

Group Hospitalization and Medical Services, Inc.

PRE-HEARING REPORT

**DISB Review of GHMSI Surplus Pursuant to the
Medical Insurance Empowerment Amendment Act of 2008,
D.C. Code § 31-3501 *et seq.***

August 31, 2009

Purpose of this Report

This Pre-Hearing Report is presented as a supplement to the report filed by Group Hospitalization and Medical Services, Inc. (GHMSI) on July 31, 2009 with the Commissioner of the District of Columbia Department of Insurance, Securities and Banking (DISB). That report described how the Company establishes and maintains the level of reserves (i.e., surplus) it holds for the protection of its subscribers and of other purposes related to the conduct of its business. This second report is submitted pursuant to the regulations issued by the Commissioner governing the hearing to be held on September 10, 2009. This hearing has been called by the Commissioner pursuant to the Medical Insurance Empowerment Amendment Act of 2008 (the MIEAA). The legislation – apparently unique among all jurisdictions – requires the following¹:

1. The Commissioner shall “review the portion of the surplus of the corporation [GHMSI] that is attributable to the District and shall issue a determination as to whether the surplus is excessive. The 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 [community health reinvestment] obligation under [section 6(a)].”

2. “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, including premium tax paid and the corporation’s contribution to the open enrollment program required by section 15.”

3. “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.”

General Context

At the outset, it is important to note that the usual posture of regulators in the health insurance field has been to focus on the solvency and financial strength of insurers. That is especially true when it comes to non-profit, single-region, single-product companies of limited size such as GHMSI. In essence, the most important