/node/797112</a></td>
</tr>
</tbody>
</table>
### Exhibit 1 – Hearing Record Index for GHMSI 2011 Surplus Review

<table>
<thead>
<tr>
<th>Short Reference</th>
<th>Full Description</th>
<th>Website Location</th>
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<tbody>
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</tr>
<tr>
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<td>Full Description</td>
<td>Website Location</td>
</tr>
<tr>
<td>------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Shaw Pre-Hearing Report</td>
<td>Mark E. Shaw, United Health Actuarial Services, Inc., Report to the D.C. Department of Insurance, Securities and Banking Group Hospitalization and Medical Services, Inc. MIEAA Surplus Review (June 10, 2014)</td>
<td>Review of CareFirst’s 2011 Surplus <a href="http://disb.dc.gov/node/844192">http://disb.dc.gov/node/844192</a></td>
</tr>
<tr>
<td>Tr.</td>
<td>Transcript, Group Hospitalization and Medical Services, Inc. Surplus Review Hearing (June 25, 2014)</td>
<td>Review of CareFirst’s 2011 Surplus <a href="http://disb.dc.gov/node/858472">http://disb.dc.gov/node/858472</a></td>
</tr>
<tr>
<td></td>
<td>Health Annual Statement for the year ended December 31, 2011 of the condition and affairs of CareFirst BlueChoice, Inc.</td>
<td>Available at <a href="http://www.naic.org">www.naic.org</a></td>
</tr>
</tbody>
</table>
### Exhibit 1 – Hearing Record Index for GHMSI 2011 Surplus Review

<table>
<thead>
<tr>
<th>Short Reference</th>
<th>Full Description</th>
<th>Website Location</th>
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Exhibit C
GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF INSURANCE, SECURITIES AND BANKING

IN THE MATTER OF

Surplus Review and Determination
for Group Hospitalization and Medical Services, Inc.

Order No.: 14-MIE-20

ORDER

During consideration of the Petition for Reconsideration and Motion to Stay Further Proceedings by Group Hospitalization and Medical Services, Inc. ("GHMSI"), the Commissioner believes that the public interest will be served by issuing a sixty (60) day stay of GHMSI's obligation to pay rebates to Eligible Subscribers, as provided in Order No. 14-MIE-19. The stay shall run from the conclusion of the 120 day compliance period provided in Order No. 14-MIE-19 until February 27, 2017. The stay shall not apply to the denial of requests for premium rate increases for subscriber contracts issued by GHMSI in the District, as required by Order No. 14-MIE-18.

SO ORDERED this 8th day of December, 2016.

[Signature]
Stephen C. Taylor
Commissioner
Department of Insurance, Securities and Banking

SEAL
Exhibit D
GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF INSURANCE, SECURITIES AND BANKING

IN THE MATTER OF

Surplus Review and Determination for Group Hospitalization and Medical Services, Inc.

Order No.: 14-MIE-21

ORDER

During consideration of the Petition for Reconsideration and Motion to Stay Further Proceedings by Group Hospitalization and Medical Services, Inc. ("GHMSI"), the Commissioner believes that the public interest will be served by issuing an additional sixty (60) day stay of GHMSI’s obligation to pay rebates to Eligible Subscribers, as provided in Order No. 14-MIE-19. The stay shall run from the conclusion of the sixty (60) day stay provided in Order No. 14-MIE-20 until April 28, 2017. The stay shall not apply to the denial of requests for premium rate increases for subscriber contracts issued by GHMSI in the District, as mandated by Order No. 14-MIE-18.

SO ORDERED this 14th day of February, 2017.

[Signature]
Stephen C. Taylor
Commissioner
Department of Insurance, Securities and Banking

SEAL
Exhibit E
COMMONWEALTH OF VIRGINIA

STATE CORPORATION COMMISSION

AT RICHMOND, OCTOBER 7, 2016

COMMONWEALTH OF VIRGINIA, ex rel.

STATE CORPORATION COMMISSION

CASE NO. INS-2015-00007

Ex Parte: In the matter of an examination of
Group Hospitalization and Medical Services, Inc.

ORDER

On June 10, 2015, we entered an Order ("2015 Order") in this matter prohibiting Group Hospitalization and Medical Services, Inc. ("GHMSI"), from "act[ing] to distribute or reduce its surplus unless approved as provided under Virginia law." The 2015 Order – and this ex parte proceeding – followed an order entered by District of Columbia Department of Insurance, Securities and Banking ("DISB") in late 2014 that required GHMSI to submit a plan for dedication of its excess surplus for community health reinvestment in the District of Columbia ("District").

Conducting this proceeding pursuant to § 38.2-4229.2 of the Code of Virginia ("Code"), we sought to determine the impact of DISB's proposed distribution of GHMSI's surplus on Virginia residents and GHMSI's solvency. As set forth in the 2015 Order, the State Corporation Commission's ("Commission") Bureau of Insurance ("Bureau") concluded that DISB's proposed distribution of GHMSI's surplus "creates the potential for future harm to Virginia residents."

Considering the comments and recommendations of GHMSI and the Bureau, however, we ordered that this proceeding remain pending since DISB had not yet issued an order regarding distribution. We further ordered GHMSI not to distribute or reduce its surplus unless approved as provided under Virginia law.
On September 2, 2016, GHMSI filed a Notice of District of Columbia Distribution Order and Request for Direction ("Notice"). As part of the Notice, GHMSI informed the Commission that DISB entered an order on August 30, 2016 ("DISB Order") regarding distribution of its surplus. Specifically, the DISB Order requires GHMSI to pay rebates in an amount totaling $51.3 million to: (i) current subscribers covered by GHMSI under medical, dental vision, Medicare supplement, or other policies issued in the District; and (ii) federal employee subscribers who reside in the District and are covered by GHMSI. The DISB Order further requires GHMSI to pay such rebates within 12 months and provides that any premium rate increases for GHMSI policies will be denied until such rebates are paid.

The Notice includes a copy of the DISB Order and GHMSI’s request for direction from the Commission. The Notice, however, does not request authorization under Virginia law to distribute GHMSI’s surplus as ordered by DISB. Nor does the Notice provide any information that is relevant to such application or approval under § 38.2-4229.2 of the Code.

On September 28, 2016, the Bureau filed Supplemental Comments stating that the distribution of GHMSI’s surplus under the DISB Order creates the potential for harm to Virginia residents.1 The Bureau also restates its concerns that distribution could leave GHMSI undercapitalized.2 The Bureau further points out the inequity and potential subsidization that results from surplus being apportioned by jurisdiction for the express purpose of providing a benefit to the residents of that particular jurisdiction.3 Finally, the Bureau disagrees with the

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1 Supplemental Comments, Case No. INS-2015-00007 at 1.
2 Id.
3 Id. at 1-2.
DISB Order's assertion that statutorily required coordination has occurred between the District and Virginia regarding the apportionment of "excess surplus" attributable to GHMSI.\(^4\)

NOW THE COMMISSION, upon consideration of this matter, orders as follows. Consistent with the 2015 Order as well as § 38.2-4229.2 of the Code, the Commission orders GHMSI not to distribute its surplus in any amount, either as directed by the DISB Order or for any other reason, without express prior approval from this Commission. Such approval has neither been sought nor granted. The Commission notes that this directive is an ongoing obligation of GHMSI, the violation of which is prohibited under Virginia law.

ACCORDINGLY, this matter is hereby DISMISSED, and the papers passed to the file for ended causes.

AN ATTESTED COPY hereof shall be sent by the Clerk of the Commission to:
Adam H. Levi, Esquire, Assistant General Counsel, Office of the General Counsel, Department of Insurance, Securities and Banking, 810 First Street, NE, Suite 701, Washington, D.C. 20002;
J. Van Lear Dorsey, Esquire, Principal Counsel, Maryland Insurance Administration, 200 St. Paul Place, Suite 2700, Baltimore, Maryland 21202; Randolph S. Sergent, Esquire, Vice President and Deputy General Counsel, Group Hospitalization and Medical Services, Inc., 1501 S. Clinton Street, CT10-06, Baltimore, Maryland 21224; Walter Smith, Executive Director, D.C. Appleseed Center, 1111 Fourteenth Street, NW, Suite 510, Washington, D.C. 20005;
Karen Cameron, FACHE, Virginia Consumer Voices for Healthcare, 1716 East Franklin Street, Richmond, Virginia 23222; Kiva Bland Pierce, Assistant Attorney General, Division of Consumer Service, Office of the Attorney General, 202 North Ninth Street, Richmond, Virginia 23219; Heidi W. Abbott, Esquire, Hunton & Williams, LLP, Riverfront Plaza, East Tower, 951

\(^4\) /d. at 2.
East Byrd Street, Richmond, Virginia 23219; and a copy shall be delivered to Jacqueline C. Cunningham, Commissioner of Insurance, and Douglas C. Stolte, Deputy Commissioner, in the Commission's Bureau of Insurance, and John O. Cox, Associate General Counsel, in the Commission's Office of General Counsel.
Exhibit F
January 22, 2015

The Hon. Alfred W. Redmer, Jr., Commissioner
Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, MD 21202

Re: Request for Action—Group Hospitalization and Medical Services, Inc.
Surplus Level

Dear Commissioner Redmer:

I am writing to request action by the Maryland Insurance Administration (MIA) related to a December 30, 2014 Decision and Order (District Order or Order) issued by the District of Columbia Insurance Commissioner (District Commissioner) regarding the 2011 surplus of Group Hospitalization and Medical Services, Inc. (GHMSI). GHMSI is a non-profit health services plan that operates in Maryland, the District of Columbia (District) and Virginia.

The Order determines, among other things, that GHMSI’s 2011 surplus of 99.8% RBC-ACL was excessive; that the appropriate level of GHMSI’s surplus should be 72.1%; that 21% of GHMSI’s surplus is attributable to the District; and that GHMSI must submit a plan by mid-February to dedicate to the District the portion of its excess 2011 surplus attributable to the District. The District Commissioner determined this amount to be $56 million.

The action requested is that you, in conjunction with the District and Virginia Insurance Commissioners, conduct a consolidated proceeding and collaborate on a review of GHMSI’s surplus level to determine whether it is excessive and the impact the Order has on GHMSI and its policyholders in Maryland and Virginia. In the interim, we request that you issue an order instructing GHMSI not to distribute or reduce its surplus pursuant to the Order until you have the opportunity to conduct and conclude your own review.1 A similar request has been made to the Virginia Commissioner.2 In the event there is objection to a consolidated proceeding among the three jurisdictions, GHMSI seeks a meeting with you.

Today, GHMSI filed a Motion seeking reconsideration of the District Order with the District Commissioner. A copy of GHMSI’s Motion seeking reconsideration is enclosed. It asserts that the District Commissioner should reconsider his Order because he did not:

1 The MIA recently commenced a review of current surplus and we are working directly with the MIA on such review.
2 Yesterday, the Virginia State Corporation Commission ordered the initiation of a proceeding to examine the impact of the Order on GHMSI’s surplus, premium rates for Virginia residents who are policyholders issued or delivered in Virginia and solvency. A report is due on or before February 27, 2015.
1. Coordinate with Maryland and Virginia as required by District law\(^3\) which leaves GHMSI with irreconcilable conflicts between the jurisdictions regarding the level of appropriate surplus GHMSI should hold;

2. Complete the analysis as prescribed by MIEAA – which requires a determination of whether "the portion of the surplus attributable to the District is excessive. The District Commissioner determined that GHMSI’s overall surplus was excessive and did not do the analysis required in the law;

3. Properly calculate the accumulation of surplus over time. The District Commissioner examined only one year of premium revenue;

4. Establish a basis for the use of a 95% confidence level – one of the most important factors in determining the appropriate level of surplus; and

5. Establish a target range – instead of a single point that cannot be safely operationalized, since it would require GHMSI to maintain surplus below this point placing GHMSI in an unsound financial position.

In a 2012 consent order, Commissioner Goldsmith determined that GHMSI should maintain a surplus in the range of 1,000-1,300% RBC-ACL. See Order No. MIA-2012-09-006. The District Commissioner’s Order directly conflicts with this pre-existing and still effective Maryland order.

These conflicting orders place GHMSI in an untenable position. GHMSI cannot possibly comply with both the District’s Order to reduce its surplus to 721% and the Maryland consent order to seek surplus at the higher level. To comply with the District’s Order puts GHMSI in violation of Commissioner Goldsmith’s order. The District Commissioner acknowledged this conflict, see Decision and Order at 65, without providing any guidance on fundamental questions including how the conflict should be resolved, which of the two orders should control, and why one order should prevail over the other given, for example, GHMSI’s operations in both jurisdictions and the indivisibility of surplus.

The District’s determination that GHMSI’s surplus is excessive and that a portion of the determined excess is attributable exclusively to a single jurisdiction as a decision with broad ramifications and affects directly – and potentially adversely – all three jurisdictions in which GHMSI operates. GHMSI has only one surplus, and the District’s Order will have extra-territorial effect on Maryland and Virginia subscribers.

We welcome the opportunity to provide other background information that would prove helpful.

Thank you for your consideration.

Sincerely,

[Signature]

Chet Burrell
President & CEO

Cc: The Hon. Jacqueline K. Cunningham
Virginia Commissioner of Insurance

The Hon. Chester McPherson
Acting Commissioner of Insurance
District of Columbia

\(^3\) The District’s Medical Insurance Empowerment Amendment Act (MIEAA) requires that the District Commissioner’s review must “be undertaken in coordination with the other jurisdictions in which the corporation conducts business.” DC Code §31-3506(e).
Exhibit G
February 10, 2015

Mr. Chet Burrell
President and Chief Executive Officer
CareFirst BlueCross BlueShield
1501 S. Clinton Street, Suite 700
Baltimore, MD 21224-5744

Re: Initiation of Examination of Group Hospitalization and Medical Services, Inc.

Dear Mr. Burrell:

Group Hospitalization and Medical Services, Inc. ("GHMSI") holds a certificate of authority to operate as a nonprofit health service plan in Maryland and is a congressionally chartered entity domiciled in the District of Columbia. GHMSI and CareFirst of Maryland Inc. ("CFMI"), also a nonprofit health service plan in Maryland, are under the common control of CareFirst, Inc. CareFirst, Inc. is chartered and domiciled in Maryland and also holds a certificate of authority to operate as a nonprofit health service plan in Maryland.

As nonprofit health service plans, CareFirst, Inc., CFMI, and GHMSI are all charged with carrying out a three-part statutory mission: (1) to provide affordable and accessible health insurance to the respective plan’s insureds and those persons insured or issued health benefit plans by affiliates or subsidiaries of the plan; (2) to assist and support public and private health care initiatives for individuals without health insurance; and (3) to promote the integration of a health care system that meets the health care needs of all of the residents of the jurisdictions in which the nonprofit health service plan operates. Ins. Art. § 14-102 (c), (d).

To qualify for a certificate of authority, an insurer, including a nonprofit health service plan, must maintain assets and surplus that are “reasonable in relation to the insurer’s outstanding liabilities and adequate to its financial needs” Ins. Art. § 4-103(c)(1). Numerous factors are considered to determine whether an insurer’s assets and surplus are reasonable in relation to the insurer’s outstanding liabilities and adequate to its financial needs. See Ins. Art. § 4-103(c)(2). Further, an insurer, including a nonprofit health service plan, should maintain an
amount of capital in excess of certain minimum risk based capital ("RBC") levels as set forth in Title 4, Subtitle 3 of the Insurance Article.

Section 14-117 defines when the Commissioner may consider the surplus (the amount by which certain defined assets exceed liabilities described in § 5-103) of a nonprofit health service plan to be excessive and the procedure by which excessive surplus may be distributed. Notably, if the Commissioner determines that the surplus is excessive, the Commissioner may order the corporation to prepare a plan for distribution of the excess surplus "only to subscribers who are covered by the corporation’s nonprofit health service plan at the time the distribution is made." Ins. Art. § 14-117(e)(3).

The Insurance Commissioner engaged in a comprehensive review of the surplus ranges of GHMSI and CFMI in 2009, 2011 and then again in 2012. In 2012, then Commissioner Therese M. Goldsmith initiated a review of the companies’ board-approved targeted surplus ranges. To assist with this review the Maryland Insurance Administration ("MIA") engaged a professional services firm to perform an independent analysis of the appropriateness of the board-approved targeted surplus ranges. Commissioner Goldsmith concluded in a Consent Order dated September 14, 2012 that the analysis and conclusions of three independent consultants – two retained by CFMI and GHMSI and one retained by the MIA supported a finding that the targeted surplus ranges adopted by the companies were appropriate to provide a high level of confidence that the surpluses would not fall below levels that would result in corrective regulatory action or jeopardize the use of the Blue Cross Blue Shield trademark. See Consent Order, Case No. MIA-2012-09-006 (the "Consent Order.") As the Commissioner noted in the Consent Order, according to the companies and the consultants, there are additional, potentially substantial risks associated with the implementation of the Affordable Care Act, in the short term at least. As a result, the Consent Order concluded that a targeted surplus range for GHMSI of 1,000% to 1,300% ACL-RBC was adequate and neither excessive nor unreasonably large. Consent Order at 7. Accordingly, the Commissioner approved a targeted surplus range for GHMSI of 1,000% to 1,300% of its authorized control level risk based capital and the companies agreed to "strive to maintain an actual surplus position...at the midpoint of the surplus range approved by the Commissioner, and to move surplus to the midpoint in a gradual manner." Id. at 8.

On December 30, 2014, the D.C. Department of Insurance, Securities and Banking ("DISB") found that as of December 31, 2011, GHMSI’s surplus of 998% ACL-RBC was excessive and that 21% of GHMSI’s surplus was attributable to D.C (the "DISB Order"). In so finding, DISB found that the appropriate level for GHMSI’s surplus was 721% ACL-RBC, well below the targeted surplus range in the Consent Order. The DISB ordered GHMSI to submit a
plan to the D.C Commissioner for dedication of its excess of 2011 surplus attributable to D.C. for community health reinvestment in a fair and equitable manner. The plan is due March 16, 2015.

Pursuant to § 14-124 of the Insurance Article, the Commissioner may conduct any investigation he considers necessary to enforce the provisions of the Insurance Article. As such, I have decided to initiate an investigation in accordance with Title 2, Subtitle 2 and § 14-124 of GHMSI’s surplus, including a review of whether the DISB order on GHMSI is harmful to the interests of residents of the State of Maryland covered by policies issued or delivered either in Maryland or in any other state.

While this investigation is ongoing and until the MIA makes a determination on the impact to Maryland residents of the DISB order, GHMSI is prohibited from reducing or distributing its surplus as a result of the DISB order and is prohibited from submitting a plan to the D.C. Commissioner for dedication of its excess of 2011 surplus attributable to D.C until submitted, reviewed and approved by the MIA.

Questions about the investigation should be directed to Associate Commissioner Christopher Buchanan at 410.468.2122.

Sincerely,

Al Redmer, Jr.
Insurance Commissioner

cc: Christopher Buchanan, Associate Commissioner, Examination & Auditing

**RIGHT TO REQUEST A HEARING**

Any person aggrieved by this determination has the right to request a hearing. A request for hearing must be made in writing and received by the Maryland Insurance Administration within thirty (30) days of the date of this Order. The request must be addressed to the Maryland Insurance Administration, 200 St. Paul Place, Suite 2700, Baltimore, Maryland 21202. Attention: Sharon Kraus, Hearings and Appeals Coordinator. Failure to request a hearing in a timely fashion, or to appear at a scheduled hearing, will result in a waiver of your right to contest the Commissioner’s action, and the determination will be final on the effective date. If a hearing is requested within ten (10) days of the date of the letter accompanying this determination, the effective date of the determination will be stayed until the matter is adjudicated.
Exhibit H
A PROPOSED RESOLUTION

IN THE COUNCIL OF THE DISTRICT OF COLUMBIA

To declare, on an emergency basis, the sense of the Council that the Department of Insurance, Securities, and Banking should promptly develop and order Group Hospitalization and Medical Services, Inc. to implement a plan for reinvesting $56 million in excess 2011 surplus under the Medical Insurance Empowerment Amendment Act of 2008.

RESOLVED, BY THE COUNCIL OF THE DISTRICT OF COLUMBIA, That this resolution may be cited as the “Sense of the Council Regarding the 2011 Surplus Review of Groups Hospitalization and Medical Services, Inc. Emergency Resolution of 2016”.

Sec. 2. The Council finds that:

(1) Group Hospitalization and Medical Services, Inc. (“GHMSI”), a subsidiary of CareFirst BlueCross BlueShield, is the District’s only nonprofit hospital and medical services
corporation, which was chartered by Congress in 1939 as a “charitable and benevolent
institution.”

(2) On December 16, 2008, the Council, citing “deep uncertainty surrounding
CareFirst’s degree of dedication to its charitable public health mission,” unanimously adopted
the Medical Insurance Empowerment Amendment Act of 2008, effective March 25, 2009 (D.C.
Law 17-369; 56 DCR 1346) (“MIEAA”), to provide “a framework to ensure that CareFirst meets
its public health obligation to the community.”

(3) MIEAA requires the Department of Insurance, Securities, and Banking
(“DISB”) to review GHMSI’s surplus at least every 3 years to determine if it is excessive; if so,
DISB must order GHMSI to submit a fair and equitable plan for dedicating the portion of the
excess attributable to the District to community health reinvestment.

(4) MIEAA further requires that if GHMSI fails to submit a plan as ordered,
DISB shall deny rate increases for 12 months, or issue such orders as are necessary to enforce
MIEAA, including developing a plan and ordering GHMSI to implement it.

(5) On October 29, 2010, DISB determined that GHMSI’s 2008 surplus of $687
million was not excessive under MIEAA and ordered a subsequent review by July 31, 2012.

(6) On September 13, 2012, following an expedited petition for review of the
October 29, 2010, decision, the District of Columbia Court of Appeals (“Court”) unanimously
determined that DISB had failed to apply MIEAA, as mandated by the Council, and remanded
the case for the next surplus review, to be completed no later than three years from the date of
the previous order.

(7) On December 30, 2014, DISB determined that GHMSI’s 2011 surplus was
excessive by $268 million over the target of $696 million (721% RBC) and ordered GHMSI to
submit a plan for dedicating $56 million of that excess attributable to the District to community

(8) On March 16, 2015, GHMSI submitted a plan claiming that its surplus was not
excessive and that, in any case, it had already reinvested $56 million.

(9) One week after GHMSI submitted its plan to DISB, on March 23, 2015,
Virginia enacted a law prohibiting GHMSI from reinvesting excess surplus pursuant to the
Commissioner’s order without the approval of the Virginia State Corporation Commission.

(10) One month after GHMSI submitted its statement to DISB, on April 14, 2015,
Maryland enacted a law prohibiting GHMSI from reinvesting excess surplus pursuant to the
Commissioner’s order without the approval of the Commissioner of the Maryland Insurance
Administration.

(11) On April 28, 2015, the Court denied petitions for review of the December 30,
2014, order by DISB. The Court determined that the petition was not ripe for review, because
DISB had “not yet determined whether the community health reinvestment plan submitted by
GHMSI is ‘fair and equitable’” under MIEAA.

(12) On December 18, 2015, Congress amended GHMSI’s charter to prohibit it
from reinvesting excess surplus without the agreement of the District, Maryland, and Virginia,
but expressly exempted the pending 2011 surplus review from this requirement.

(13) On March 1, 2016, GHMSI reported a 2015 surplus of $960 million (882%
RBC). This shows that a reinvestment of the $56 million ordered by the DISB would result in a
surplus of $904 million (829% RBC), which far exceeds the target surplus of 721% RBC
established by the December 30, 2014, order by DISB.
(14) To date, the Commissioner has not issued a final order in the 2011 GHMSI surplus review under MIEAA.

(15) It has been 7 years since the Council adopted MIEAA, and its intent to hold GHMSI accountable has never been effectuated, which undermines the Council’s legislative authority.

(16) It has been more than 2 years since the date the Court determined that the remanded proceeding should be completed.

(17) It has been more than a year since GHMSI filed a reinvestment plan, and DISB has not issued a final order on the merits of that plan.

(18) During the delay, Maryland, Virginia, and Congress have taken steps to limit the District’s authority as the GHMSI’s primary regulator, which undermines the District’s home rule.

(19) The delay means that $56 million in excess surplus funds has not yet been devoted to community health reinvestment as it should have been.

Sec. 3. It is the sense of the Council that DISB should promptly bring the 2011 surplus review to a conclusion by:

(1) Within 20 days of the effective date of this resolution, publishing notice of the agency’s intent in the *District of Columbia Register* to develop a community reinvestment plan for $56 million in excess GHMSI 2011 surplus consistent with MIEAA;

(2) Allowing public comment on a community reinvestment plan until 30 days after publication of notice in the *District of Columbia Register*; and

(3) Approving the plan within 45 days of the deadline for public comment and ordering GHMSI to implement that plan within 30 days.
Sec. 4. The Secretary to the Council shall transmit copies of this resolution, upon its adoption, to the Mayor and the Commissioner of the Department of Insurance, Securities, and Banking.

Sec. 5. This resolution shall take effect immediately.
MEMORANDUM

TO: Councilmember Vincent B. Orange

FROM: Ellen A. Efros, General Counsel

DATE: March 31, 2016


The measure is legally and technically sufficient for Council consideration.

The proposed resolution does not establish law or rule. It expresses the sense of the Council that the Department of Insurance, Securities and Banking should act without delay to implement a plan to use 2011 excess surplus funds of Group Hospitalization and Medical Services, Inc. for community health reinvestment, as mandated by the Hospital and Medical Services Corporation Regulatory Act of 1996.\(^1\)

I am available if you have any questions.

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Exhibit I
February 20, 2015

The Honorable Alfred W. Redmer Jr., Commissioner
Maryland Insurance Administration
200 St. Paul Place
Suite 2700
Baltimore, Maryland 21202-2272
Attention: Sharon Kraus, Hearings and Appeals Coordinator

Re: Request for Hearing and Stay

Dear Commissioner Redmer:

On February 10, 2015, you issued a letter determining that Group Hospitalization and Medical Services, Inc. (“GHMSI”) “is prohibited from reducing or distributing its surplus as a result of the” D.C. Department of Insurance, Securities and Banking’s December 30, 2014, order “until the MIA makes a determination on the impact to Maryland residents of” that order. Letter from Al Redmer Jr., Comm’r, Md. Ins. Admin., to Chet Burrell, President and Chief Exec. Officer, CareFirst BlueCross BlueShield 3 (Feb. 10, 2015). Your letter also determined that GHMSI “is prohibited from submitting a plan to the D.C. Commissioner for dedication of its excess of 2011 surplus attributable to D.C. until submitted, reviewed and approved by the MIA.” Id. DC Appleseed Center for Law and Justice, Inc. (“DC Appleseed”) is aggrieved by these prohibitions and therefore requests a hearing and a stay until the matter is adjudicated. Md. Code Ann., Ins. §§ 2-210(a)(2)(ii), (b)(1), 2-212(a)(1)(ii).

The requirement that a person be “aggrieved” by an agency determination “mirrors general common law standing principles applicable to judicial review of administrative decisions.” Sugarloaf Citizens Ass’n v. Dep’t of Env’t, 344 Md. 272, 288, 686 A.2d 605, 614 (1996) (quoting Med. Waste Assocs., Inc. v. Md. Waste Coal., 327 Md. 596, 611 n.9, 612 A.2d 248–49 n.9 (1992)). The D.C. Court of Appeals has recognized that DC Appleseed has standing to seek judicial enforcement of the Medical Insurance Empowerment Amendment Act of 2008 (“MIEAA”), D.C. Code §§ 31-3501 to -3524, both because it is a GHMSI subscriber that would benefit from MIEAA’s application, and because the failure to enforce MIEAA would directly conflict with the organization’s mission. D.C. Appleseed Ctr. for Law & Justice v. D.C. Dep’t of Ins., Secs., & Banking, 54 A.3d 1188, 1204, 1210 (D.C. 2012). Pursuant to MIEAA’s requirements, the D.C. Commissioner reviewed GHMSI’s surplus as of December 31, 2011, determined that it was excessive, and ordered the company to submit a plan for reducing excess surplus attributable to the District by March 16, 2015. Your February 10 prohibitions directed to GHMSI are contrary to the D.C.
The relief DC Appleseed would seek at the requested hearing is a determination that while
the Maryland Commissioner has authority and discretion to determine whether and how excess
GHMSI surplus attributable to Maryland should be spent down, he does not have authority to
override and countermand corresponding determinations made by the D.C. Commissioner
concerning excess surplus attributable to the District. GHMSI’s federal charter, which provides that
GHMSI “shall be licensed and regulated by the District of Columbia in accordance with the laws
(1993), is fully consistent with the D.C. Commissioner’s primary authority and oversight in this
matter. Indeed, Congress’ understanding of GHMSI’s charter confirms that this provision was
added “because the venue rests in the District of Columbia.” 139 Cong. Rec. S8618 (July 13, 1993)
(statement of Sen. Sam Nunn); see also S. Rep. No. 104-92, at 53 (1995) (noting that the charter
amendment was based on the proposition that “the primary oversight of an insurance carrier rests
with the authorities in the company’s ‘State of domicile’”).

For the foregoing reasons, which we would further document and explain if our request is
granted, we request a hearing regarding your February 10, 2015, prohibitions and a stay pending
adjudication of this matter.

Sincerely,

Walter Smith, Executive Director
DC Appleseed Center

Richard B. Herzog
Harkins Cunningham LLP

Deborah Chollet, Ph.D.

Marialuisa S. Gallozzi
Covington & Burling LLP

cc: The Honorable Chester A. McPherson, Acting Commissioner
D.C. Department of Insurance, Securities and Banking
Exhibit J
March 24, 2015

VIA EMAIL
Richard B. Herzog, Esq.
Harkins Cunningham LLP
1700 K Street, NW
Suite 400
Washington, D.C. 20006

VIA EMAIL
Randolph S. Sergent, Esq.
Vice President and Deputy General Counsel
CareFirst BlueCross BlueShield
1501 S. Clinton Street, CT 10-06
Baltimore, Maryland 21224

VIA EMAIL
Marialuisa S. Gallozzi, Esq.
Covington & Burling LLP
One CityCenter
850 Tenth Street, NW
Washington, D.C. 20001

VIA EMAIL
Walter Smith, Executive Director
DC Appleseed
1111 Fourteenth Street, NW
Suite 510
Washington, D.C. 20005

Re: In re Examination of GHMSI Surplus
MIA File No.: MIA-2015-03-028

Dear Counsel:

Please be advised that, as discussed during the telephone conference call with the parties yesterday, Complainant DC Appleseed's request for a hearing is stayed at this time pending further action in the underlying matter. Any party that subsequently thinks that a hearing is warranted may contact this Office to request that a hearing be scheduled.

If you have any questions or need any information, please contact Hearings and Appeals Coordinator Sharon Kraus at sharon.kraus@maryland.gov or at (410) 468-2018. Thank you.

Sincerely,

Michele T. Oshman
Associate Deputy Commissioner

MTO/smk
cc: Commissioner Al Redmer
    J. Van Lear Dorsey, Esq.
    Commissioner Chester A. McPherson
    Commissioner Jacqueline K. Cunningham
Exhibit K
GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF INSURANCE, SECURITIES AND BANKING

___________________________________

IN THE MATTER OF

Surplus Review and Determination for Group Hospitalization and Medical Services, Inc.

Order No.: 14-MIE-019

PETITION FOR RECONSIDERATION AND MOTION TO STAY FURTHER PROCEEDINGS BY GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC.

Group Hospitalization and Medical Services, Inc. (GHMSI), respectfully requests that the Commissioner of the Department of Insurance, Securities and Banking (DISB) reconsider the August 30, 2016, Order. GHMSI also respectfully requests that DISB stay all further proceedings in this matter, including execution of the relief required by that Order, until the D.C. Court of Appeals has ruled on any appeal filed by GHMSI and a directly related federal suit has been resolved.

The conclusions and directives contained in August 2016 Order are fundamentally mistaken on the merits, for the array of reasons GHMSI has delineated in previous filings before the Commissioner. Moreover, the Order failed to account for a number of important technical concerns. Reconsideration is warranted so that the Commissioner can give full and appropriate weight to GHMSI’s arguments. Reconsideration is further needed so that the Commissioner can, among other things, properly evaluate the Order’s impact on taxable income for employee subscribers and determine whether the federal Office of Personnel Management would permit payment of rebates to federal employee subscribers—all of which would directly affect the content of a corrected Order.
GHMSI will also suffer irreparable harm if it is required to implement the Commissioner’s August 2016 Order now—distributing rebates to eligible subscribers within 120 days, and having any premium rate increases denied until the rebates are distributed—before any appeal is taken up and decided. If GHMSI later prevailed on appeal, it would be unable to recoup the disbursed funds or recover any losses from denied premium rate increases that are otherwise justified. This case also presents unique and significant legal issues that deserve an opportunity for full consideration by the D.C. Court of Appeals before any irrevocable steps are taken. No parties would be harmed by a stay in the interim, and the public interest supports a stay. GHMSI is prepared to seek expedited review in the D.C. Court of Appeals if a stay is granted, in order to bring this proceeding to resolution as quickly as practicable.

In addition, GHMSI has filed suit in the United States District Court for the District of Maryland, seeking a declaration from the federal court as to the application of GHMSI’s federal Charter and to resolve the conflict between the Commissioner’s Orders in these proceedings and conflicting orders issued by the Maryland Insurance Commissioner and the Virginia State Corporation Commission. GHMSI has requested expedited resolution of the federal suit as well. The Commissioner is a party to that action, and GHMSI asks that, at a minimum, the August 2016 Order be stayed until the federal court rules on the federal law questions and addresses the conflicting orders by differing state regulators.\footnote{To be clear, a stay may not actually be needed until both cases are resolved. It would only be needed until one of the two courts rules in GHMSI’s favor. If \textit{either} the D.C. Court of Appeals or the federal court grants GHMSI’s requested relief, the stay would become moot.}

**BACKGROUND**

The Commissioner’s August 2016 Order sets forth a surplus plan for GHMSI. In that Order, the Commissioner (1) states that DISB will continue to deny any filed requests for
premium rate increases in the District; (2) requires GHMSI to “pay rebates in the total amount of its revised excess 2011 surplus attributable to the District” to “Eligible Subscribers” in six designated categories; (3) sets a scheme for calculating each rebate, based on a subscriber’s current annual premiums; (4) stipulates that “[t]he cost of calculating, preparing and distributing the rebates shall be borne by GHMSI”; and (5) provides that the rate-increase denial will be lifted when GHMSI certifies that all required rebates have been issued. DISB Order No. 14-MIE-019 at 31-33 (Aug. 30, 2016).

The August 2016 Order constitutes a final order in the proceedings related to GHMSI’s 2011 surplus. See Order, Nos. 15-AA-108, 15-AA-109 at 2 (D.C. Apr. 28, 2015) (per curiam) (dismissing petitions for review) (explaining that a final order must “impose an obligation, deny a right, or fix some legal relationship as a consummation of the administrative process” (quoting Levy v. D.C. Bd. of Zoning Adjustment, 570 A.2d 739, 749 n.14 (D.C. 1990))). GHMSI intends to appeal the August 2016 Order and, inter alia, findings in the June 14, 2016, and December 30, 2014, Orders entered in these proceedings. GHMSI asks the Commissioner to stay the effects of the August 2016 Order until the resolution of GHMSI’s appeal before the D.C. Court of Appeals and the resolution of the federal proceedings in Maryland.

ARGUMENT

I. THE COMMISSIONER SHOULD RECONSIDER THE AUGUST 2016 ORDER.

The Commissioner has the inherent authority to reconsider his own orders. See, e.g., Spanish Int’l Broad. Co. v. FCC, 385 F.2d 615, 621 (D.C. Cir. 1967); Albertson v. FCC, 182 F.2d 397, 399-400 (D.C. Cir. 1950). Reconsideration is warranted here to correct fundamental

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2 The Order is not deemed final while GHMSI’s petition for reconsideration remains pending before the Commissioner. See infra note 3.
errors in the Commissioner’s August 2016 Order (and in the earlier orders on which the August 2016 Order is based) and to address significant technical issues not discussed in the Order.

As GHMSI has previously explained, the course of action mandated by DISB is profoundly mistaken. Among its defects, and as outlined below, the August 2016 Order lacks support in the record, exceeds the requirements of the Medical Insurance Empowerment Amendment Act of 2008 (MIEAA), directly conflicts with decisions by the authorities in Maryland and Virginia, ignores Congress’s express instructions in GHMSI’s federal Charter, and disregards GHMSI’s extensive community-reinvestment activities in the District. See GHMSI Comments in Response to June 2016 Order (July 14, 2016); GHMSI Motion for Reconsideration of December 2014 Order (Jan. 22, 2015); infra at 6-8. Moreover, by the time GHMSI submitted its remedial plan to address the “excess” 2011 surplus claimed by DISB, GHMSI had already reduced the surplus attributable to the District by more than was required under DISB’s December 2014 Order. GHMSI Plan Pursuant to December 2014 Order at 4 (Mar. 16, 2015). By denying rate increases and requiring GHMSI to distribute tens of millions of dollars in rebates, the August 2016 Order converts DISB’s prior analytic errors into a defective demand for duplicative relief. The Commissioner should reconsider the August 2016 Order in its entirety.

Furthermore, the Commissioner has failed to account for a number of consequential technical questions. For example, employees in the District who receive healthcare coverage through their employers may find that some of the money that employees collect through the rebates from GHMSI is taxable as income. The Commissioner may wish to evaluate the extent to which subscribers may incur tax liabilities through the ordered rebates, because their coverage was subsidized by employers. In addition, the federal government subsidizes the majority of the cost of its employees’ health insurance. The Commissioner insufficiently addressed the
treatment of GHMSI subscribers in the District who are federal employees. In particular, the Commissioner has not indicated whether it has conferred with the United States Office of Personnel Management to resolve how any rebates from GHMSI would be allocated among the federal government and federal employee subscribers. The August 2016 Order thus not only was mistaken on the merits, but also specifically failed to give due consideration to important factors that could affect the proper disposition of this matter.3

II. A STAY IS WARRANTED UNDER THE FOUR-PART TEST ARTICULATED BY THE D.C. COURT OF APPEALS.

“To prevail on a motion for stay, a movant must show [1] that he or she is likely to succeed on the merits, [2] that irreparable injury will result if the stay is denied, [3] that opposing parties will not be harmed by a stay, and [4] that the public interest favors the granting of a stay.” Salvattera v. Ramirez, 105 A.3d 1003, 1005 (D.C. 2014) (quoting Barry v. Wash. Post Co., 529 A.2d 319, 320-321 (D.C. 1987)). “These factors interrelate on a sliding scale and must be balanced against each other.” Id. (quoting Serono Labs., Inc. v. Shalala, 158 F.3d 1313, 1318 (D.C. Cir. 1998)). And where a case presents “serious legal question[s],” “[a]n order maintaining the status quo may be appropriate.” Walter E. Lynch & Co. v. Fuisz, 862 A.2d 929,

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3 So long as GHMSI’s petition for reconsideration remains pending before the Commissioner, the August 2016 Order is not considered final for the purposes of judicial review. See D.C. Ct. App. R. 15(b); D.C. Dep’t of Emp’t Servs. v. Vilche, 934 A.2d 356, 358-359 (D.C. 2007); see also 2 Am. Jur. 2d Administrative Law § 436 (rev. 2016). GHMSI reserves the right to file a timely petition for review of the Order to protect its right to an appeal, in the event that petition for reconsideration is denied. GHMSI therefore intends to seek review of the Order before the D.C. Court of Appeals promptly, “within 30 days after notice is given, in conformance with the rules or regulations of the agency.” D.C. Ct. App. R. 15(a)(2); see also Drivers, Chauffeurs & Helpers Local Union No. 639 v. District of Columbia, 631 A.2d 1205, 1213 (D.C. 1993) (concluding that, where an agency had “no Rule expressly authorizing petitions for reconsideration, but [did] accept such petitions for filing and acts upon them,” the “time for seeking judicial review did not begin to run until the motion for reconsideration was acted upon by the [agency]”).
932 (D.C. 2004). If the other factors are satisfied, “it will ordinarily be enough that the [appellant] has raised questions going to the merits so serious, substantial, difficult and doubtful, as to make them a fair ground for litigation and thus for more deliberative investigation.” Wash. Metro. Area Transit Comm’n v. Holiday Tours, Inc., 559 F.2d 841, 844 (D.C. Cir. 1977) (quoting Hamilton Watch Co. v. Benrus Watch Co., 206 F.2d 738, 740 (2d Cir. 1953)).

Here, all of the factors counsel in favor of a stay: (1) GHMSI has identified significant legal issues that require consideration by the D.C. Court of Appeals, as well as the federal court; (2) irreparable injury will result without a stay because GHMSI will be unable to recoup any disbursed funds; (3) no party will be harmed by a stay; and (4) the public interest weighs in favor of granting a stay until these questions are resolved.

A. GHMSI Has Raised Unique Legal Issues That Deserve A Full Hearing Before The D.C. Court Of Appeals And The Federal Court.

GHMSI expects to base its appeal on issues raised in response to the December 2014, June 2016, and August 2016 Orders in these proceedings. These are significant legal questions, and they include but are not limited to the following issues:

1. GHMSI intends to appeal the findings in the December 2014 Order, for all of the reasons set out in GHMSI’s January 22, 2015, Motion for Reconsideration. A ruling in GHMSI’s favor on any one of those points, among others, would void that Order and the subsequent remedial plan:

   a. The conclusions in the December 2014 Order that GHMSI’s 2011 surplus was excessive, and the methodology and findings leading to that conclusion, are unsupported by any evidence in the record and ignore the testimony of DISB’s own expert consultant.
b. DISB failed to coordinate with Maryland and Virginia, as required by the MIEAA, leading directly to the conflicting orders among the three jurisdictions that the federal court now must resolve.

c. DISB failed to apportion GHMSI’s surplus in the manner required by the MIEAA.

2. GHMSI intends to appeal the findings in the June 2016 Order, upon which the remedial plan is also based. In particular, GHMSI has undertaken substantial community reinvestment in the District since 2011, at a substantial loss. DISB has taken the position that only a small portion of GHMSI’s rate reductions are to be counted as a reduction of “excess surplus”—despite the fact that, from 2012 to 2014, GHMSI provided $11 million in direct community giving, incurred $62 million in underwriting losses in the District, contributed $15 million to the Healthy DC fund, and provided $24 million in subsidies for the District’s open enrollment program, and did so by drawing down its surplus. GHMSI Comments at 9, 10, 13, 14.

3. The course of action ordered by DISB is directly contrary to the terms set by Congress in GHMSI’s federal Charter. As GHMSI has stated in its pleadings before the federal court, GHMSI’s federal Charter requires DISB to reach an explicit agreement with Maryland and Virginia before ordering GHMSI to reduce its present or future surplus. In essence, when it amended the Charter in December 2015, Congress imposed the same concurrence requirement already mandated by the MIEAA—so it is now a matter of federal law. See Financial Services and General Government Appropriations Act, 2016 § 747, enacted in Consolidated Appropriations Act, 2016, Pub. L. No. 114-113; D.C. Code § 31-3506(e). As with the issues
referenced above, should the D.C. Court of Appeals or the federal court agree with GHMSI on this issue, the remedial plan would be improper.

All of those issues, and others, present unique questions of first impression, and success on any one of them will result in reversal of the Commissioner’s August 2016 Order. For the purposes of granting a stay, GHMSI need not prove it will prevail; all it must do is raise “serious” and “substantial” questions requiring “more deliberative investigation.” *Holiday Tours*, 559 F.2d at 844. GHMSI has cleared that bar. The important questions in this case require full consideration by the D.C. Court of Appeals and the federal court before a remedial plan may be imposed.

B. GHMSI Will Suffer Irreparable Harm Without A Stay.

Executing the Commissioner’s plan while an appeal remains pending would cause irreparable harm to GHMSI. The Commissioner’s plan requires GHMSI to pay and distribute tens of millions of dollars in rebates to subscribers across the District. It also forbids DISB from approving any increase in GHMSI’s filed premium rates until all rebates have been issued, which forces GHMSI to relinquish any income that it would otherwise receive during that period. Both before the 120-day deadline (while rate increases are denied) and afterward (once the rebates are paid), compliance with the Commissioner’s Order will cause continued financial harm to GHMSI.

not be raised retroactively. Either way, once disbursed, those tens of millions of dollars in funds would not exist in any recoverable place. Requiring GHMSI to execute on DISB’s remedial plan now would thus remove any “possibility that adequate compensatory or other corrective relief will be available at a later date,” should GHMSI prevail on appeal. *Zirkle v. District of Columbia*, 830 A.2d 1250, 1257 (D.C. 2003) (quoting *Va. Petrol. Jobbers Ass’n v. Fed. Power Comm’n*, 259 F.2d 921, 925 (D.C. Cir. 1958)). If GHMSI cannot recoup its funds after prevailing on appeal, that harm is “irreparable,” by definition. *Black’s Law Dictionary* 958 (10th ed. 2014) (describing “irreparable” as “[i]ncapable of being rectified, restored, remedied, cured, regained, or repaired”). GHMSI could not be made whole again. Effectively “mooting” a case in this way is disfavored. *See, e.g., FTC v. Weyerhaeuser Co.*, 665 F.2d 1072, 1077 (D.C. Cir. 1981) (noting that “the suggestion of mootness” during the appeal “was made possible only by the district court’s resistance to a holding order of any kind,” and rebuking the district court for not entering a stay).

The clearly irreparable harm in this case, moreover, simplifies the Commissioner’s overall stay evaluation. Because “irreparable harm is clearly shown” here, a stay may be entered if GHMSI shows merely that it has a “substantial case on the merits.” *Akassy v. William Penn Apartments Ltd. P’ship*, 891 A.2d 291, 310 (D.C. 2006) (quoting *In re Antioch Univ.*, 418 A.2d 105, 110-111 (D.C. 1980)); *see also id.* (“[A] stay may be granted with either a high probability of success and some injury, or vice versa.” (quoting *Cuomo v. U.S. Nuclear Regulatory Comm’n*, 772 F.2d 972, 974 (D.C. Cir. 1985))). The irreparability of the prospective harm to GHMSI further underscores the point that if the Commissioner grants a stay, he should not be deemed to have conceded GHMSI’s legal arguments on the merits.
C. No Party Or Other Person Will Be Harmed By A Stay.

Granting a stay will not harm any opposing party, because there is no other party in this action. No person or entity would be harmed if GHMSI is given the opportunity to pursue its appeal before irrevocably disbursing funds. D.C. Appleseed, which is not a party and is pursuing its own appeal, would also not be harmed by affording time for an appeal. GHMSI’s subscribers would likewise not be harmed, since subscribers in the District would still benefit from the DISB plan, if the plan were upheld on appeal. Those subscribers also have a countervailing interest in GHMSI’s financial soundness—and that interest would be harmed if a remedial plan is imposed, and GHMSI’s surplus is irrevocably reduced, when no such reduction should have occurred. This case, moreover, does not involve an ongoing alleged harm to others that requires immediate abatement: the subject of this action, after all, is GHMSI’s 2011 surplus. DISB Order No. 14-MIE-012 at 1 (Dec. 30, 2014).

GHMSI also is willing to seek (or to join with DISB to seek) expedited review of its appeal before the D.C. Court of Appeals, to shorten the time between noticing the appeal and any decision, and it has already sought an expedited decision from the federal court.

D. Granting A Stay Is In The Public Interest.

The public interest favors affording the D.C. Court of Appeals and the federal court an opportunity to consider GHMSI’s arguments before GHMSI loses any prospect of recouping the disbursed funds. Entering a stay would serve the public interest in several specific ways.

First, the Commissioner has mandated a tremendous undertaking for GHMSI. He gave GHMSI 120 days to calculate, prepare, and distribute all the rebates—signaling the significant effort involved in satisfying this extraordinary Order. GHMSI will need to ascertain which of its subscribers qualify under the six categories enumerated in the Commissioner’s Order, and then
determine the appropriate rebate amount for each eligible subscriber. August 2016 Order at 32-33. All the while, GHMSI will remain subject to the Commissioner’s rate-increase denial. Id. at 31-33. The Commissioner, indeed, specifically ordered that any costs associated with the rebates “shall be borne by GHMSI.” Id. at 33. In any event, GHMSI should at least be able to embark on this project with legal certainty from the D.C. Court of Appeals and the federal court.

Second, the 120-day implementation period may very well cover much of the time needed by the D.C. Court of Appeals and the federal court to consider and decide GHMSI’s appeal, if GHMSI and the District join in seeking expedited review. A stay will simply maintain that status quo.

Third, declining to stay the proceedings will aggravate conflicts among the jurisdictions that regulate GHMSI. Maryland and Virginia have both already signaled that DISB should not act to draw down GHMSI’s surplus without their participation and consent. See, e.g., Maryland Insurance Commissioner Statement at 2 (July 11, 2016); Virginia Bureau of Insurance Report at 7 (Apr. 15, 2015).

Last, it is in the public interest for this process to advance in an orderly way, and it surely is in the public interest to permit GHMSI to pursue its appeal of right before irrevocably depriving GHMSI of tens of millions of dollars in funding. The same is true of fully resolving the substantive legal issues raised by GHMSI. If “there is a public interest in preserving contracts as written,” Akassy, 891 A.2d at 310, then there is certainly a public interest in correctly interpreting and enforcing D.C. and federal laws as written.
CONCLUSION

The Commissioner should reconsider the August 30, 2016, Order. DISB also should stay all further proceedings, including any attempt to execute the terms of that Order, until the conclusion of an appeal by GHMSI before the D.C. Court of Appeals and the resolution of GHMSI’s pending federal complaint.

Respectfully submitted,

/s/ Catherine E. Stetson
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Counsel for Group Hospitalization and Medical Services, Inc.

September 22, 2016
Exhibit L
July 14, 2016

Hon. Stephen C. Taylor
Commissioner
Department of Insurance, Securities and Banking
810 First Street NE, Suite 701
Washington, D C 20002

Dear Commissioner Taylor,

Group Hospitalization and Medical Services, Inc.’s (“GHMSI” or the “company”) response to the questions posed in the June 14, 2016 DISB Order (the “Order”) is enclosed.

This letter provides a larger view of the issues posed by the Order, places these issues in historical and legal context and expresses the company’s position on the issues.

We start with the straightforward observation that the company’s certificate holders (“subscribers”) rightfully expect when they make their payments to the company for health care coverage that these payments will be fully used for their benefit. Indeed, the federal law that established the company in 1939 – that constitutes its Congressional Charter – explicitly requires that this be done. GHMSI is the only Blue Cross Blue Shield plan in the U.S. chartered by Congress. The Charter clearly states:

“Said corporation shall not be conducted for profit, but shall be conducted for the benefit of the aforesaid certificate holders.”

The most recent amendment to the Charter enacted by Congress in late 2015, reinforces and clarifies this core purpose of the company – and speaks directly to the issue of how “excessive” surplus is to be handled:

“The surplus of the corporation is for the benefit and protection of all of its certificate holders and shall be available for the satisfaction of all obligations of the corporation regardless of the jurisdiction in which such surplus originated or such obligations arise. The corporation shall not divide, attribute, distribute, or reduce its surplus pursuant to any statute, regulation, or order of any jurisdiction without the express agreement of the District of Columbia, Maryland, and Virginia—(1) that the entire surplus of the corporation is excessive; and (2) to any plan for reduction or distribution of surplus.”

1 Section 747(b) of the Financial Services and General Government Appropriations Act, 2016, enacted as part of the Act of December 18, 2015, Publ. L. No. 114-113, 129 Stat. 2242, states “[t]he amendments made by subsection (a) shall apply with respect to the surplus of Group Hospitalization and Medical Services, Inc. for any year after 2011.
In plain, clear terms, GHMSI’s federal Charter has prescribed from the beginning, and continuously thereafter, that the company exists for the benefit of its subscribers. This means exactly what it says.

To go to the heart of the matter, the company holds surplus to assure that its promise to protect its subscribers by covering the costs of their health care services – come what may – will be fulfilled and that neither a single large event, such as an epidemic, nor a series of smaller events will undermine this promise or cause it to be unfulfilled. For example, should a threat like the Zika or Ebola viruses ever materialize on a large scale, the company must be able to fulfill its obligations to its subscribers to pay their claims.

The surplus is built up in two ways: first, by the retention and set aside of earnings each year from subscriber premium payments and second, by the additional investment income earned on the amounts set aside. Since the company is non-profit and operates essentially near cost (earnings average less than 2 percent per year), it takes many years to build up surplus. The surplus could be depleted very quickly, however, by an epidemic or series of other lesser events.

Additionally, since the advent of the Affordable Care Act, there are strict federal rules that limit how much a health insurance company can retain in earnings on health care coverage plans. Hence, surplus funds – once established – are precious resources, not easily replenished.

Further, GHMSI’s federal Charter plainly provides that the surplus must be held as a common pool of funds that is available to protect all subscribers, regardless of the jurisdiction in which they live. It forbids the company from dividing or attributing a portion of the surplus or assigning a portion to a particular jurisdiction. This is in keeping with long established practice and policy in the health insurance field.

In the event that one jurisdiction (e.g., the District) were to conclude that surplus is too large, the federal Charter requires that all three jurisdictions reach agreement about whether the company holds too much total surplus and on any plan to remedy any excess.

Thus, the Charter establishes a clear framework within which the company must operate that governs its purpose, the scope of its operations and the use of the funds it obtains from its subscribers. Simply stated, the company exists to serve its subscribers and to “be there” for them under any set of circumstances.

With this said, as a general matter, it would be entirely appropriate for a regulator to determine whether the company – or any insurance company – holds too much surplus (i.e., holds more than what it needs to fulfill its promise to its subscribers). It is also appropriate for a regulator to determine whether it holds too little. In fact, the concern that an insurer holds too little surplus has historically been the most common focus of regulators and one need not look far to see the consequences of too little surplus when times are tough. GHMSI itself faced near bankruptcy in the early 1990s when its surplus was depleted. No government entity stepped in to save it. Fellow Blue Cross Blue Shield plans came to the rescue – an event the company hopes never needs to be repeated.

Determining the right level of surplus needed is a complicated question requiring qualified independent actuarial experts to provide advice and recommendations. This is not unlike the kind of technical expertise needed in determining whether a bridge can withstand different traffic loads in all weather conditions or how much capital banks must hold in reserve to protect against potential adverse economic events. In each of these cases, expert opinions are critical because the cost of getting it wrong may be catastrophic.

The company’s surplus has been repeatedly and extensively studied with well over a dozen formal studies in the past decade by a range of expert, independent actuarial firms engaged by the company as well as by the company’s regulators in the District, Maryland and Virginia – the three jurisdictions in which it operates.
Not a single one of these studies has concluded that the company holds too much surplus. Indeed, the dominant theme of these studies has been that the company holds *too little* surplus when compared to an ideal range of surplus needed to safeguard against the risks the company faces.

In accord with all of these formal studies, the DISB’s own most recent expert actuarial consultant held that the company did not have too much surplus in 2011 – the same year that is the subject of the DISB’s Order.

Nevertheless, despite overwhelming expert opinion to the contrary, the previous Acting DISB Commissioner independently decided that the company held too much surplus in 2011 and determined that a portion of this alleged excess (21%) was attributable to the District. This is the genesis of the $56.2 million sought in the current Order that now upholds the previously Acting Commissioner’s decision.

Both the former Acting Commissioner’s and the current Commissioner’s Orders were issued under a District law, enacted in 2009, that conflicts with the federal Charter of the company. This local law, which was enacted at the urging of DC Appleseed, introduced the idea of a broader obligation on the part of the company to the community in general – namely, that the company has an obligation to undertake “community health reinvestment” to the “maximum extent feasible”.

The District law requires that the company strive to meet the health care needs of the community beyond those of its subscribers – and to do so with subscriber money. In other words, it requires GHMSI to spend down subscriber funds set aside in surplus for their benefit and protection so that other public health needs of the non-subscriber community can be better met. This places a great additional burden on subscribers who are already burdened by the high cost of health care coverage – a burden Congress never intended, as reflected in its clear articulation that the company is to be *conducted for the benefit of the aforesaid certificate holders*.

The requirements of the District law are also accompanied by the idea that the company’s surplus can be divided into parts – that is, that a portion of the surplus can be “attributed” to the District alone and that the funds in surplus – those in “excess” – can be used for District-only purposes, even though those funds were built up by subscribers in all three jurisdictions for the protection of subscribers in all three jurisdictions. In fact, actuaries who have reviewed this concept in District law of “attributing” surplus have pointed out that it is invalid to divide or attribute surplus in the case of a health insurance company operating in multiple jurisdictions. Certainly the federal Charter is clear in forbidding it.

Nevertheless, it was pursuant to this District law that Acting Commissioner McPherson concluded in his December 30, 2014 Order that GHMSI’s surplus position was excessive and that the portion of this alleged “excess” attributable to the District was $56.2 million. The June 14 Order adopts this conclusion. It also offers the view that the contributions that the company has voluntarily made to the community with subscriber funds cannot be counted as “community health reinvestments” – even though this was clearly their intent and effect and despite the fact they were drawn from funds in surplus.

The Order has far-reaching implications. Over 88 percent of the company’s members live in Maryland, Virginia and other jurisdictions, while less than 12 percent live in the District of Columbia. In other words, the legal framework created by District law requires that the common pool of surplus funded by all subscribers – the vast majority of whom are *not* District residents – are subject to being drawn off for *non-subscribers*, at the District’s sole discretion.

Thus, District law provides a powerful motivation to find “excess” because it enables the District to tap into a substantial source of funds for purposes – however worthy – that are other than for the benefit of subscribers. All that is necessary for this to happen is for the Commissioner of the DISB to declare that an excessive surplus exists, “attribute” a portion to the District, and then approve a plan for disposition of the alleged excess for the benefit of the District’s larger community. This is, in effect, a government
taking of property that is rightfully owned by subscribers, the vast majority of whom do not reside in the District of Columbia.

In the case of the surplus review conducted for 2011, this is exactly what has happened – leaving the only remaining question as to exactly how the alleged excess attributable to the District is to be spent. For this, the Commissioner seeks public comment, which, no doubt, will be bountifully forthcoming.

Once the 2009 District law was enacted and the DISB undertook surplus review proceedings in accordance with it, the other two jurisdictions – Maryland and Virginia – reacted strongly. Both States passed protective legislation and heightened their vigilance to guard the company’s surplus. Their States’ insurance regulators issued protective orders. Indeed, the company is currently under active orders from both Maryland and Virginia not to distribute any surplus funds pursuant to a District order without their approval. For the very year that is the subject of the DISB Order (2011), Maryland ordered the company to strive to increase its surplus in direct contradiction to the DISB Orders.

The Congress acted as well. The 2015 amendment to the Charter arose out of Congressional concern with actions either taken or intended by the District under its local law that were believed by the Congress to be inconsistent with the original intent of the Charter.

The central question now is which framework applies – the one set up by Congress or the one established by the District? There is only one possible answer: the framework established by Congress as embodied in federal law (the Charter) applies.

We believe that previous and current DISB orders holding that the company has excess surplus have no merit and are based on serious analytical errors that contradict the advice of the numerous experts who have reviewed the matter. We do not seek here to add to the arguments we have previously made regarding these errors. Rather, we seek to speak further to the central issues that now must be addressed.

The following five statements are true:

First, the company has only one surplus. A portion of it cannot be attributed to the District alone. It must remain available for the protection and benefit of all subscribers in all jurisdictions. This is federal law clearly set forth in the Charter. The federal law applies to all years, including 2011.

Second, if the District believes that the surplus the company holds is excessive in any year – including 2011 – it cannot, by unilateral action, order a reduction of the alleged excess surplus without the approval of the other jurisdictions. The District has not obtained or even sought this approval.

Indeed, the two other interested jurisdictions have acted to block any attempt by the District to reduce the company’s surplus without their express approval.

We may debate what the term “coordination” with another jurisdiction means under District law, but the Charter is crystal clear that agreement is needed among the three jurisdictions to declare excess and to distribute such excess. This has not occurred and the company now faces contradictory orders from the jurisdictions – a circumstance that the Congressional Charter’s command was specifically designed to avoid. As Maryland Insurance Commissioner Redmer observed in his July 11, 2016 Statement, “That conflicting orders between the jurisdictions exist highlights the fact that, to date, no coordination has taken place between the District and the other jurisdictions.” Further, the company is commanded by its federal Charter not to obey an order to reduce or distribute its surplus unless all three jurisdictions agree.

Third, the reference in the 2015 amendment to the Congressional Charter, regarding the applicability of the newly added subsection “for any year after 2011” does not give the District free rein to unilaterally do what it wants with regard to 2011 surplus. There is no “2011 surplus.” There is only current (2016) or future surplus. Any reduction in current or future surplus must first be approved by the other jurisdictions. This, too, is federal law. The District has not acted in a manner required by this law.
Fourth, a premium rate freeze as a tool to reduce surplus or to punish the company for failure to produce a plan to reduce surplus to the Commissioner’s satisfaction is impermissible. Less-than-adequate rates deplete present or future surplus, which in turn requires the agreement of the other jurisdictions – something that has been neither sought nor given.

Fifth, if the DISB orders the distribution of $56.2 million in subscriber funds to support community health reinvestment in the District, it will violate federal law under the Charter because such an order is not for the benefit of the subscribers whose payments built the surplus and for whose protection it is intended. And, because such an order constitutes an unconstitutional taking of private property without compensation by the government, the DISB should refrain from entering a final order that will trigger that serious constitutional question.

There simply cannot be two competing frameworks under which the company operates – one established by the District and the other by federal law. The best way for this to be resolved is for the District to rescind its June 14 Order and to work with the other jurisdictions toward consensus on the surplus position of the company as provided for in the company’s Congressional Charter.

Sincerely,

[Signature]

Chat Burrell
President & CEO

Cc: Commissioner Jacqueline Cunningham
Virginia Bureau of Insurance

Commissioner Al Redmer
Maryland Insurance Administration
GHMSI COMMENTS IN RESPONSE TO DISB’S ORDER OF JUNE 14, 2016

Group Hospitalization and Medical Services, Inc. ("GHMSI"), submits the following comments, in response to the June 14, 2016 Order ("the June 14 Order") issued by the Department of Insurance, Securities and Banking ("DISB"). DISB has far exceeded the bounds of its own statute, has ignored the express instructions of Congress set out in GHMSI’s federal Charter, and is in direct conflict with Maryland and Virginia, which are rightly concerned that their residents will be forced to subsidize reinvestment in the District. GHMSI suggests that the only legal and prudent course for DISB at this time is to rescind the June 14, 2016 Order, coordinate with Maryland and Virginia to reach agreement on any differences among the jurisdictions regarding GHMSI’s surplus, as is required by law, and correct the defects in Acting Commissioner McPherson’s decision issued on December 30, 2014 (the “December 2014 Order”).

GHMSI has previously detailed how the proposed course of action taken by DISB in this proceeding is contrary to the Medical Insurance Empowerment Amendment Act ("MIEAA"),
and will not repeat those arguments here.\(^1\) In making this submission, GHMSI expressly incorporates all of its prior submissions and filings in connection with the December 2014 Order and the June 14 Order. GHMSI does not waive any argument previously made. In this memorandum, Section I details how the proposed course of action taken by DISB is contrary to the terms set by Congress in GHMSI's federal Charter. Section II addresses other issues relating to DISB's proposed, but not yet disclosed, plan.

I. DISB’s Proposed Course of Action Violates Federal Law.

A. DISB Cannot Proceed Without The Agreement Of Maryland and Virginia.

The GHMSI Charter expressly requires DISB to obtain approval of Maryland and Virginia before it may order GHMSI to reduce its present or any future surplus. In December 2015, Congress enacted and the President signed the Consolidated Appropriations Act of 2016, which added the following new section to GHMSI’s Congressional Charter:

SEC. 11. The surplus of the corporation is for the benefit and protection of all of its certificate holders and shall be available for the satisfaction of all obligations of the corporation regardless of the jurisdiction in which such surplus originated or such obligations arise. The corporation shall not divide, attribute, distribute, or reduce its surplus pursuant to any statute, regulation, or order of any jurisdiction without the express agreement of the District of Columbia, Maryland, and Virginia—(1) that the entire surplus of the corporation is excessive; and (2) to any plan for reduction or distribution of surplus.

Financial Services and General Government Appropriations Act, 2016 § 747, enacted as part of Consolidated Appropriations Act of 2016 (emphasis added) (“the Charter Amendment”). This

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\(^1\)GHMSI previously outlined the defects in the December 2014 Order at length. When he issued the December 2014 Order, former Acting Commissioner Chester McPherson: (1) failed to coordinate with Maryland and Virginia, as the MIEAA requires; (2) ignored the opinion of his own expert, Rector & Associates, and the overwhelming evidence in the record when he rejected the well-established 98% confidence level; and (3) ignored every actuarial opinion and the evidence when he determined that GHMSI should manage surplus to a single target point, despite the fact that surplus is organic and fluctuates constantly, and cannot be predicted with precision from one year to the next. The finding that GHMSI’s surplus was excessive was based entirely on these errors, and would not have been made without them.
amendment imposes the same requirement that was already required by the MIEAA in D.C. Code § 31-5506(e), but now does so as a matter of federal law.\(^2\)

The Charter Amendment applies to any decision by DISB to reduce GHMSI surplus after 2011. \(\textit{Id.}\) (stating that the amendment “shall apply with respect to the surplus of Group Hospitalization and Medical Services, Inc. for any year after 2011.”). This means that the Charter Amendment applies to any apportionment, reduction, or distribution of the surplus that GHMSI holds \textit{today} or in the future, and the surplus held by GHMSI \textit{today} cannot be apportioned, reduced, or distributed unless Maryland, the District and Virginia all agree both that GHMSI’s present surplus is excessive \textit{and} as to the details of any plan for reduction or distribution. To the extent that any jurisdiction wants to “attribute” surplus to itself out of GHMSI’s present surplus, it cannot do so unless all three jurisdictions agree. The District has no authority to act alone.\(^3\)

\(^2\) As GHMSI has stated before, the MIEAA required DISB to reach agreement with Maryland and Virginia even before the federal government amended the GHMSI Charter, in response to the December 2014 Order. “Coordination” means more than simply accepting, and then disregarding, written testimony. Coordination “envisions more than unilateral action.” \textit{MAMSI Life & Health Ins. Co. v. Wu}, 411 Md. 166, 203 n.10 (Md. 2008). To “coordinate,” parties must “harmonize, work together, or bring into a common action, effort or condition,” \textit{Network Commerce, Inc. v. Microsoft Corp.}, 260 F. Supp. 2d 1034, 1041 (D. Wash. 2003), \textit{aff’d} 422 F.3d 1353 (Fed. Cir. 2005)—that is, “work together properly and well” in order “to cause (two or more things) to not conflict with or contradict each other.” \textit{Merriam-Webster Online Dictionary}, available at \url{http://www.merriam-webster.com/dictionary/coordinate}. DISB’s assertion in the June 14 Order, that it may “coordinate” simply by accepting written testimony and then determining for itself the interests of Marylanders and Virginians is simply wrong. DISB’s unilateral actions are leading to the very intra-jurisdictional conflict that the “coordination” language in MIEAA was designed to avoid. In all events, however, federal law now makes clear that the DISB must obtain the agreement of Maryland and Virginia before unilaterally taking any action with regard to any surplus of GHMSI.

\(^3\) Indeed, any contrary interpretation of DISB’s authority would raise serious constitutional questions under the Fifth Amendment and the Supremacy and Commerce Clauses. The fundamental flaw in DISB’s position is that it allows DISB to reduce a fictional surplus allocated by DISB to GHMSI while still retaining the whole surplus for the protection of DC subscribers of GHMSI, all at the expense of CareFirst subscribers in Maryland and Virginia. Congress avoided the constitutional issues by making clear in the Charter Amendment that any surplus was to be considered as a whole for all of GHMSI and
DISB cannot avoid the Charter Amendment by now ordering a reduction of a fictional “2011 surplus.” GHMSI’s surplus at a given point in time reflects the assets of the company at that time. There are no assets set aside as “2011 surplus,” as opposed to GHMSI’s surplus today. There is no “2011 surplus” that could be distributed, and no “2011 surplus” that could be reduced. GHMSI can reduce only its present (2016) or future surplus. By making it clear that the Charter Amendment would apply to any surplus after 2011, Congress chose not to interfere with the review of GHMSI’s 2011 surplus by the Commissioner, which unilaterally found surplus to be excessive and unilaterally sought to apportion surplus (despite the MIEAA’s requirement of coordination). However, to the extent that DISB now seeks to impose a remedy reducing GHMSI’s present surplus, Congress has made clear that Maryland and Virginia must agree to any such reduction, and that those States may do so only after a finding that GHMSI’s present surplus is excessive and based upon a distribution plan accepted by all three jurisdictions. No such agreement has been obtained. DISB’s decision to proceed unilaterally violates federal law, as well as the MIEAA.

This point is obvious if one considers the mechanics of how GHMSI would reduce its surplus. There are only two ways in which GHMSI can reduce surplus to the benefit of its subscribers as required by its federal Charter. If GHMSI moderated future rates, the result would be a reduction in GHMSI’s future surplus. If GHMSI distributed funds today to subscribers, GHMSI would reduce its present surplus. In either case, any order by DISB would compel reduction or distribution of GHMSI’s surplus in a year after 2011. If DISB proceeds to order a reduction in GHMSI’s surplus without the concurrence of Maryland and Virginia, it is violating that the regulators in the three jurisdictions, DC, Maryland and Virginia, had to agree on any reduction in the surplus because all three are affected by any such action.
federal law as well as the MIEAA. The MIEAA cannot override the federal Charter of GHMSI, and the Charter prohibits the unilateral action proposed by DISB.

B. DISB Cannot Use Subscriber Funds to Benefit Non-Subscribers.

Question (f) in the June 2014 Order asks whether distribution of funds to policyholders would be community reinvestment. In fact, if a distribution or reduction of surplus were authorized and appropriate, DISB would not be able to distribute funds to persons other than subscribers. Any Order requiring GHMSI to distribute funds within the District to persons other than GHMSI subscribers would violate GHMSI's federal charter. DISB has no authority to transfer GHMSI surplus funds to non-subscribers. Both the long-standing provisions of the GHMSI Charter and the recent Charter Amendment forbid it.

II. DISB Cannot Ignore GHMSI’s Substantial Community Reinvestment And Its Substantial Loss of Surplus Since 2011.

The June 14 Order categorically rejects each and every grant, contribution, rate reduction, and other act of community reinvestment undertaken by GHMSI in the District of Columbia since 2011. The Order claims that none of these actions, each of which benefitted the District community at GHMSI’s expense, constitute a reduction of “excess surplus,” even though GHMSI lost $37 million dollars in the District from 2012 to 2014 (even after including investment gains attributable to the District) and GHMSI’s total surplus for all jurisdictions fell by $30 million dollars. Community reinvestment undertaken by GHMSI in the District at a loss must be credited to a reduction of any finding of “excess surplus.”

A. Any Plan For Dedication Of Excess Surplus Must Account For Surplus Reductions That Already Have Occurred.

In Question (c), the June 14 Order asks “[w]hether the amount of excess surplus to be dedicated should be offset by any reduction in surplus between December 31, 2011 and
December 31, 2015.” June 14 Order at 20. Under the MIEAA, any remedial plan must consider
GHMSI’s present surplus and must ensure that GHMSI’s surplus remains above the level
required for “financial soundness.” Equally important, under the MIEAA, the “surplus” that
must be examined for this purpose is the surplus attributable to the District of Columbia, to
ensure that the District is not appropriating surplus dollars that DISB itself apportioned to
Maryland and Virginia.

The MIEAA makes clear that DISB must determine the level of surplus required for
“financial soundness and efficiency,” and that GHMSI cannot be required to engage in
community reinvestment if surplus falls below that level. See D.C. Code §§ 31-3501.01 & 31-
3506(e)(2). DISB stated this in the December 2014 Order itself:

[T]he Commissioner interprets section 31-3506(e)(2) as requiring him to
determine the level of surplus that maximizes GHMSI’s community health
reinvestment without undermining GHMSI’s financial soundness and efficiency.
Stated differently, the Act requires the Commissioner to determine the amount
of surplus that is large enough to be consistent with financial soundness and
efficiency, but no larger.

December 2014 Order at 5 (emphasis added). To the extent that GHMSI has reduced its surplus
since the end of 2011, any remedial plan must take such reductions into account.

The “surplus” at issue with respect to any remedial plan is at most the portion of surplus
that has been attributed to the District of Columbia, not GHMSI’s surplus as a whole. The
MIEAA requires DISB to “review the portion of the surplus of the corporation that is attributable
to the District” and determine “whether the surplus of the corporation attributable to the District
is excessive.” D.C. Code § 31-3506(e) & (f); see also D.C. Code § 31-3506(h) (authorizing
DISB to hire consultants “[w]hen determining what surplus is attributable to the District and
whether the surplus is excessive”).
Since DISB created an artificial “District-specific” surplus as of year-end 2011 (which DISB did in the December 2014 Order), DISB now must track that surplus from year-to-year going forward, to determine whether this District-only surplus has grown or shrunk based upon the results of business in the District. DISB must do this in order to ensure that the District does not drain away surplus generated by Maryland and Virginia subscribers. The MIEAA does not authorize distribution of surplus allocated to Maryland and Virginia for “community reinvestment” in the District. Neither Maryland nor Virginia has sought to reduce the surplus attributable to their jurisdictions, and the MIEAA does not allow DISB to do so.

In Questions (c) and (d), the June 14 Order asked whether a dedication of surplus to community health reinvestment under MIEAA “could be modified pursuant to future reviews of GHMSI’s surplus,” and whether any dedication of surplus “should be suspended or modified in the event that adverse conditions reduce GHMSI’s surplus.” June 14 Order at 19-20. The answer to both of these questions is plainly “yes.” If GHMSI’s present surplus attributed to the District has fallen below the level that DISB itself finds necessary for financial soundness, then there is by definition no longer any excess surplus to distribute.

GHMSI has lost money on its business in the District since 2011. From 2012 to 2014, GHMSI incurred $62 million in underwriting losses on its District business. Underwriting losses are an expenditure made by GHMSI for the benefit of its subscribers regardless of what GHMSI originally proposed in its rate filings, and surplus is reduced as a result of such losses to the same extent. Even adding back an attributed portion of investment gains, the surplus attributed to the District in the December 2014 Order fell by $37 million between the end of 2011 and year-end 2014, from the $202 million attributed in the December 2014 Order to $165 million. See GHMSI March 16, 2015 Plan, at Ex. 1. During this same period, GHMSI’s overall surplus only
fell by $30 million, meaning that Maryland and Virginia had positive results to offset some of the losses in the District. *Id.* Unless the District intends to seize and distribute surplus that DISB *itself* attributed to Maryland and Virginia, or to force GHMSI’s District-attributed surplus below the level that DISB *itself* determined was required for financial soundness, then DISB must account for these losses before ordering any distributions of “excess” surplus.

GHMSI has already performed this analysis. The portion of surplus attributed to the District by DISB *itself* has fallen far below 721% RBC (“risk based capital”), using the same RBC calculations used to examine GHMSI’s surplus as a whole, but with the inputs to those calculations based on District-specific business rather than GHMSI’s entire financial statement. *See* GHMSI’s March 16, 2015 Plan at Ex. 1 (concluding that the surplus attributed to the District in the December 2014 Order had fallen to 569% RBC by year-end 2014). Even under the flawed logic of the December 2014 Order, it would not be consistent with “financial soundness” to require additional reductions of the surplus attributed to the District by DISB. Nothing in the MIEAA authorizes DISB to force GHMSI’s surplus *today* below the level required for financial soundness based upon a finding that GHMSI’s surplus was once excessive four and a half years ago.

Most importantly, while GHMSI addresses in this and the following sections the requirements of the MIEAA and a remedial plan under that Act as ordered by DISB, the Charter Amendment makes clear that the artificial distinctions drawn by DISB under the MIEAA are not valid and must yield to the Charter as amended. *There is no separate surplus for the District of Columbia, for Maryland or for Virginia.* At any time, there is only one surplus; the surplus of GHMSI, and that surplus, as the Charter Amendment provides, is for the benefit of all three
jurisdictions. Hence, all three jurisdictions must agree on any distribution of GHMSI’s surplus, if one even exists.⁴

B. GHMSI Has Already Reduced The “Excess Surplus” By Providing Community Giving Between 2011 And 2014.

In Question (g), the June 14 Order asks “[w]hether there were any negative contributions to surplus made by GHMSI that should be taken into account for the plan.” June 14 Order at 20. GHMSI made negative contributions to surplus through many means, not just its rate filings, which are discussed in § II.C, below. GHMSI also made negative contributions to its surplus through direct community giving and other reinvestment in years when GHMSI incurred surplus losses.

During 2012 to 2014, GHMSI provided $11 million in direct community giving in the District, while GHMSI’s total surplus fell by $30 million and the surplus attributed to the District in the December 2014 Order actually fell by $37 million:

- In 2012, GHMSI engaged in $3.9 million in direct community giving, GHMSI’s total surplus fell by $23 million, and the surplus attributed to the District in the December 2014 Order also fell by $23 million.

- In 2013, GHMSI engaged in $3.4 million in direct community giving, GHMSI’s total surplus fell by $6 million, and the surplus attributed to the District in the December 2014 Order fell by $3 million.

- In 2014, GHMSI engaged in $3.7 million in direct community giving, GHMSI’s total surplus fell by $1 million, but the surplus attributed to the District in the December 2014 Order fell by $11 million.

See GHMSI’s March 16, 2015 Plan at Exs. 1 & 2.

⁴ To the extent that the MIEAA purports to require allocation of any GHMSI surplus among the three jurisdictions and attribution of a portion to the District, the Act is not only unrealistic and unworkable, it violates federal law and must yield to the unitary approach of the federal Charter. While the DISB may not have the power to question the constitutionality of the MIEAA, see, e.g., Stackhouse v. D.C. Dep’t of Employment Servs., 111 A.3d 636, 639 (D.C. 2015), DISB certainly has an obligation to avoid an unconstitutional interpretation or implementation of the Act.
None of these grants was made out of “premium dollars.” During this same period of time, GHMSI incurred $62 million in underwriting losses in the District and GHMSI’s premiums failed to cover even the company’s operating costs. In each year, GHMSI engaged in community giving that (a) was direct community health reinvestment to the District, (b) was not covered by any income received from District business, and (c) therefore directly reduced GHMSI’s year-end surplus for the year in which the giving occurred. Giving by GHMSI that reduces its surplus constitutes a reduction in the “excess surplus” found in the December 2014 Order.

As stated above, there is no pool of funds labeled “excess 2011 surplus” from which community giving can be drawn. If GHMSI engages in community giving at the same time that it incurs underwriting losses, it only can do so by drawing down its surplus.

C. GHMSI’s Rate Reductions Were Taken From “Excess Surplus.”

Starting in 2011, GHMSI began taking specific steps to reduce rates in order to reduce its surplus. There was no mystery about why GHMSI was taking these steps – GHMSI specifically reported on these reductions to DISB and the market at the time and long before this proceeding. The reductions were specifically described to DISB at the time as a set of actions undertaken to reinvest in the community and to reduce GHMSI’s surplus to the levels set by GHMSI board policy. As stated in GHMSI’s June 1, 2011 filing with DISB, “[t]he Boards [of GHMSI and CareFirst, Inc.] have reviewed and adjusted surplus ranges as necessary” and “have overseen the filing of self-initiated premium rate reductions that carry out a policy of community health reinvestment.” GHMSI Annual 2011 Report on Surplus at 10 (dated June 1, 2011, and attached as Exhibit 1). As GHMSI informed DISB:

[t]his reduction/moderation in premium rates is a self-initiated set of coordinated actions that are designed to prevent any further accumulation of surplus, return surplus levels to the middle of the target range and return value directly to
subscribers through lower rates. Indeed, we believe such actions are the very essence of ‘community health reinvestment.’

Id. at 9.

In Question (g), the June 14 Order asks “[w]hether there were any negative contributions to surplus made by GHMSI that should be taken into account for the plan.” June 14 Order at 20. As set forth in Exhibit 2 (attached), GHMSI’s small group and individual rate filings demonstrated a consistent and dedicated approach to rate moderation through the use of negative contributions to reserve, which resulted in a $42.44M reduction in surplus from 2011 through January 2014. Each small group rate filing for effective dates from May 1, 2011, through January 1, 2013, were filed with a negative contribution to reserve, which resulted in a total of $35.13M being reinvested through rate moderation. 5 Similarly, GHMSI included negative contributions to reserves in its individual rate filings from June 1, 2011, through January 1, 2014, which resulted in a reduction of surplus of $7.31M. 6

5The following small group rate filings include a reduction in surplus as a negative contribution to reserve: CFAP-127044248 (effective May 1, 2011); CFAP-127118704 (effective August 1, 2011); CFAP-127350283 (effective November 1, 2011); CFAP-127388738 (effective January 1, 2012); CFAP-127779155 (effective April 1, 2012); CFAP-128093858 (effective July 1, 2012); CFAP CFAP-128355618 (effective October 1, 2012); and CFAP-128650978 (effective January 1, 2013). As part of the Proposed Rate Change Deviation and Pricing Pages included with these filings, GHMSI included two sets of rate changes: the “Required Rate Change” and “Proposed Rate Change.” The Required Rate Change is the change necessary to achieve the “Contribution to Reserve” identified under the Company’s proposed retention. In each filing, to demonstrate a negative contribution to reserve, GHMSI included either (1) an express negative Contribution to Reserve in the schedule, with an identical Required and Proposed Rate Change, or (2) a Proposed Rate Change that was less than the Required Rate Change, which resulted in a reduced retention and a negative Contribution to Reserve.

6From the period of 2011 through January 1, 2014, 24 of GHMSI’s 27 individual (under 65) rate filings included a reduction in surplus as a negative contribution to reserve: CFAP-127049232, CFAP-127049232, CFAP-127049176 (effective June 1, 2011); CFAP-127074908, CFAP-127074181 (effective July 1, 2011); CFAP-127159629, CFAP-127159563 (effective October 1, 2011); CFAP-127360767, CFAP-127360790 (effective January 1, 2012); CFAP-127812299, CFAP-127812318 (effective April 1, 2012); CFAP-128088866 (effective July 1, 2012); CFAP-128343804, CFAP-128343860 (effective October 1, 2012); CFAP-128659634, CFAP-128659635 (effective January 1, 2013); CFAP-128718533 (effective April 1, 2013); CFAP-128902801, CFAP-1289085891 (effective July 1, 2013); CFAP-128905891 (effective October 1, 2013); and CFAP-12919773 (effective January 1, 2014). These filings also included negative contributions to reserve as described in Note 5.
GHMSI clearly explained these reductions to DISB as part of its January 1, 2012, rate filing:

As of 12/31/10, the “Risk-Based Capital” (RBC) percentage for GHMSI was 1098%. In 2011, two independent actuarial consultants, Milliman and the Lewin Group, updated their recommended optimal RBC range to reflect the impact of federal healthcare reform. Based on their surplus evaluations, management filed with their respective regulators revised GHMSI RBC ranges of 1000% - 1300% (Board Approved). These ranges have increased significantly over the previous ranges that were set in 2008, which were 750%-1050%.

For the 8/1/11 filing, prior to the approval of the new GHMSI RBC, the year-end RBC of 1098% was above the high end of the 2008 range. Our Board RBC policy prescribes that we reduce rates to invest the surplus in our subscribers when we are above the high end of the range, which is why the Contribution to Reserve target was set negative for the 8/1 filing.

GHMSI response to Objection 1, SERFF Tracking Number CFAP-127388738 (Oct. 13, 2011) (emphasis added). As further stated in the response, GHMSI’s filing for rates effective January 1, 2012, was after board approval of new RBC ranges, which were higher than previous ranges. As a result, GHMSI would need to increase its surplus, but would do so gradually, while continuing to include a negative contribution to reserve through the use of filed rate changes that were less than the rate change necessary for a positive contribution to reserve.

GHMSI’s rate moderation activities were also well communicated to the market, and circulated to the broker community as part of a CareFirst Sales Flash for rate effective May 1, 2011. In the Sales Flash, brokers, general and full-service producers were all told that:

Consistent with its mission, CareFirst strives to set rates that make health coverage affordable for the maximum number of residents in the communities that we serve, while maintaining prudent financial stability. Health insurers nationally have seen health care spending decrease from levels projected in late 2009 and early 2010. As a result CareFirst is moderating rates even in the face of the uncertainties posed by federal health care reform.

CareFirst Sales Flash, March 8, 2011 (emphasis added) (attached as Exhibit 3).
To the extent that the June 14 Order speculates that rate moderation may have been motivated by market factors, such speculation is both unsupported in the record and irrelevant. Nothing in the definition of community health reinvestment hinges on GHMSI’s intentions – it applies so long as GHMSI has made an expenditure that benefits its subscribers or the community. Here, however, GHMSI intended to moderate rates, continued its program of rate moderation for 2012 through 2014, and incurred $62 million in underwriting losses as a result. It defies logic to conclude that such rate reductions and moderation may be ignored.

D. GHMSI’s Contributions To Healthy DC Were Taken from “Excess Surplus.”

In 2012 through 2014, GHMSI was required to provide $5 million to the Healthy DC fund each year. These funds did not come from premium dollars – GHMSI’s premium receipts in the District were insufficient to recover even its day to day operating expenses. There can be no reasonable dispute whether this $15 million contribution to Health DC constitutes a community reinvestment – “community health reinvestment” includes any “expenditures that promote and safeguard the public health or that benefit current or future subscribers.” D.C. Code § 31-3501(1A).

It does not matter whether such expenditures are required under a statute or under a public-private partnership agreement – the definition of community health reinvestment applies to any expenditure within the scope of the definition, not merely to voluntary expenses. Id. The remedial provisions of the MIEAA similarly make no distinction between community reinvestments that are required by law and ones that are voluntary – either may reduce surplus and either must be properly considered in any plan to dedicate excess surplus.

Where GHMSI incurred $62 million in underwriting losses during the period of 2012 to 2014, it cannot reasonably be concluded that this $15 million contribution was included in or
paid out of received “premiums.” It was not – GHMSI’s surplus provides the only source for such payments. To the extent that these contributions caused a reduction in GHMSI’s District-attributed surplus (which they did), they must be recognized as a reduction of excess surplus in any remedial plan.

E. GHMSI’s Open Enrollment Losses Were Taken from “Excess Surplus.”

In 2012, 2013 and 2014, GHMSI provided $24 million in subsidies for the District’s open enrollment program ($7.5 million in 2012, $10.3 million in 2013, and 6.2 million in 2014). Again, there can be no reasonable dispute that such subsidies constitute community reinvestment – they are plainly expenditures of GHMSI “that benefit current or future subscribers.” D.C. Code § 31-3501(1A). Nor can one reasonably argue that such subsidies were included in premium dollars, where the subsidies were specifically provided because premiums were inadequate to cover costs, and where GHMSI incurred $62 million in underwriting losses during the same period. As with the Healthy DC contributions, to the extent that GHMSI’s District-attributed surplus was reduced by these subsidies, the subsidies must be recognized as a reduction of excess surplus in any remedial plan.

F. DISB Has No Authority To Develop And Then Approve Its Own Surplus Distribution Plan, Other Than Denying Rate Increases For 12 Months.

The MIEAA did not confer upon DISB the power to develop and then “approve” its own surplus distribution plan. The MIEAA sets forth a particular process that DISB must follow, identifies the precise determinations that DISB must make, and then specifies precise remedies that only apply after a finding of excessiveness. These remedies specifically provide only two alternatives: (1) a plan submitted by GHMSI or (2) a decision by DISB to deny premium increases for twelve months. See D.C. Code § 31-3506(i) (emphasis added). DISB’s own
regulations refer only to the specific remedy of denying premium rate increases, and do not specify any other potential remedies that DISB may order. See D.C.M.R. 26-A4603.3.

The remedy provided in the MIEAA, to deny premium increases for twelve months, is precisely in line with the DISB’s authority to review surplus annually, and its role in approving annual rates. After DISB freezes rates for twelve months, DISB may on the next surplus review continue to freeze rates if any excess surplus remains. This remedy provides a limited exception to the general requirement that rates must be adequate, and it is consistent with the requirement in the GHMSI Charter that GHMSI must be operated solely for the benefit of its subscribers. DISB has no authority to replace the statutory remedy set out in the MIEAA with its own remedial plan.

CONCLUSION

For all of the foregoing reasons and those stated in prior submissions, GHMSI respectfully requests that DISB engage with Maryland and Virginia to achieve a joint resolution of the issues raised by this case as required by MIEAA and GHMSI’s Federal Charter before issuing any remedial plan or final Order.

7However, the DISB must first obtain approval of Maryland and Virginia under the Charter before GHMSI’s rate increases can be frozen, as the freezing of any rate increases will be used as a means to distribute excess surplus.
June 1, 2011

The Honorable William P. White
Commissioner
D.C. Department of Insurance, Securities and Banking
810 First Street, NE, Suite 701
Washington, DC 20002

Dear Commissioner White:

Pursuant to DCMR Sections 4601.1-4601.2, Group Hospitalization and Medical Services, Inc. (GHMSI), an affiliate of CareFirst, Inc. (CFI), submits this Report on GHMSI's surplus as of Year-End 2010. Also included is a brief summary of the history of GHMSI's surplus positions as well as related information and background material to provide context intended to aid your review. The major points discussed below are as follows:

- GHMSI’s surplus at Year-End 2010 was 1098 percent Risk-Based Capital - Authorized Control Level (RBC-ACL), up from 902 percent at Year-End 2009, as a result of an unprecedented, industry-wide drop in medical care trend costs.

- When it became clear that medical care costs would be lower than anyone had anticipated, GHMSI began taking steps to limit surplus, including filing for premium rate reductions where appropriate.

- In light of the changes and uncertainty accompanying federal health care reform, GHMSI commissioned new actuarial evaluations of its appropriate surplus range from two separate independent experts. Those reports identified substantial new risks posed by federal health care reform and recommended surplus ranges of 1050-1300 percent RBC-ACL and 1000-1550 percent RBC-ACL.

- The Boards of CFI, GHMSI and CareFirst of Maryland, Inc. (CFMI) have reviewed these recommendations and chosen to adopt for GHMSI the lower recommended figure for both the bottom and top of the range, producing a target of 1000-1300 percent RBC-ACL for the period 2011-2013. GHMSI plans to re-evaluate surplus requirements by mid-2013 in light of what will undoubtedly be the availability of substantially more data on the impacts of federal reform.

- GHMSI continues to give generously to the community in order to serve the most vulnerable populations in our community, contributing nearly $55 million in community health reinvestment in 2008-2010.
Background and History

This report follows the issuance last year of two orders by the Commissioner of the Department of Insurance, Securities and Banking (DISB) regarding GHMSI's surplus level in 2008. On August 6, 2010, the Commissioner issued an initial Decision and Order which, among other things, addressed the two-part statutory test for surplus required under the Medical Insurance Empowerment Amendment Act (MIEAA), after extensive public hearings and examining five reports submitted by various actuarial experts in connection with the proceeding.

The Decision and Order noted that, despite using varying methodologies to calculate an appropriate RBC-ACL for GHMSI's surplus, the results of four of the five expert reports "overlap substantially." One of these reports was performed by the expert Inotex Group (Inotex) engaged by the Maryland Insurance Administration (MIA) to review both GHMSI's and CFMI's surplus positions. The DISB Commissioner accorded no weight to the fifth report by Actuarial Risk Management (ARM) retained by the DC Appleseed Center. The Decision and Order noted that "all four ranges determined by the experts include the RBC-ACL range of 750% to 850% as a subset."

However, the Commissioner declined at that time to reach a decision about a reasonable surplus level for GHMSI, noting that two events following the experts' reports – federal health care reform and certain statutory changes in the District of Columbia that limited GHMSI's ability to increase rates – could affect GHMSI's future risks and surplus needs. Accordingly, the Commissioner reopened the record, in particular seeking additional input on the impact on GHMSI's surplus needs resulting from federal health care reform.

Following receipt and evaluation of additional reports from the experts, the Commissioner on October 29, 2010, issued her Final Decision and Order in which she established 850 percent RBC-ACL as the approved surplus level and accordingly determined that GHMSI's Year-End 2008 surplus of 845 percent RBC-ACL was not unreasonably large. While noting that GHMSI's surplus had increased to 902 percent RBC in 2009, the Commissioner recognized that "the Federal Health Care Reform Act may have a financial impact on GHMSI in the short term that warrants a higher level of surplus." The Commissioner noted that "the underlying assumptions of this review [the 2008 review] are expected to change." Hence, her Final Decision and Order stated that the DISB would undertake a new review of GHMSI's surplus by July 2012, after federal rules and their likely impacts were more thoroughly understood.

This process followed by the Commissioner, as well as her decision, were entirely consistent with the MIEAA which requires the Commissioner to periodically review GHMSI's surplus (annually in the discretion of the Commissioner, but no less frequently than every three years). The Commissioner must "review the portion of the surplus of the corporation [GHMSI] that is attributable to the District and may issue a determination as to whether the surplus is excessive." D.C. Code §31-3506(e). GHMSI's surplus may be considered excessive only if:

1. The surplus is greater than the appropriate risk-based capital requirements as determined by the Commissioner for the immediately preceding calendar year; and

2. After a hearing, the Commissioner determines that the surplus is unreasonably large and inconsistent with the corporation's obligation under §31-3505(a).

Id. This latter clause refers to a provision that requires "[a] corporation [to] engage in community health reinvestment to the maximum feasible extent consistent with financial soundness and efficiency." Id. § 31-3505.01. It is noteworthy that "community health reinvestment" is defined to mean "expenditures that promote and safeguard the public health or that benefit current or future subscribers, including premium rate reductions." Id. §31-3501(1A).
As a plain reading of the statute reveals, surplus must be both "unreasonably large" and "inconsistent" with the obligation to engage in community health reinvestment if it is to be considered "excessive" by the Commissioner. Based on the substantial record of largely overlapping expert analyses developed pre- and post-public hearing, the Commissioner determined that GHMSI's surplus level in 2008 was not unreasonably large.

**Coordination with Maryland**

MIEAA requires the Commissioner to coordinate with other jurisdictions in reaching any determination on GHMSI's surplus. For purposes of DISB's 2008 surplus review this was facilitated by the fact that the MIA performed its own extensive analysis of GHMSI's surplus at essentially the same time as the matter was under review at the DISB. As noted above, the MIA used its own outside expert – Inovex – whose results were included in the DISB Commissioner's review and referenced in her Orders. The MIA came to the same conclusion on the same set of facts: that GHMSI's surplus was "neither unreasonably large nor excessive." The MIA issued its own order to this effect in January 2010. In so doing, it established a target surplus range for GHMSI of 700-950 percent RBC. Chart 1 shows GHMSI's RBC in the context of the lowest and highest of the four recommended ranges to which the Commissioner gave weight.

**Chart 1**

**GHMSI Recommended 2008 Target RBC Range**

Recently, at the MIA's request, GHMSI and CFMI negotiated and executed a Consent Order with the MIA that provides a framework in Maryland for establishing a balance in the setting and regulatory review of surplus. This Consent Order, along with an accompanying letter from the companies on the matter of establishing targeted surplus ranges, is provided for reference as Attachment A in light of the MIEAA's coordination requirement. Finally, we understand that MIA has taken steps to retain outside expertise in its review of GHMSI's new targeted surplus range under the Consent Order and expects to get underway with this review over the next several months. This will provide an important new reference point which we believe should be taken into account by the DISB as part of its coordination with Maryland regulators.
CareFirst Surplus Policy
In 2008, well before the Commissioner’s 2010 orders, the Boards for GHMSI, CFMI and CFI collectively adopted a policy on the interaction between surplus, rate setting and community giving. This policy is titled Summary of CareFirst BlueCross BlueShield’s Approach to Community Giving in the Context of its Role as a Not-for-Profit Health Plan and is attached to this letter as Attachment B. Simply put, this policy provides that the companies establish a surplus range for each affiliate no less frequently than every three years based on the best possible expert advice from highly qualified independent actuaries. The range for each affiliate is intended to be appropriate, reasonable and prudent, with a midpoint that serves as the target surplus level each affiliate strives to maintain.

The policy provides that should one of the affiliates be low in its intended range (i.e., below midpoint, or below the bottom of the range as is currently the case for CFMI), the affiliate would include a margin in its rates to slowly build up its surplus position toward the midpoint of the range. Conversely, if an affiliate were high in its range or above its intended range, the affiliate would remove any margin in its rates or even reduce rates below cost to bring surplus back to the midpoint of the intended range.

Thus, the companies seek to hold only the level of surplus necessary to preserve their financial solvency and meet their financial needs – and no more. The target level is the midpoint of a range for each affiliate that reflects each affiliate’s particular risk profile and financial solvency needs. It is the responsibility of the Boards of CFI and its affiliates to establish the appropriate targeted surplus range in the first instance. To do otherwise would strip accountability from them – thereby seriously undermining their duty to protect subscribers and drive to remain viable and competitive in the market and press on with infrastructure and product enhancements.

CareFirst Community Giving Policy
GHMSI believes that the Congressional Charter under which it operates and the fulfillment of its mission require it to provide the lowest possible rates for its subscribers and that this represents the greatest good it can do for the larger community it serves. In other words, rate moderation constitutes the best and most effective way for GHMSI to make a “community health reinvestment.” As shown above, MIEAA explicitly recognizes rate moderation and reduction as “community health reinvestment.” Indeed, there is a long history of this view, going back to then-DISB Commissioner Lawrence Mirel’s 2005 finding that GHMSI could fulfill its obligation to the community and carry out its mission solely by service to its subscribers.

Nevertheless, beyond keeping premium rates as low as possible, GHMSI takes its commitment to give to its community very seriously. To this end, GHMSI gives generously to a wide range of community organizations and causes. The level of this community giving has risen steadily to its highest levels in recent years, totaling nearly $55 million in the three years 2008-2010. This is shown in Chart 2.
When the premium taxes GHMSI pays to the District of Columbia are added to its other community giving, GHMSI's "community health reinvestment" is among the most robust in the nation relative to other Blue Cross and Blue Shield plans. Indeed, GHMSI was recently recognized in the Washington Business Journal as the second most generous corporate contributor in the District, giving to various worthy causes that focus heavily on the most vulnerable populations in the community. These contributions to the community are important to GHMSI - but they also represent a substantial cost to subscribers, and as a result GHMSI's Board of Trustees must be careful to balance community giving against subscribers' need for the lowest possible rates.

The Nature of the Challenge in Surplus Setting
Setting a prudent surplus level for a company like GHMSI is a complex undertaking that requires special expertise and sophisticated computer-based modeling. The results of modeling must then be passed through the filter of experience and sound actuarial/business judgment. The task is somewhat similar in nature to determining the stress-bearing capabilities of a suspension bridge under varying loads of traffic, wind, currents and earthquake risks. What effect on the bridge's stability will all these forces have when taken individually or in various combinations? And, what degree of confidence does one want when crossing the bridge - 90 percent? 98 percent? 100 percent? To reach an answer requires special expertise and knowledge.

The stresses on GHMSI are considerable and constantly shifting. Risks range from capital market risks and customer payment risks to misjudging medical care cost trends for thousands of individuals and small groups with different demographics, products and health risks. GHMSI's risk exposure is accentuated by the fact that it is a one product line-one region company of modest size when compared to the multi-region, multi-product line profiles of its primary competitors. It is also seen as a preferred source of insurance services by those most in need of such services - a place of safety for adverse risks. Indeed, GHMSI's own policies induce this perception since they convey the intent of the company to reach and serve as many of these risks as possible consistent with the requirements of solvency and competitiveness.

Further, GHMSI must serve as its own source of funding for investment in new health coverage plan products and their underlying technologies. This must occur in an increasingly demanding and rapidly changing environment where complexity is increasing nearly exponentially and where national competitors have deeper pockets. To meet these demands, GHMSI can take on debt only under extreme limitations and cannot issue
shares to raise capital and surplus. It must fund all initiatives out of its own cash flow and surplus. And, it knows from hard experience that were it to run into serious financial difficulty, there are no safety nets or bailouts from government at any level.

Now, the era of federal health care reform is dawning and adds tremendously to the complexity and uncertainty of the environment in which GHMSI must operate. The advent of minimum medical loss ratio requirements with their attendant rebate exposure, unreasonable rate limits, risk adjustments, stringent benefit/coverage requirements, guaranteed issue of policies to all comers and a host of other newly imposed obligations and standards create crosswinds and stresses on the GHMSI "bridge" to a degree never envisioned. New product standards, new methods of bringing products to market (Insurance Exchanges) and the unintended effects of all these things – when taken together – creates uncertainty in outcome at a level never known before. All of this occurs without removing or mitigating the considerable risks that have historically defined the nature of the business.

Indeed, there is an asymmetrical nature to the risks GHMSI now faces. The speed, agility and range of action the company may be able to take in reaction to a worsened risk profile are all constrained – and will continue to be increasingly constrained by federal health care reform – while the risks and unknowns are augmented. In short, the Commissioner was correct in saying that the assumptions and conclusions reached in the relatively placid "old" world of 2008 may no longer apply to the "new" more stormy and uncertain world of early reform (2010-2013) in which the company now operates. The later stages of reform (2014 onward) are likely to further exacerbate both the risks and the constraints on GHMSI in dealing with them.

The central point here is obvious: Setting surplus levels wisely and correctly is a complex undertaking. In this case, for GHMSI the correct surplus level must allow the company to reliably bear up under the heavy traffic loads it handles for its subscribers and the larger community with little or no margin for error and no government safety net.

Nevertheless, GHMSI recognizes the legitimate concern of government to see to it that the drive for solvency does not lead to excess in surplus any more than it should lead to insufficiency. The CFI and GHMSI Board of Trustees, as explained above, have put in place policies in an effort to assure that excess surplus is not maintained. And, these policies have been put into practice – principally through rate moderation and rate reductions as explained below.

**Updated Actuarial Analyses Reveal Need for Higher Surplus Level**

In recognition of the changing environment described above, the GHMSI, CFMI and CFI Boards decided to undertake an immediate, comprehensive review of the current surplus levels of the affiliates and of the companies as a whole. This new review was undertaken sooner than company policy calls for (i.e., less than three years after completion of the last reviews) in light of the already-emerging impacts of federal health care reform.

Milliman, Inc. (Milliman) and The Lewin Group (Lewin) were asked to conduct these de novo reviews because of their status as leading, nationally recognized experts in the field of actuarial science, their breadth of experience with other Blue Plans, and their familiarity with the circumstances, experience and history of the companies. Each was given full access to all underlying company experience and data and each was instructed to conduct its review completely independently. Each used its own different, proprietary methodological approach. Neither spoke to nor consulted with the other in any way.

In essence, the Boards wanted to know whether their approved surplus range for GHMSI of 750 to 1050 percent RBC-ACL was still appropriate, reasonable and prudent given the changing landscape the company
was entering. Hence, the review was forward-looking and is meant to apply to the period 2011-13. Based on its extensive work, Milliman has made a recommendation that GHMSI’s target surplus range be raised to a range of 1050 to 1300 percent of RBC-ACL. It notes in its report that when the full impacts and details of federal health care reform are known, an additional 100-150 percentage point increase in this new range may be called for. For its part, Lewin recommends a new, broader range of between 1000 to 1550 percent of RBC-ACL. These ranges overlap substantially even though they were arrived at through different methodologies. The firms’ full reports are attached as Attachments C and D.

Both firms based their ranges on confidence levels ranging from 90-95 percent certainty that GHMSI’s surplus would not fall below the 375 percent BCBSA early warning monitoring threshold (requiring special reporting and aggressive financial management) and a 95-98 percent confidence level that GHMSI would not fall below the regulatory and loss of trademark threshold of 200 percent RBC-ACL. The reports explain why these confidence levels are appropriate, and why each range suffices to give GHMSI reasonable assurance against dropping below these thresholds. But, even these degrees of confidence still leave some risk that the lower threshold will be pierced, to the detriment of GHMSI and its subscribers.

The CFI, CFMI and GHMSI Boards extensively reviewed and discussed these recommendations during their regular committee and full Board meetings in May. They decided to adopt the lower recommended figure for both the top and bottom of the range, thus producing a target range of 1000 percent of RBC-ACL (Lewin’s low end) to 1300 RBC-ACL (Milliman’s high end) on a going-forward basis for the next 24 months. The Boards called for a full new review by mid-2013, at which point the Boards should have a far more complete understanding of the impacts of federal health care reform. The newly adopted range is shown in Chart 3 below. The new ranges are in effect immediately.

**Chart 3**

**GHMSI Approved Target RBC Ranges**

GHMSI’s Current Surplus Level
GHMSI’s surplus stood at 1098 percent RBC-ACL at Year-End 2010, a rise of 196 points from Year-End 2009. That increase was the result of an unforeseen, and precipitous, drop in what had been an upward trend for medical care costs. As was the case with most health insurance carriers in the U.S. last year, GHMSI saw
overall medical care cost trends plummeted in 2010 to a level last seen in the early 1990’s. No one, including the company itself, predicted this. Nor is anyone, including the company, sure of how long and to what degree it will last. Chart 4 shows this abrupt downward trend taking hold in 2010.

Chart 4

GHMSI Overall Risk Medical Trends (2006-2010)

This drop in trend had several effects on GHMSI’s financial results. First, GHMSI saw an increase in its underwriting margin, which rebounded from a slight loss in 2009 to a gain of approximately 2 percent. 2009 was the low point in underwriting performance for the company in the last decade – a ten year period that saw average gains of 1.7 percent and a high of 3.9 percent in 2004. On the strength of this improvement in underwriting gain as well as strong returns in the financial markets in 2010, GHMSI’s overall net income rose to 3.0 percent – a better than average year when looking back over the past decade, as reflected in Chart 5. The combination of the decline in medical care cost trends and the strong returns in capital markets translated into the increase in GHMSI’s surplus, which resulted in a higher RBC-ACL for GHMSI.

Chart 5
CareFirst/GHMSI Actions to Date in Accordance with its Policy
As the positive trends began to emerge in 2010, GHMSI began to act. It did so principally by filing ever-more moderate premium rate increases. This began in late 2010 and has continued into 2011 with each passing quarter as greater credibility was assigned to the emerging slowdown in the rise of medical costs. Chart 6 shows this data.

Chart 6
Average Renewal Rate Increases Individual and Small Group
Filed with and Approved by DISB

In 2011, GHMSI took the initiative to file for premium rate reductions with the DISB, as did BlueChoice where operating results were unusually strong. GHMSI is closely monitoring emerging trends to assess any changes in direction, particularly a reversion to the former, higher mean. This reduction/moderation in premium rates is a self-initiated set of coordinated actions that are designed to prevent any further accumulation of surplus, return surplus levels to the middle of the target range and return value directly to subscribers through lower rates. Indeed, we believe such actions are the very essence of “community health reinvestment.”

Now, there is a new surplus range that must be addressed. The company expects to continue to moderate or reduce premium rates for as long as trends indicate this is the correct course. The 2010 ending level of 1098 percent of RCB-ACL is not quite at the middle of this new range. The company’s objective remains the same: Keep the actual surplus at the middle of the new range through rate filings that prevent any further strengthening in surplus over the next two years until a new assessment can be made regarding the appropriateness of GHMSI’s surplus level.

Conclusion
GHMSI is striving by its policies and its actions to carry out the mandates of its Congressional Charter and to operate within both the spirit and letter of the law in the District of Columbia. In furtherance of this, the Boards of GHMSI, CFMI and CFI have sought expert advice – on a timely basis – to assure that the companies operate with financial soundness within the ever changing environments in which they find themselves. The judgment the Boards bring to the issue of how much surplus GHMSI must carry is undertaken only after obtaining the best possible advice from leading experts.
The Boards have reviewed and adjusted surplus ranges as necessary. They have overseen the filing of self-initiated premium rate reductions that carry out a policy of community health reinvestment. They have seen to it that company resources are invested wisely and conservatively so that investment returns can contribute to increasing the affordability of health care coverage and lessen the financial burdens borne by subscribers who carry CareFirst coverage. They have seen to it that substantial community giving is carried out — indeed the most of any carrier in the region and the nation — with a particular focus on the most vulnerable and disadvantaged among us. And, they have used community giving to spur catalytic changes in the health care system that hold promise for more effective cost control in the future while stimulating improvements in quality as well.

It is GHMSI’s view that a sound process for properly establishing and monitoring surplus level — and its close interconnection to community giving and premium rates — has been followed with great attentiveness, thoughtfulness and seriousness. Neither our Boards nor anyone else predicted the Great Recession, or the meltdown in the financial markets in 2008, or the positive impacts of the dramatic drop in medical care cost trends, or even that federal health care reform would become law. This all occurred in just the last three years. What other unknowns lie ahead? GHMSI operates in an ever-changing and uncertain environment — and, even in a good year, produces only slim margins in exchange for the substantial risks it bears.

A surplus level at the mid-point of a range established by the Boards on the coinciding and overlapping advice of two independent experts, we believe, cannot be unreasonably large or excessive. And, premium rate actions designed to keep it there in a changing, even stormy environment, are the very fulfillment of the community health reinvestment objective of MIEAA.

We look forward to discussing the material enclosed and to aiding your review of GHMSI’s surplus in any way we can.

Sincerely,

Chet Burrell
President and Chief Executive Officer
CareFirst BlueCross BlueShield

Cc: Therese Goldsmith, Commissioner (appointed), Maryland Insurance Administration
    Beth Sammis, Interim Commissioner, Maryland Insurance Administration
    Jacqueline K. Cunningham, Commissioner Virginia Bureau of Insurance

Attachments:

A – Consent Decree – Maryland Insurance Administration 05-24-1
B – CareFirst’s Policy: Summary of CareFirst BlueCross BlueShield’s Approach to Community Giving
C – Milliman, Inc. Recommendations on GHMSI Reserves
D – The Lewin Group Recommendations on GHMSI Reserves
## Estimated Negative Contribution to Surplus
### GHMSI Small Group Rate Filings in the District of Columbia

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<th>Proposed Rate Change **</th>
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* This is the rate GHMSI calculated that is necessary to achieve the required contribution to reserve (CIR).

** This is the rate GHMSI filed for approval, and when lower than the Required Rate Change, results in a lower CIR than included in the Required Rate Change.

*** This is the rate and resulting CIR as approved by the DISB.
### Estimated Negative Contribution to Surplus

#### GHMSI Individual Rate Filings in the District of Columbia

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* This is the rate GHMSI calculated that is necessary to achieve the required contribution to reserve (CTR).

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*** This is the rate and resulting CTR as approved by the DISB.
March 8, 2011

Rate Reductions - Pricing Updates Effective 5/1/2011

MARKET: MSGR, VA 1-50, DC 1-50, NON-MSGR/MD PARITY

CareFirst BlueCross BlueShield (CareFirst) and CareFirst BlueChoice, Inc. (collectively CareFirst) are extremely pleased to announce the following rate reductions that have been filed and approved for May 1, 2011. Rates will be updated shortly in the CareFirst rating systems and in the General and Full-Service Producer proposal systems. Please note that the percentages indicated are changes over the 4/1/2011 rate actions. You will notice larger rate reductions in the DC and Virginia markets. CareFirst will revisit the next rate adjustments for DC and VA 1-50 groups sometime in August/September for an October effective date.

Reason for the Rate Reductions
Consistent with its mission, CareFirst strives to set rates that make health coverage affordable for the maximum number of residents in the communities that we serve, while maintaining prudent financial stability. Health insurers nationally have seen health care spending decrease from levels projected in late 2009 and early 2010. As a result, CareFirst is moderating rates even in the face of the uncertainties posed by federal health care reform.

MSGR (Medical and Rx):
- HealthyBlue: 5.0% decrease for non-CDH; 5.0% decrease for CDH

MD Non-MSGR/MD Parity (Medical and Rx):
- No Changes
- Renewal cap remains at 24%; floor is still at 0%

VA 1-50 (Medical and Rx):
- HealthyBlue: 11.0% decrease for non-CDH; 10.7% decrease for HSA; 10.3% decrease for HRA
- GHMSI: 8.2% decrease for non-CDH; 8.3% decrease for CDH
- BlueChoice: 10.9% decrease for non-CDH; 11.8% decrease for CDH
- Renewal cap remains at 34.5%; floor is still at 0%
- New Business discount remains at 12.5%

DC 1-50 (Medical and Rx):
- HealthyBlue: 8.4% decrease for non-CDH; 8.4% decrease for CDH
- GHMSI: 11.3% decrease for non-CDH; 11.1% decrease for CDH
- BlueChoice: 8.2% decrease for non-CDH; 9.2% decrease for CDH
- Renewal cap remains at 34.5%; floor is still at -25.7%
- New Business discount remains at 12.5%

Recent DC Legislation Results in Age Band Adjustments
Earlier this year, the District of Columbia passed Bill 792 the “Reasonable Health Insurance Ratemaking and Health Care Reform Act of 2010” part of which affects rating in the DC small group market. The law
states that “the standard rate for any age shall not be more than 104% of the standard rate for the previous age.” In order to comply, CareFirst will change from the 3-year age band currently used to a single year age band effective 5/1/2011. We will continue to use an average age methodology.

Moving forward, when CareFirst releases rate charts to our General and Full-Service Producers, there will be a total of 41 rows for the DC rates, where there used to be 12. There are no plans to make changes to the MD or VA rate charts, as those age bands will remain the same.

Should you have any questions, please contact your Broker Sales Representative.

Shekar Subramaniam
Associate Vice President, Broker Sales
Exhibit M
MOTION FOR RECONSIDERATION AND
COORDINATED PROCEEDINGS WITH MARYLAND AND VIRGINIA

Group Hospitalization and Medical Services, Inc. ("GHMSI") respectfully seeks reconsideration of the Decision and Order ("Order") dated December 30, 2014. GHMSI also requests that the Commissioner stay the Order, and delay the filing of any remedial plan until 45 days after ruling on GHMSI’s motion for reconsideration.

INTRODUCTION AND GROUNDS

The Order is incorrect on both the facts and the law when it concludes that the portion of GHMSI’s 2011 surplus that is attributable to the District was “excessive,” and seeks to attribute surplus based on a single financial statement filed in a single year. In reaching its conclusions, the Order ignores the Commissioner’s duty to coordinate with other jurisdictions, fails to apply the specific analysis required by the Medical Insurance Empowerment Amendment Act ("MIEAA"), contradicts the factual record, and raises new issues that were not fully reviewed or heard before the Order was issued.

The Order seeks to reduce GHMSI’s surplus at a time that is particularly dangerous for GHMSI. GHMSI’s total surplus level already has declined dramatically due to significant new market risks posed by the Affordable Care Act, and this decline is expected to continue. Between 2010 and the end of 2014, GHMSI’s surplus has fallen from 1,098% RBC-ACL to an
estimated 845% RBC-ACL – a fall of more than 250 points in four years. In 2013 and 2014, GHMSI lost surplus in total dollars, as well as a percentage of risk based capital. The Order ignores the conditions that have caused and continue to cause this drop in surplus.

In particular, the Order contains five key errors that the Commissioner should address here:

1. The Commissioner failed to coordinate his decision with Maryland and Virginia, as required by DC Code § 31-3506(e). “Coordination” under the MIEAA requires far more than merely accepting written testimony – it requires Maryland, Virginia and the District to come to agreement regarding the many multi-jurisdictional issues relating to GHMSI’s surplus. Because of this failure to coordinate, the Order is now in direct conflict with the 2012 order of the Maryland Insurance Administration (“MIA”) regarding GHMSI’s surplus, which requires GHMSI to maintain its surplus between 1,000% and 1,300% RBC-ACL. See Exhibit A hereto. GHMSI cannot comply with both. This inter-jurisdictional conflict violates GHMSI’s fundamental rights under the Due Process and Commerce Clauses of the United States Constitution, both of which forbid states from saddling entities like GHMSI with conflicting regulatory commands.

There are potential conflicts with Virginia as well. On January 21, 2015, the Virginia State Corporation Commission issued an order to the Virginia Insurance Commissioner, directing the Commissioner to examine the Order issued in this case and report on whether the impact of GHMSI is harmful to the residents of Virginia. See Exhibit B hereto.

Maryland and Virginia have strong interests in the regulation of GHMSI’s surplus. Under the Commissioner’s own analysis, 79% of GHMSI’s surplus is attributable to those jurisdictions. Equally important, GHMSI has only one surplus and the entire amount of that
surplus is available to satisfy any debt of GHMSI, no matter where the debt is incurred. A reduction in GHMSI’s financial strength affects GHMSI’s Maryland and Virginia members, regardless of how surplus is attributed. A reduction in GHMSI’s financial strength also affects members in other CareFirst plans. BlueChoice is jointly owned by GHMSI and CareFirst of Maryland, Inc., and 40% of GHMSI’s surplus is BlueChoice surplus held by BlueChoice to ensure its ability to meet obligations to BlueChoice members.

The Order itself has created these conflicts, and accordingly the issues are new ones that could not have been previously raised. As required by D.C. Code § 31-3506(e), the Commissioner must work with the regulators in Maryland and Virginia to resolve such conflicts. Along with this Motion, GHMSI is filing requests with the Insurance Commissioners of Maryland and Virginia, asking each to participate in a consolidated proceeding to determine GHMSI’s proper surplus level and resolve competing attribution claims. The Commissioner should reopen these proceedings and coordinate with these other affected jurisdictions.

2. The Order fails to evaluate whether the portion of GHMSI’s surplus attributable to the District is excessive, and therefore fails to make the analysis required by the MIEAA. Before the Commissioner can require any distribution or reduction of surplus, the Commissioner must specifically find the portion of the surplus attributable to the District of Columbia to be excessive. See § 31-3506(e)-(g). This analysis must start with a determination of the specific surplus and ongoing business attributable to the District of Columbia, and examine the specific surplus needs arising from that portion of the business. The Order does not conduct this analysis, but instead determines only that the entire surplus was excessive, based on factors attributable to GHMSI’s entire business. The Order’s approach does not comply with District law.
3. The Order’s method of attributing surplus to the District is arbitrary and fails to comply with the MIEAA. Attribution of surplus requires a determination of which jurisdiction contributed to the surplus over time. This was not done. Instead, the Order relies primarily on premium filings in a single year, and does not attempt to determine which business segments in which jurisdictions generated the profits that built the surplus.

As a result, the Order does not address any of the complexities that must be resolved before determining how GHMSI’s surplus was built up over time (literally since the beginning of its operations). For example, the Order does not consider how to address the portion of surplus generated by investment income despite the large portion of surplus so built, nor does it consider how BlueChoice or other sources contributed to surplus, even though those contributions are significant. Because it fails to conduct the required analysis, the Order likely misappropriates surplus dollars generated in Maryland and Virginia for the benefit of District residents. The Order’s method of attribution is incorrect both as a matter of law and in its result, thereby injuring the interests of the other jurisdictions.

4. The Order’s use of a 95% confidence level with respect to the risk of dropping to 200% RBC-ACL is arbitrary and capricious, because the overwhelming evidence presented throughout the proceedings does not support such a conclusion. The record demonstrates that 98% is the appropriate confidence level, and the Order fails to articulate any reason based on supporting evidence to justify the 95% standard. In fact, the 95% confidence level is inconsistent with the Order’s findings as to the severe effect on GHMSI, its members, and the District’s insurance market if GHMSI were to drop to 200% RBC-ACL, fall into regulatory supervision, and lose its membership in the Blue Cross and Blue Shield Association.
5. There is no evidence or legal support for the use of a single surplus target point, rather than a surplus range. It is intrinsic that surplus fluctuates month to month and quarter to quarter as well as on an annual basis. To the extent that the Commissioner is concerned that the upper bound of a range should not be treated as a “target,” that concern is easily and directly addressed. GHMSI can seek the mid-point of a range, and develop its rates accordingly. The MIA has ordered just such an approach, which can serve as a ready model. It must be recognized that GHMSI cannot cause a specific surplus outcome to occur. Actual results will vary both above and below any target level. If a single target point is used, the only way GHMSI could avoid having “excessive” surplus, and being subject to a future order to reduce surplus, would be to ensure that it maintains too little surplus, falling below the target point every time. That result would be directly contrary to the MIEAA’s command that GHMSI should retain the level of surplus needed to remain financially sound.

For these reasons, and those set forth below, the Commissioner should withdraw and reconsider his December 30, 2014 Order and reopen these proceedings. The Commissioner also should stay the filing of any remedial plan until after this motion is decided. The issues raised in this motion are material, and each of them has the potential to significantly alter the Order and the contents of any plan.

ARGUMENT

I. The Commissioner Should Hold Joint Proceedings With Maryland and Virginia To Resolve the Conflicts Raised by the Order and Address the Order’s Extraterritorial Effects.

A. The MIEAA Requires the Commissioner to Actively Resolve the Conflict Between the Order and Maryland’s 2012 Consent Order.

The MIEAA requires that the Commissioner’s review must “be undertaken in coordination with the other jurisdictions in which the corporation conducts business.” D.C. Code
§ 31-3506(e). In 2012, the Maryland Insurance Commissioner entered an order that “[t]he approved targeted surplus range for GHMSI effective from the date of this Order shall be 1,000% to 1,300% of its authorized control level risk based capital.” Exhibit A, Order of Maryland Insurance Commissioner, at 7. GHMSI is required to maintain its surplus towards the midpoint of that range. Id. In approving this targeted range, the Maryland Commissioner did not assert that some portion of the surplus was attributable to Maryland or to GHMSI’s business in Maryland; rather, the surplus was treated as an indivisible asset available to protect the solvency of the entire company and to ensure payment of all subscribers’ claims without regard to jurisdiction. The MIA issued this order after an extensive process, including an independent, expert review. Id. at 5-7.

While the Order acknowledges the existence of the Maryland order, it does nothing to resolve the conflict between the two. It is not possible for GHMSI to retain its surplus at the 1,000% to 1,300% RBC-ACL level required by Maryland while also reducing surplus to 721% RBC-ACL. By complying with the order of one jurisdiction, GHMSI necessarily violates the other.

The DISB cannot assume that its order would supersede or override the Maryland order. GHMSI is a unique entity subject to intensive regulation in each of the three jurisdictions in which it operates. While its Congressional Charter provides that GHMSI’s legal domicile is the District, GHMSI has far more business in Maryland and Virginia. GHMSI subscribers who have no contact whatsoever with the District of Columbia are affected by the Order to the same degree as subscribers who live there. In fact, the entire CareFirst holding company is affected. A full

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1 Highlighting the importance of the views of the other relevant jurisdictions, District of Columbia law provides that the Commissioner must also “consider the interests and needs of the jurisdictions in the corporation’s service area.” D.C. Code § 31-3506.01(e).
40% of GHMSI’s surplus belongs to BlueChoice and protects insured BlueChoice members, nearly 88% of whom reside in Maryland and Virginia. CFMI owns 50% of BlueChoice and, when BlueChoice surplus is reduced, CFMI’s own surplus is reduced even though CFMI sells no insurance in the District at all. One jurisdiction cannot simply “go it alone” and ignore the other.

The MIEAA itself requires the Commissioner to actively avoid such a result. “Coordination” means more than simply accepting, and then disregarding, written testimony. See 1618 Twenty-First St. Tenants’ Ass’n v. Phillips Collection, 829 A.2d 201, 204 (D.C. 2003) (observing that statutory terms must “be construed according to their ordinary sense and with the meaning commonly attributed to them”). Coordination “envisions more than unilateral action.” MAMSI Life & Health Ins. Co. v. Wu, 411 Md. 166, 203 n.10 (Md. 2008). It requires parties “to harmonize, work together, or bring into a common action, effort or condition,” Network Commerce, Inc. v. Microsoft Corp., 260 F. Supp. 2d 1034, 1041 (D. Wash. 2003), aff’d 422 F.3d 1353 (Fed. Cir. 2005)—that is, to “work together properly and well” in order “to cause (two or more things) to not conflict with or contradict each other.” Merriam-Webster Online Dictionary, available at http://www.merriam-webster.com/dictionary/coordinate.

In other words, the MIEAA requires the Commissioner to work directly with Maryland and Virginia to ensure that his decision neither conflicts with nor contradicts the decisions issued by those jurisdictions. That coordination has not taken place.

B. Because of the Lack of Coordination and Resulting Conflicting Orders, the Order is Arbitrary and Capricious, and Violates GHMSI’s Constitutional Rights.

Because there was no active coordination in this proceeding, GHMSI is now subject to directly conflicting obligations from its regulators. GHMSI cannot comply with the Order’s requirement that surplus be limited to 721% RBC-ACL, while satisfying the Maryland Order’s
requirement that surplus be maintained within 1,000% to 1,300% RBC-ACL. As a result of this failure to coordinate, the Order is unreasonable and unenforceable, and therefore arbitrary and capricious under the Administrative Procedure Act. See Alliance for Cannabis Therapeutics v. Drug Enforcement Admin., 930 F.2d 936, 940 (D.C. Cir. 1991) (concluding that “[i]mpossible requirements imposed by an agency are perforce unreasonable,” and subject to reversal on the grounds that they are arbitrary and capricious).

Moreover, this conflict infringes GHMSI’s rights under the United States Constitution. An “inconsistency that makes it literally impossible to adhere to one state’s requirements without breaching another’s” violates the Due Process Clause. Lake Carriers’ Ass’n v. EPA, 652 F.3d 1, 8 (D.C. Cir. 2011); accord United States v. Dexter, 165 F.3d 1120, 1125 (7th Cir. 1999). As Justice Black put it, “the very enactment of two statutes side by side, one encouraging” a particular action “and another making it a crime” to engage in that action, “would be contrary to the very idea of government by law. It would create doubt, ambiguity, and uncertainty, making it impossible for citizens to know which one of the two conflicting laws to follow, and would thus violate one of the first principles of due process.” N. Carolina v. Pearce, 395 U.S. 711, 738-39 (1969) (Black, J., concurring in part and dissenting in part).

Such a conflict also violates the Commerce Clause, which “invalidate[s] statutes that may adversely affect interstate commerce by subjecting activities to inconsistent regulations.” CTS Corp. v. Dynamics Corp. of Am., 481 U.S. 69, 88 (1987); accord Healy v. Beer Institute, 491 U.S. 324, 336-337 (1989); Brown-Forman Distillers Corp. v. New York State Liquor Auth., 476 U.S. 573, 585 (1986).2 The Order is particularly subject to Commerce Clause scrutiny because

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2 While some state regulation of insurance is protected by the McCarran-Ferguson Act, 15 U.S.C. § 1011 et seq., that protection does not apply here. McCarran-Ferguson authorizes states to regulate certain aspects of the insurance market and thus cuts back on regulated entities’ ability to challenge insurance regulation under the dormant Commerce Clause. However, the statute’s authorization is a limited one: It
of its extraterritorial effects upon subscribers who have no contact with the District. “A statute that directly controls commerce occurring wholly outside the boundaries of a State exceeds the inherent limits of the enacting State’s authority and is invalid whether the statute’s extraterritorial reach was intended by the legislature.” Healy, 491 U.S. at 336. The “critical inquiry is whether the practical effect of the regulation is to control conduct beyond the boundaries of the State.” Id.; Int’l Dairy Foods Ass’n v. Boggs, 622 F.3d 628, 645 (6th Cir. 2010) (“[A] state regulation that controls extraterritorial conduct is per se invalid.”); Pharm. Research & Mfrs. of Am. v. District of Columbia, 406 F. Supp. 2d 56, 71 (D.D.C. 2005) (holding provision of D.C. Code as applied to certain sales unconstitutional because it had a per se invalid extraterritorial reach in violation of the Commerce Clause).

The Order necessarily regulates conduct in Maryland and Virginia. As discussed in Section I, GHMSI has only one surplus that is available for satisfaction of all GHMSI obligations, and a forced reduction of surplus affects all GHMSI and BlueChoice subscribers. For this reason, and because of the lack of coordination and the direct conflict that has resulted, the Order is arbitrary and capricious under District law and constitutionally defective.

C. The Commissioner Should Hold Joint Proceedings with Maryland and Virginia to Resolve the Conflicting Orders.

GHMSI’s surplus level and the attribution of GHMSI’s surplus raise issues that can only be resolved through agreement between the affected jurisdictions. It is for that reason that the MIEAA expressly requires the Commissioner to coordinate his review. D.C. Code § 31-3506(e). Along with this Motion, GHMSI is filing requests with the Insurance Commissioners of

Maryland and Virginia, asking each to participate in a coordinated proceeding to determine
GHMSI’s proper surplus level and resolve competing attribution claims. The Commissioner
should withdraw the Order until that proceeding is complete and the conflicts have been
resolved.

II. The Commissioner Failed to Conduct an Analysis of Whether the Surplus
“Attributable to the District” was Excessive.

The Order should be reconsidered because it does not apply the analysis required by
MIEAA. The MIEAA instructs the Commissioner to “review the portion of the surplus of the
corporation that is attributable to the District” and determine whether that portion is excessive.
D.C. Code § 31-3506(e) (emphasis added). Only after making that specific determination can
the agency “order the corporation to submit a plan for dedication of the excess to community
health reinvestment in a fair and equitable manner.” Id. § 31-3506(g)(1). The Order makes no
such finding, but instead finds that the “appropriate level” for GHMSI’s entire surplus is 721%
RBC-ACL, and that GHMSI’s surplus is excessive because the entire surplus as of December 31,
2011 stood at 998% RBC-ACL. Order at 49-50. This is not the analysis required by MIEAA.

MIEAA’s requirement that the Commissioner must analyze the surplus caused only by
one jurisdiction is necessarily different from the review of a company’s overall surplus. A
company’s overall surplus is not limited by jurisdiction, but is affected by the conditions in every
market in which the company operates. To perform the analysis that MIEAA requires, the
Commissioner cannot focus on GHMSI as a whole, but must look at both the surplus level and
the surplus need that is specific to the District. Different markets have different medical cost
trends and medical claims ratios, benefit mandates, and rates of premium growth, among other
things. The Commissioner cannot determine whether the surplus attributable to the District is
excessive until it is compared to the specific surplus requirements for business in the District. This review is very different from an assessment of GHMSI’s overall surplus needs.

GHMSI did not object to the Commissioner’s initial review of GHMSI’s total surplus, because it is not, in fact, excessive, and because the surplus needs of the District alone will necessarily be higher than the surplus needs of GHMSI as a whole. As GHMSI warned during the first review under MIEAA, “[i]f one were . . . to divine a way to calculate an RBC for a subset of GHMSI’s total service area, the RBC ‘attributable to D.C.’ by necessity would be higher—perhaps dramatically higher—than the optimal RBC range Milliman has calculated for GHMSI as a whole.” GHMSI Pre-Hearing Br. for 2008 Surplus Review, Attachment E at 27 n.27.

This higher RBC requirement is true for several reasons. First, the business conducted by GHMSI in the District is much smaller than GHMSI’s entire book of business, and therefore inherently more volatile. A higher RBC level is required to address such volatility: “The ratio of reserves an insurer needs to ensure financial soundness generally rises in inverse proportion to the company’s size; the smaller the subscriber base over which to spread risk, the greater the reserves needed to guard against an unexpected medical or financial catastrophe.” Id. Pennsylvania reached the same conclusion when it determined that its smaller non-profit health plans had higher RBC requirements than larger plans.3 Second, surplus requirements turn on risk, and GHMSI faces risks in the District that are different than it faces in Maryland and

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Virginia, such as a smaller market, a different health benefit exchange, and the lack of any off-exchange sales.

Unless and until the DISB makes the finding required by statute, it lacks the statutory authority to order a remedial plan. Under the MIEAA, the Commissioner “shall order the corporation to submit a plan for dedication of the excess to community health reinvestment” only if the Commissioner has found that “the surplus of the corporation that is attributable to the District is excessive.” D.C. Code § 31-3506(f), (g)(1) (emphasis added). “An administrative agency is a creature of statute and may not act in excess of its statutory authority,” and “[t]he purported exercise of jurisdiction beyond that conferred upon the agency by the legislature is ultra vires and a nullity.” *District of Columbia Office of Tax & Revenue v. Shuman*, 82 A.3d 58, 67 (D.C. 2013) (citations omitted). The Commissioner has power to order a remedial plan if and only if he finds that the portion of the surplus attributable to the District is excessive. The Order does not make that finding – it finds only that the entire surplus is excessive.

Without a specific analysis of the surplus needs attributable to the District relative to the actual size of the surplus attributable to the District, it is also factually impossible to implement any remedial plan. Even if 721% RBC-ACL were determined to be the correct surplus target applicable to GHMSI’s entire surplus, it is impossible to know how much surplus would need to be reduced or distributed to achieve that target without a calculation of the specific RBC level for the District business, a calculation the Order does not make. If GHMSI’s overall surplus were reduced by $56 million, as ordered by the DISB, GHMSI’s *entire* surplus would not drop to 721% RBC-ACL, because the District’s share is only a fraction of the whole. Does this mean that yet more surplus would need to be bled off until an overall surplus level of 721% RBC-ACL is achieved? We think not – the $268 million difference between GHMSI’s overall 2011 surplus
and a 721% target is larger than the $202 million in surplus attributed to the District in the Order. Yet, if a District specific surplus were calculated, and $56 million taken from this far smaller number, GHMSI’s District specific surplus could be far lower than 721% RBC-ACL. The Commissioner could not reasonably seek further distributions or reductions based on GHMSI’s entire surplus, when the DC-only surplus already has been reduced. This is why the MIEAA says what it does – that the Commissioner must specifically analyze the actual surplus level against the surplus requirements attributable to the District, not GHMSI’s surplus as a whole.

III. The Order Fails to Determine How The Surplus Was Caused Over Time, and Fails To Coordinate the Attribution Analysis With Maryland and Virginia.

The Order’s attribution of surplus is incorrect as a matter of law. As the Order acknowledges, the attribution of surplus requires a determination of how that surplus was caused. The word “attributable” means “due to, caused by, or generated by.” Order at 53 (quoting Electrolux Holdings, Inc. v. United States, 491 F.3d 1327, 1330-31 (Fed. Cir. 2007)). “In other words, [t]he question to be answered is where did the [surplus] come from?” Id. (quoting Benedek v. Commissioner, 429 F.3d 41, 43 (2d Cir. 1970)) (quotation marks omitted). The Order does not attempt to answer this question, however. It apportions GHMSI’s 2011 business, and fails to apportion the GHMSI’s surplus. The Order relies almost exclusively on the 2011 premium filings; it ignores the fact that only profits (in the sense of excess income over costs) contribute to surplus, not raw premium charges; and it ignores the fact that surplus is built up over time and its source is not reflected in any one year financial statement.

As a result, the Order does not address any of the complexities that must be resolved in order to attribute surplus in the manner that MIEAA requires. Such an analysis must determine how GHMSI’s surplus was built since the beginning of its operations. To do so, the analysis must address limitations in available records; the large portion of surplus generated by
investment income; how BlueChoice or other sources contributed to surplus; and many other considerations. That analysis has not been done and, as a result, the Order likely misappropriates surplus dollars generated in Maryland and Virginia for the benefit of District residents.

The attribution analysis required by MIEAA can only take place in coordination with Maryland and Virginia. Both Maryland and Virginia have expressed their interest in and concern with this proceeding, and with attribution in particular. The Maryland Commissioner expressed, in her written submission, a strong concern with the effort to attribute surplus under MIEAA, and her view that GHMSI’s surplus could not be divided in the manner proposed in the Order.\textsuperscript{4} Virginia explained in its submission that Virginia law requires the Virginia State Corporation Commission to consider the effect of the Order on Virginians, while attributing surplus based on residency of members.\textsuperscript{5} Virginia has already begun the examination required under its statute, and has requested initial documents from GHMSI.

Neither Maryland nor Virginia is likely to accept the attribution of surplus chosen in the Order. There is no established financial methodology for attributing a carrier’s surplus, since no such analysis has ever been required to be performed. The MIEAA thus requires the Commissioner to do something that is financially novel and untried – but it does so in a way that protects GHMSI from competing demands by requiring the Commissioner to coordinate his decision with Maryland and Virginia. D.C. Code § 31-3506(e). Without such coordination, the Commissioner would be asserting control over surplus likely to be claimed by another State. The Commissioner can only resolve this conflict by engaging in the coordination that MIEAA requires.

\textsuperscript{4} See Statement of Commissioner Therese Goldsmith (June 18, 2014).
\textsuperscript{5} See Statement of the Virginia State Corporation Commission’s Bureau of Insurance (Sep. 29, 2014).
IV. The Order’s Use of the 95% Confidence Level is Arbitrary and Capricious.

The Order’s use of a 95% confidence level with respect to the 200% RBC-ACL benchmark is not supported, and the decision is arbitrary and capricious as a result. *Dickson v. Secretary of Defense*, 68 F.3d 1396, 1407 (D.C. Cir. 1995); see also *D.C. Appleseed Ctr. for Law & Justice, Inc. v. D.C. Dep’t of Ins., Sec., & Banking*, 54 A.3d 1188, 1216 (D.C. 2012). In fact, the Order provides no specific explanation as to why 95% is appropriate, or 98% is inappropriate, despite the APA’s requirement that there must be a “rational connection between the facts found and the choice made.” *Dickson*, 68 F.3d at 1407.

There is no support for any confidence level below 98%. Rector & Associates, the Commissioner’s own expert consultant, testified that the 98% confidence level should be used, and the record is replete with similar expert conclusions. See Exhibit 12 to Pre-Hearing Br. (Milliman 2011 Report) at 13; Rector Report at 15; RSM McGladrey, Inc., *Maryland Insurance Administration Examination and Auditing: Surplus Evaluation Consulting Services Report: CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc.*, May 29, 2012 (“McGladrey Report”) at 21; Invotex, Group, *Report on: Surplus Evaluation Consulting Services*, Oct. 30, 2009 (“Invotex Report”) at 53. Even DC Appleseed’s own actuary endorsed the 98 percent confidence level. See, e.g., *Letter from Mark Shaw to Walter Smith*, Jan. 18, 2013 at 4. The MIA, with which the DISB is obligated to coordinate in this proceeding, likewise endorsed 98 percent. See Exhibit 15 to Pre-Hearing Br. (MIA 2012 Consent Order).

The Order cites only a single data point for its 95 percent figure: the fact that Lewin used a 95% confidence level in a surplus analysis using its own proprietary model. Lewin, however,  

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6 The D.C. Court of Appeals has said it is proper to “look to case law interpreting the federal APA” because “the DCAPA requirements as to notice and comment are closely analogous to the requirements of the Federal Administrative Procedure Act.” *Andrews v. D.C. Police & Firefighters Ret. & Relief Bd.*, 991 A.2d 763, 769 n.11 (D.C. 2010) (citation omitted).
did not testify, did not provide any explanation regarding how its confidence level was incorporated into its model, used much more conservative assumptions within its model, and proposed a surplus target of 1,000% to 1,550% RBC-ACL, far above the levels proposed by Milliman or Rector. Lewin’s use of 95% confidence in a different model with very conservative assumptions cannot support adoption of the 95% confidence level here, where far narrower assumptions have been drawn. See The Washington Times, 724 A.2d at 1216 (rejecting administrative conclusion that does not “flow rationally from” the record facts); Phillips v. Astrue, 413 F. App’x 878, 886 (7th Cir. 2010) (unpublished) (administrative judge’s findings not supported by substantial evidence when he relied on the one “outlier” opinion in the record to deny a claimant benefits).

The 95% standard is inconsistent with the Order’s own assessment of the risks GHMSI faces. The Order concludes that falling to 200% RBC-ACL would be catastrophic for GHMSI, that it would cause “extreme distress” in the D.C. market, that GHMSI would lose its Blue Cross membership, and that it would be nearly impossible for GHMSI to recover surplus once lost. Order at 24-26. And yet the Order adopts a confidence level that, by definition, gives GHMSI a 5% chance of falling to or below 200% RBC-ACL during the period of analysis. As this confidence level is applied on an ongoing basis, from year to year, GHMSI’s surplus would be expected drop to or below 200% RBC-ACL every two decades. An Order that knowingly inflicts “extreme distress” on the regulated market once a generation is unreasonable on its face.

The Order also fails to articulate any basis for the selection of one confidence level over another. The Order provides no explanation why a 1 in 20 risk of failure is acceptable, or why 95% was a more appropriate level than 98% – the only confidence level supported by evidence. The Court of Appeals has already cautioned that it would not affirm “a truncated and conclusory
explanation, especially where, as here, the technical nature of the actuarial reports requires a far more detailed discussion of a decision in which even a small variance can implicate millions of dollars.” *D.C. Appleseed*, 54 A.3d at 1219 (emphasis added). Other than its cursory assertion that GHMSI’s expert may not have considered the MIEAA’s requirements in selecting its proposed confidence level, *id.* at 27, the Order is silent on all these key questions.

The DISB’s silence is particularly troubling in light of the fact that the confidence level is a critical—perhaps the *most* critical—component of the larger surplus determination. The DISB’s move from a 98% to a 95% confidence level single-handedly lowered GHMSI’s surplus requirement by 159% RBC-ACL, more than $153 million in dollar terms. Such a dramatic result cannot be accomplished by silence and *ipse dixit*.

While determination of the appropriate confidence level “ultimately is entrusted to the Commissioner’s reasonable discretion,” Order at 28, the Commissioner does not have *carte blanche* to adopt a standard for which there was no record support. Discretion must be informed and guided by competent evidence. *See Dunkwu v. Neville*, 575 A.2d 293, 294 (D.C. 1990). The Order ignores the competent evidence in the record and fails to explain why it is justified in doing so.

V. **Use of a Single Target Point is Inconsistent with MIEAA’s Requirement That GHMSI Should Retain Surplus Needed to Remain Financially Sound.**

The Order’s use of a single target point to determine whether surplus is excessive, rather than a reasonable range, is inconsistent with MIEAA’s stated purpose of ensuring that GHMSI

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7 The Order’s assertion that Milliman or Rector did not modify their confidence level on account of the MIEAA, Order at 27, does not support the selection of 95%, or any other level. In fact, it misunderstands the point of the Milliman and Rector analysis. Both Milliman and Rector assessed the level of surplus required for GHMSI to remain *financially sound*, a prime concern of the MIEAA. In arbitrarily selecting a confidence level below that recommended by his own expert, the Commissioner undermines the very purposes of MIEAA and poses a grave threat to the long-term viability of GHMSI.

retains surplus needed to remain financially sound. See Order at 46. The Commissioner’s expressed concern that the upper bound of a range should not become the “target” is easily addressed in the same manner as in the Maryland Order. Through its rate filings and other planning, GHMSI can seek to achieve the mid-point of the range on an ongoing basis. However, GHMSI cannot achieve a specific surplus target with precision, and imposing a single target in this review will necessarily force GHMSI to retain surplus below the target level, thereby retaining less surplus than needed for financial soundness.

Surplus fluctuates from day to day based on factors outside of GHMSI’s control, such as claim costs and investment returns. GHMSI cannot know exactly how much surplus it holds at any one time, until well after the fact (such as upon completion of its annual filings, months after the close of the year). Rector correctly observed in its report that the selection of a single RBC-ACL target number “implies a degree of precision that does not, in fact, exist.” Rector Report at 12. As Rector explained:

Given the numerous variables and judgments that are necessary to select the assumptions underlying the calculations, this implied level of precision is misleading. . . . Further, even if the target level could be determined precisely, it would be impractical for the DISB to require GHMSI to increase community health reinvestment expenditures, or to reduce expenditures in order to build surplus, merely because of relatively modest fluctuations in surplus that happen normally from year to year.


By definition, the selection of a single point, rather than a range, will require GHMSI to act inconsistently with the MIEAA. The Order defines a single point as the sole surplus level that is neither too high (thereby requiring community reinvestment) nor too low (underneath the level of surplus required for financial soundness). See Order at 46. But GHMSI cannot possibly maintain its surplus at this precise target, and therefore can only avoid holding too much surplus
by holding too little. GHMSI must aim for an RBC-ACL figure under the target selected by DISB to ensure that its constantly changing RBC-ACL will not exceed the legal maximum. The Commissioner’s selection of a single target point necessarily forces GHMSI to maintain surplus below the level that is necessary to maintain the financial soundness of the company.

Such a result is contrary to the MIEAA, under which community health reinvestment is appropriate only when “consistent with financial soundness and efficiency.” D.C. Code § 31-3505.01; see also Comcast Corp. v. F.C.C., 579 F.3d 1, 10 (D.C. Cir. 2009) (holding that agency rules should be overturned where they “fail[] adequately to take account of’ facts relevant to the market in which the regulated entities do business). The Commissioner’s concern should be managed prospectively – utilizing appropriate surplus targets in rate filings and other planning. The purposes of the MIEAA are only met, however, if a reasonable range of surplus is used in this retrospective review.

CONCLUSION

For all of the reasons stated above, the Commissioner should grant GHMSI’s motion for reconsideration and begin a coordinated proceeding with Maryland and Virginia.

Respectfully submitted,

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January 22, 2015
Exhibit N
GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF INSURANCE, SECURITIES AND BANKING

IN THE MATTER OF

Surplus Review and Determination for Group Hospitalization and Medical Services, Inc.

Order No.: 14-MIE-016

DECISION AND ORDER ON GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC. PLAN


The Commissioner rejects the plan after concluding that the plan does not comply with the Act for the reasons described herein.

I. BACKGROUND

A. Procedural History

After a multi-year process involving a full-day hearing and thousands of pages of expert reports, statements, and briefs, former Acting Commissioner Chester A. McPherson (“Acting
Commissioner”) concluded, in his December 30 Order, that GHMSI’s 2011 surplus attributable to the District of Columbia (“District”) was “excessive” as defined by the Act. Specifically, the Acting Commissioner concluded that (a) the appropriate level for GHMSI’s 2011 surplus was 721% RBC-ACL (approximately $695.9 million); (b) GHMSI’s 2011 surplus was excessive because GHMSI’s actual surplus as of December 31, 2011 was $963.5 million (998% RBC-ACL); and (c) 21% of GHMSI’s 2011 surplus was attributable to the District. *Id.* at 1. The Acting Commissioner determined that $56,213,088.72 is the amount of GHMSI’s 2011 excess surplus attributable to the District (“Excess Surplus”). The Acting Commissioner ordered GHMSI to submit “a plan for dedication of the excess surplus attributable to the District to community health reinvestment in a fair and equitable manner . . . .” *Id.* at 66 (citing D.C. Official Code § 31-3506(g) (2012 Repl.) and 26A DCMR § 4603.2). Accordingly, GHMSI was required to submit a plan to dedicate the Excess Surplus to community health reinvestment.


The Court of Appeals dismissed the appeals as having been taken from a non-final and non-appealable order, reasoning that the Commissioner had not yet reviewed GHMSI’s plan and thus the “administrative process is not yet complete, and no specific, enforceable obligations regarding the excess assets have been imposed on GHMSI.” Order, Appeal Nos. 15-AA-108 and 15-AA-109 (D.C. Ct. App. Apr. 28, 2015), available at http://disb.dc.gov/node/1056192.

B. The Plan and Responses to It

On March 16, 2015, GHMSI submitted a plan “pursuant to the instruction” in the December 30 Order. See Plan of Group Hospitalization and Medical Services, Inc. filed with the Department of Insurance, Securities and Banking Pursuant to December 30, 2014 Order No. 14-MIE-012 (Mar. 16, 2015), available at http://disb.dc.gov/node/1028982 (“Plan”). In the Plan, GHMSI argues that no distribution of surplus is required. In brief, GHMSI maintains that no distribution is needed because there was not excess surplus, and alternatively, since 2011, GHMSI has spent more than the excess surplus attributable to the District in community health reinvestment in addition to incurring underwriting losses and experiencing a decline in surplus. GHMSI also argues, among other things, that the Department of Insurance, Securities and
Banking ("Department") did not sufficiently coordinate with Maryland and Virginia before issuing the December 30 Order.

The Department received and considered materials addressing the Plan, including correspondence from Appleseed. See Appleseed Letter to Commissioner (March 9, 2015), available at [http://disb.dc.gov/node/1024882](http://disb.dc.gov/node/1024882), and Appleseed Letter to Commissioner (May 13, 2015), available at [http://disb.dc.gov/node/1064632](http://disb.dc.gov/node/1064632) (advocating for public hearing); Appleseed Letter to Commissioner (March 25, 2015), available at [http://disb.dc.gov/node/1034262](http://disb.dc.gov/node/1034262) (arguing that the Plan does not comply with the December 30 Order or District law). GHMSI responded to Appleseed by arguing that it has complied with the December 30 Order and that Appleseed mischaracterized the law and misstated the facts. See Statement of Group Hospitalization and Medical Services, Inc. in Support of its March 16, 2015 Plan (Apr. 6, 2015), available at [http://disb.dc.gov/node/1043412](http://disb.dc.gov/node/1043412). The Commissioner also considered the Virginia Report to the extent it was relevant to the issues presented by the Plan. Finally, the Commissioner reviewed GHMSI’s public rate filings submitted to the Department.

II. STANDARD OF REVIEW

The Act mandates that, if the Commissioner determines that GHMSI’s surplus attributable to the District is excessive, then “the Commissioner shall order the corporation to submit a plan for dedication of the excess to community health reinvestment in a fair and equitable manner.” D.C. Official Code Section 31-3506(g) (2012 Repl.). The Acting Commissioner determined that GHMSI’s 2011 surplus was excessive. Accordingly, the Acting Commissioner instructed GHMSI to “submit to . . . a plan for dedication of the excess surplus

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1The Commissioner considered the suggestion that he hold a public hearing on GHMSI’s Plan. A public hearing is not required by law. The Commissioner determined that a public hearing would not advance or otherwise assist the evaluation of the Plan.
attributable to the District to community health reinvestment in a fair and equitable manner . . . .” December 30 Order at 66. To comply with the Act’s mandate as reflected in the December 30 Order, the Plan must satisfy the following criteria:

First, the Plan must address the excess surplus by dedicating it to “community health reinvestment.” D.C. Official Code § 31-3506(g)(1). In other words, in light of the Act’s definition of “community health reinvestment,” the Plan must consist of “expenditures that promote and safeguard the public health or that benefit current or future subscribers, including premium rate reductions.” D.C. Official Code § 31-3501(1A).

Second, the Plan must dedicate the excess surplus to community health reinvestment “in a fair and equitable manner.” D.C. Official Code § 31-3506(g)(1).

III. PLAN EVALUATION

GHMSI’s Plan does not comply with statutory requirements. Rather than presenting a plan for dedication of its excess surplus to community health reinvestment, GHMSI argues that it did not have excess surplus in 2011, and even if it did, it need not make any expenditures for community health reinvestment because “no further reduction in GHMSI surplus attributable to the District would be appropriate” in light of developments since 2011 and other factors. See Plan at 4. Specifically, GHMSI cites (a) underwriting losses incurred and expenditures made between 2012 and 2014; (b) an allocation theory purportedly resulting in a decline in “District-specific surplus”; and (c) a purported lack of coordination with other jurisdictions which made the December 30 Order defective. The Commissioner cannot accept any of GHMSI’s arguments

 GHMSI had the option of crafting a plan for excess surplus that “consist entirely of expenditures for the benefit of current subscribers . . . .” D.C. Official Code § 31-3506(g)(2).
as justification for GHMSI’s failure to set forth a plan as required by the Act and the December 30 Order for the reasons detailed below.

A. **GHMSI’s Plan Does Not Fulfill Statutory Criteria.**

The “core” of the Plan is GHMSI’s argument that it already has reduced its surplus attributable to the District by more than the approximately $56 million required under the December 30 Order based on expenditures and underwriting losses between 2012 and 2014. Specifically, GHMSI claims (a) $62 million in underwriting losses attributable to the District; (b) $50 million in community giving, open enrollment subsidies, and HealthCare Alliance funding; and (c) nearly $30 million in premium rate reductions and moderation. Plan at 4-5. The Commissioner evaluates each of these categories in light of the criteria specified by the Act.

1. **Underwriting Losses**

To the extent GHMSI contends that its underwriting losses between 2012 and 2014 should be credited to its Plan, the Commissioner must reject that assertion because such losses, by themselves, do not constitute “community health reinvestment.” Under the Act, a compliant plan must dedicate excess surplus to community health reinvestment. See D.C. Official Code § 31-3506 (g) (2012 Repl.). In this context, the term “community health reinvestment” means “expenditures that promote and safeguard the public health or that benefit current or future subscribers, including premium rate reductions.” Id. at § 31-3501(1A). Underwriting losses do not promote and safeguard the public health. Nor do they necessarily benefit current or future

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3 GHMSI states that, between 2012 and 2014, it incurred $62 million in underwriting losses attributable to the District. Plan at 4.
subscribers. Thus, underwriting losses, by and of themselves, are not community health reinvestment.\(^4\)

It also is important to recognize that the analysis the Acting Commissioner conducted of GHMSI’s 2011 surplus to determine whether it is excessive was based on reasonable projections of GHMSI’s post-2011 performance, including the possibility of underwriting losses. \textit{See, e.g.}, December 30 Order at 30, 39 (discussing modeling generally and the rating adequacy and fluctuation risk factor in particular).\(^5\) In other words, the fact that GHMSI experienced underwriting losses does not change the Acting Commissioner’s determination that the 2011 surplus was excessive. Nor does it change the Act’s mandate that GHMSI submit a plan for the dedication of the excess surplus to community health reinvestment.

If GHMSI were experiencing losses that placed the company’s solvency in question and that were not included in the surplus review analysis, the Commissioner could revisit the December 30 Order with respect to the requirement of GHMSI to dedicate the $56 million of excess surplus, or simply address the losses through the enforcement of the Plan. But no such losses have occurred. The company’s total net loss between 2012 and 2014 was $15 million. Plan at Table 1. This amount is, to say the least, an extremely small negative margin (0.15\%) on GHMSI’s total revenues of $9.68 billion over the same period. \textit{See id.} By any reasonable standard, GHMSI has been operating on a break-even basis or very nearly so. Indeed, as GHMSI testified at the surplus review hearing, because the company is a nonprofit entity, it

\(^4\) The Commissioner does, however, recognize that some rate reductions that are intended to result in negative contribution to surplus may constitute community health reinvestment, as discussed further in Section III.A.3 below.

\(^5\) In addition, the Acting Commissioner heard testimony on GHMSI’s underwriting losses. Hearing Tr. 175:13-15 (GHMSI representative G. Mark Chaney testified that, since 2009, GHMSI had averaged about $25 to $30 million in underwriting losses).
“[l]argely seek[s] only to break even with a small margin that would keep us financially sound.”

Hearing Tr. at 109:19-20. GHMSI has essentially met that goal. Accordingly, the
Commissioner, based on the information in the Plan, does not view GHMSI’s small net loss as a
material impediment to preparing and executing a plan.

2. **Community Giving, Open Enrollment Subsidies and HealthCare Alliance Funding**

According to the Plan, between 2012 and 2014 GHMSI provided $11 million in direct community giving, $24 million in subsidies for the District’s open enrollment program and $15 million in funding for the District’s HealthCare Alliance Program. Plan at 5-6. GHMSI’s reported expenditures in these categories were very consistent from year to year. See Plan, Exhibit 3.\(^6\) While GHMSI’s continued community giving is commendable; this giving, even when combined with its statutorily mandated support of the open enrollment and HealthCare Alliance programs,\(^7\) does not satisfy the Act’s requirement for a plan.

The Act requires that a compliant plan must, among other things, consist of expenditures of excess surplus. D.C. Official Code § 31-3506(g)(2) (2012 Repl.). For two reasons, GHMSI’s expenditures for community giving, open enrollment subsidies and HealthCare Alliance funding do not meet this requirement.

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\(^6\) GHMSI’s expenditures in 2011 included $3.4 million for community giving, $5 million for the HealthCare Alliance, and $4.5 million for open enrollment subsidies. Between 2012 and 2014, GHMSI’s annual community giving varied between $3.4 million and $3.9 million; funding for the HealthCare Alliance was even more consistent, at $5 million per year, each year; and open enrollment subsidies varied between $7.5 million and $10.3 million annually, but also were fairly consistent over time. See Plan, Exhibit 3.

\(^7\) See D.C. Official Code § 31-3514 (requiring a hospital and medical services corporation to make an open enrollment program available to District citizens); *id.* at § 31-3505(e)(2) (requiring a hospital and medical services corporation to enter into a public-private partnership as a condition of receiving a certificate of authority to operate in the District).
First, as annual, programmatic, and, in the case of open enrollment and the HealthCare Alliance, compulsory, expenses, these GHMSI’s expenditures are drawn directly from subscriber premium dollars. Thus, they do not constitute expenditures of excess surplus.

Second, the Acting Commissioner’s review of GHMSI’s surplus took into account all of the GHMSI’s likely and planned obligations, including annual expenditures for community giving, open enrollment subsidies and the HealthCare Alliance. Indeed, the Act required the Acting Commissioner to consider GHMSI’s open enrollment subsidies and HealthCare Alliance funding in making his determination. D.C. Official Code § 31-3506(f). In other words, the excess surplus identified by the Acting Commissioner was surplus over and above the amount of surplus necessary to meet these and other obligations of GHMSI. Accordingly, such expenditures cannot constitute expenditures of excess surplus.

3. Rate Reductions and Moderation

In order for rate reductions to be part of a compliant plan, they must constitute “expenditures that promote and safeguard the public health or that benefit current or future subscribers, including premium rate reductions.” D.C. Official Code § 31-3501(1A) (2012 Repl.). This definition thus expressly includes premium rate reductions, so long as such reductions benefit current or future subscribers.

GHMSI’s Plan seeks credit for nearly $30 million in claimed rate reductions and moderation since 2011. Plan at 5. Based on the Plan, the Commissioner is unable to credit GHMSI for these rate adjustments towards its community reinvestment obligations under the December 30 Order.

GHMSI states that it undertook these reductions and moderation in rates in an effort to reduce its surplus, which had climbed to 1098% RBC at year-end 2010 due to unanticipated
favorable claims experience that year. Plan at 5. As a practical, mathematical matter, if a company lowers rates when its costs are lower than expected, then there should be little or no impact on the company’s surplus – it should be a (close to) zero sum exercise. Thus, while GHMSI may have undertook the adjustments to keep its rates in line with its costs, it offered no evidence that such reductions also served to reduce its surplus for the year end 2011. As such, the reductions cannot constitute community health reinvestment. See also December 30 Order at 60-61 (addressing consideration of rate reductions in surplus review).

In more closely reviewing GHMSI’s rate filings, however, the Commissioner believes that there may be a portion of rate adjustments that could be quantified and reasonably characterized as expenditures of excess surplus for the benefit of subscribers. In some cases, the rates filed by GHMSI reflected a “negative contribution to surplus.” Rate adjustments which are “negative contribution to surplus” appear to be part of a deliberate effort to reduce surplus for the benefit of subscribers and therefore could be credited as community health reinvestment in compliance with the Act. The Commissioner would have been willing to consider “negative contributions to surplus” in the District as community health reinvestment, had GHMSI identified these specific amounts and referenced specific rate filings and/or other supporting documentation.

B. GHMSI’s Arguments Concerning Attribution of Surplus are Irrelevant to the Evaluation of the Plan.

In the Plan, GHMSI also argues that no further surplus reduction is needed because, according to its newly-presented calculations, its surplus attributable to the District would have been reduced by more than $56 million by the end of 2015. To reach this conclusion, GHMSI disregards its surplus as a whole and offers its own, new calculations of what it characterizes as “District-specific surplus” and “District-specific RBC.” Plan at 4-5. In light of its calculations,
GHMSI suggests that there no longer is any excess surplus attributable to the District. *See* Plan at 5.

This line of reasoning is based on the argument, first articulated in the GHMSI Motion for Reconsideration, that the Commissioner must first attribute surplus to the District and only then determine whether the District-specific surplus is excessive. *See* GHMSI Motion for Reconsideration at 3-4, 10-13. Essentially, GHMSI argues that the Acting Commissioner erred in his finding of excess surplus as result of his failure to properly attribute surplus and risk to the District. This argument is irrelevant to the determination of whether GHMSI has filed a plan that complies with the Act and the December 30 Order.

In addition to its irrelevance to the Plan, the Acting Commissioner rejected this argument with respect to his finding of excess surplus. First, as the Acting Commissioner explained in his Order denying the GHMSI Motion for Reconsideration, GHMSI could have made this argument at any time during the lengthy proceedings preceding the December 30 Order but chose not to do so. Order No. 14-MIE-014 at 2. Accordingly, the Acting Commissioner determined that it was not in the public interest or an efficient use of public resources to reconsider the excess surplus determination in light of arguments GHMSI had every opportunity to present previously but did not.

Second, the Acting Commissioner rejected GHMSI’s contention that he must first attribute surplus to the District and then evaluate the District-specific surplus to determine whether it is excessive because it was directly contrary to the position GHMSI has repeatedly advocated throughout the surplus review proceedings. The Department’s regulations implementing the Act require GHMSI to file an annual financial report with the Commissioner “which details the company’s surplus and examines whether the company’s surplus is considered
excessive under the Act.” 26A DCMR § 4601.1. On June 1, 2012, GHMSI filed the required report with respect to its 2011 surplus, concluding that the surplus was not “excessive” under the test required by Act. CareFirst BlueCross BlueShield, Report on GHMSI Surplus, at 11 (June 1, 2012), available at http://disb.dc.gov/node/311302. In support of this conclusion, GHMSI cited a number of actuarial studies, every one of which, including those commissioned by GHMSI, evaluated the company’s surplus as a whole.

GHMSI’s pre-hearing brief and its testimony at the surplus review hearing similarly reflect GHMSI’s view that the proper way to determine whether the company’s surplus is excessive under the Act is to evaluate it as a whole. For example, a central subject of inquiry during the hearing was the report prepared for the Acting Commissioner by Rector & Associates evaluating whether GHMSI’s 2011 surplus was excessive. Rector & Associates, Inc., Report to the D.C. Department of Insurance, Securities and Banking – Group Hospitalization and Medical Services, Inc. (Dec. 9, 2013), available at http://disb.dc.gov/node/756762 (the “Rector Report”). The Rector Report reviewed GHMSI’s surplus as a whole. At the hearing, GHMSI endorsed the Rector Report, calling it “essentially a creditable piece of work” which “represents a sound set of conclusions.” Hearing Tr. 101:13-15.

Perhaps the clearest statement of GHMSI’s position on this issue is found in its response to a question posed by the Acting Commissioner: “Please provide your recommendations regarding how the Commissioner should determine the amount of GHMSI’s surplus that is attributable to the District.” Third Scheduling Order, Order No. 14-MIE-005 (Aug. 7, 2015), available at http://disb.dc.gov/node/878702. In response, GHMSI stated,

GHMSI recommends that the Commissioner not address the attribution of GHMSI’s surplus at this time. The Commissioner is not required to address attribution unless he concludes that GHMSI’s surplus, as a whole, is excessive. Both Rector and Milliman have determined that GHMSI’s
year-end 2011 surplus was not excessive as a whole, based on detailed analyses that follow sound actuarial practice. The Commissioner should make the same finding for all the reasons set forth in GHMSI’s testimony, Pre-Hearing Report, and other filings.


The Acting Commissioner also declined to adopt the unprecedented approach to surplus attribution and review urged in the GHMSI Motion for Reconsideration because it would be contrary to the Act and any sound analysis of the company’s surplus. The Act states: “In determining whether the surplus of the corporation that is attributable to the District is excessive, the Commissioner shall take into account all of the corporation’s financial obligations arising in connection with the conduct of the corporation’s insurance business . . . .” D.C. Official Code § 31-3506(f) (2012 Repl.). Thus, the Acting Commissioner found that the Act itself therefore requires an examination of the surplus as a whole.

Moreover, the concepts of financial soundness and efficiency that underpin the surplus review reasonably require an examination of the surplus as a whole in the first instance. Following guidance from the Court of Appeals, the Acting Commissioner interpreted the Act to require him to evaluate GHMSI’s surplus by determining the amount of surplus that is large enough to be consistent with financial soundness and efficiency, but no larger. December 30 Order at 15-16. It makes no sense to evaluate the company’s surplus for financial soundness on any basis other than as a whole. GHMSI’s surplus is maintained against all risks and contingencies the company may encounter, regardless of origin. Accordingly, any risk or contingency, if incurred, will affect the company’s surplus as a whole. Thus, the Acting
Commissioner determined that the only rational way to evaluate the surplus for solvency is to review it as a whole.

Similarly, the only reasonable way to evaluate the surplus for efficiency – i.e., whether it is neither so high as to be wasteful of a company’s resources nor so low as to render the company unable to respond to reasonable risks and contingencies – is as a whole. See December 30 Order at 20-21 (discussing role of efficiency in evaluating surplus). Because the concepts of financial soundness and efficiency only have meaning when applied to the surplus as a whole, any other interpretation would lead to unreasonable and absurd results.

In short, the Acting Commissioner, in his review and evaluation of GHMSI’s surplus, concluded that the Act requires that GHMSI’s surplus first be evaluated as a whole to determine whether it is excessive and only if any excess is found, then evaluated to determine how much of the excess is attributable to the District. This is not to say that if and when the surplus is determined to be excessive, as the December 30 Order has done, the excess cannot be apportioned in a reasonable way by jurisdiction to determine how much excess surplus must be devoted to community health reinvestment. Indeed, the Act requires that this be done. For the reasons stated in the December 30 Order, the Acting Commissioner believed the allocation methodology he adopted – allocating GHMSI’s excess surplus based on the geographic location of the business generating the surplus, December 30 Order at 52 – was reasonable and consistent with the letter and spirit of the Act.

As a final matter, the Commissioner acknowledges that GHMSI’s surplus as a whole has declined modestly – falling by 0.35% – since 2011, from $964 million at year-end 2011 to $960 million at the end of 2015. As with underwriting results, the possibility that GHMSI’s surplus might decline was factored into the Acting Commissioner’s surplus review. The small reduction
in surplus experienced by GHMSI does not change the Acting Commissioner’s determination that the 2011 surplus was excessive. Moreover, the reduction in surplus does not relieve GHMSI of its obligation to submit a plan for dedication of the excess to community health reinvestment.\(^8\)

C. **GHMSI’s Argument that the December 30 Order was Erroneous Because the Acting Commissioner Failed to Coordinate His Surplus Review is Irrelevant to the Evaluation of the Plan.**

GHMSI’s Plan seeks to revisit an issue previously raised in challenging the December 30 Order, which required GHMSI to submit a plan as required by the Act. Specifically, GHMSI asserts that the Commissioner did not properly coordinate with Maryland and Virginia in reviewing GHMSI’s surplus and arriving at the determination that it is excessive. *See Plan at 6-7; see also* GHMSI Motion for Reconsideration at 2-3. Similar to its attribution argument referenced in Section III.B above, this argument is not relevant to the single question at hand: Has GHMSI submitted a plan to dedicate its excess surplus to community health reinvestment in a fair and equitable manner? Whether the Acting Commissioner failed to appropriately coordinated with other regulators does not relieve GHMSI from submitting the required plan or prevent the Commissioner from determining whether the Plan complies with the Act and December 30 Order.

In addition to being irrelevant, the Acting Commissioner considered and rejected this argument challenging his finding of excess surplus under the Act and upheld the determinations he made in his December 30 Order. The Acting Commissioner concluded that he fully complied with the statutory mandate to coordinate with the other jurisdictions in which GHMSI conducts business and to “consider the interests and needs of the jurisdictions in the corporation’s service area.” D.C. Official Code §§ 31-3506(e), 31-3506.01(b) (2012 Repl.).

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\(^8\) While GHMSI is mandated to file a plan, it could have fashioned its plan to factor-in any reduction in surplus with respect to is community health reinvestments.
The Acting Commissioner and his staff communicated with the Maryland and Virginia insurance commissioners and their staff, including through correspondence advising them of the surplus review hearing and soliciting their participation. The Acting Commissioner would have welcomed live testimony from other regulators, but they chose instead to submit written statements. The Acting Commissioner specifically solicited input from the Maryland and Virginia insurance commissioners after the hearing, and carefully considered the written statements that they submitted in response. See also December 30 Order at 62-65 (describing coordination efforts). The Acting Commissioner’s staff responded to all inquiries from Maryland and Virginia insurance regulators. Virginia regulators reported not that the Department failed to coordinate with them in the surplus review process, but rather that they did not take full advantage of the opportunities presented (and intend to participate more fully in future surplus reviews). See Virginia Report at 7.

GHMSI’s argument that the Acting Commissioner failed to coordinate seems to rest on an erroneous interpretation of the Act. GHMSI conflates “coordination” with “agreement.” See, e.g., GHMSI Motion for Reconsideration at 2 (asserting that “coordination” under the Act “requires Maryland, Virginia and the District to come to agreement regarding the many multi-jurisdictional issues relating to GHMSI’s surplus.”); Plan at 6-9. However, nothing in the Act suggests that the Commissioner must come to agreement with regulators in Maryland and Virginia in determining whether GHMSI’s surplus is excessive or in determining the proper attribution of surplus among jurisdictions. To the contrary, the Act vests sole authority in the Commissioner to make these determinations. The Act states GHMSI’s “surplus may be

9 GHMSI appeared to recognize the weakness in its own legal argument when it sought an amendment to GHMSI’s congressional charter requiring agreement among the jurisdictions for any distribution of surplus.
considered excessive only if . . . the Commissioner determines that the surplus is unreasonably large and inconsistent with corporation’s obligation” to engage in community health reinvestment. D.C. Official Code § 31-3506(e) (emphasis added). Similarly, the Act entrusts to the Commissioner alone the determination of how much surplus is attributable to the District. Id. at § 31-3506(f), (h). The Commissioner may not cede authority to other jurisdictions in making these determinations.

Furthermore, the notion that all affected jurisdictions must come to agreement on the determinations required by the Act is directly contrary to the Act’s purpose and intent. The Act requires the Commissioner to apply a specific standard to determine whether GHMSI’s surplus is excessive. This standard is unique to the District and provides that the surplus may be considered excessive only if it is “unreasonably large and inconsistent with the corporation’s obligation” to engage in community health reinvestment to the maximum feasible extent consistent with financial soundness and efficiency. D.C. Official Code § 31-3506(e). The Act does not permit the Commissioner to employ any other standard, as likely would be required to reach agreement with Maryland and Virginia. \[10\] The Commissioner has no authority under the Act to substitute Maryland’s standard, or any standard Virginia may adopt, for the District’s own.

Rather than requiring agreement, the Act directs the Commissioner to coordinate with Maryland and Virginia and consider their interests and needs, which is what the Acting Commissioner determined that he did. As detailed above, the Acting Commissioner solicited the advice and consultation of insurance regulators in Maryland and Virginia before, during and after

\[10\] Indeed, Maryland has a different standard for surplus review. Under Maryland law, GHMSI’s surplus may be considered excessive only if the Maryland Insurance Commissioner determines it is “unreasonably large.” Md. Code, Ins. § 14-117(e)(1).
the surplus review hearing. The Acting Commissioner stated that he carefully considered all input received from Maryland and Virginia insurance regulators in reaching the decisions reflected in the December 30 Order. Throughout these proceedings, the Acting Commissioner sought to balance the interests and needs of Maryland and Virginia, as articulated by their regulators and evaluated by the Acting Commissioner, with the interests and needs of the District and the requirements of the Act. Notably, Virginia regulators acknowledged that the December 30 Order “was thorough and deliberative” and they did not recommend taking action against distribution of GHMSI’s excess surplus attributable to the District. Virginia Report at 7. Virginia regulators also recommended “taking a more active role in coordinating with the Department as well as the Maryland Insurance Administration on future actions related to GHMSI’s surplus. In particular, participating in the next surplus review of GHMSI, either as a party or participant, would be beneficial.” Id. The Commissioner welcomes greater input and participation by the Virginia and Maryland insurance regulators in future surplus reviews.11

IV. CONCLUSIONS AND ORDER

For the reasons detailed above, the Commissioner concludes that GHMSI’s Plan does not comply with the Act because it does not dedicate to community health reinvestment the company’s excess surplus attributable to the District. The Commissioner therefore finds that GHMSI failed to submit a plan as ordered by the Acting Commissioner under D.C. Official Code § 31-3506(g) (2012 Repl.).

11 Any future surplus review process may be impacted by the amendment to GHMSI’s corporate charter that was enacted by Section 747 of the Consolidated Appropriations Act, 2016 (Pub. Law 114-113). That amendment provided in part that with respect to GHMSI’s surplus for any year after 2011, “[t]he corporation shall not divide, attribute, distribute, or reduce its surplus . . . without the express agreement of the District of Columbia, Maryland, and Virginia . . . that the entire surplus of the corporation is excessive . . . and . . . to any plan for reduction or distribution of surplus.’’
Under these circumstances, the Act provides:

If the Commissioner determines that the corporation failed to submit a plan as ordered under subsection (g) of this section within a reasonable period or failed to execute within a reasonable period a plan already submitted . . . the Commissioner shall deny for 12 months all premium rate increases for subscriber policies written in the District . . . and may issue such orders as are necessary to enforce the purposes of this chapter.

D.C. Official Code § 31-3506(i). See also 26A DCMR § 4603.3 (allowing denial of rate increase “until the company complies with the order” to submit a plan in accord with the statute).

Accordingly, the Commissioner ORDERS:

1. Effective immediately, all requests for premium rate increases for subscriber policies written by GHMSI in the District are hereby denied for 12 months from the date of this Order, or until the Commissioner develops and approves a plan pursuant to this Order, whichever occurs first;

2. Pursuant to his authority to issue such orders as are necessary to enforce the purposes of the Act, the Commissioner shall develop and approve a plan for GHMSI to dedicate the excess surplus determined by the December 30 Order in a fair and equitable manner after providing a 30-day period of public comment beginning on the date of this Order;

3. There shall be a 30-day period of public comment beginning on the date of this Order for the public to provide written comments on the plan to be developed by the Commissioner pursuant to this Order, and persons providing comments are asked to include comments that specifically address the following issues:

   a. Length of time for the dedication of the excess surplus;

   b. Whether the Patient Protection and Affordable Care Act, 42 U.S.C. §§ 18001 et seq. should impact the timing of the dedication of the excess surplus;
c. Whether the amount of excess surplus to be dedicated should be offset by any reduction in surplus between December 31, 2011 and December 31, 2015;

d. Whether the dedication of excess surplus should be suspended or modified in the event that adverse conditions reduce GHMSI’s surplus. If yes, describe the types of adverse conditions that should be considered;

e. Whether the dedication of excess surplus could be modified pursuant to future reviews of GHMSI’s surplus;

f. Whether rebates to current or past policyholders would be an appropriate expenditure for community health reinvestment;

g. Whether there were any negative contributions to surplus made by GHMSI that should be taken into account for the plan; and

4. No later than 30 days after the expiration of the public comment period set forth in this Order, the Commissioner shall issue and approve a plan to dedicate the excess surplus to community health reinvestment in a fair and equitable manner.

Dated: June 14, 2016

[Signature]

Stephen C. Taylor
Commissioner
Department of Insurance, Securities and Banking

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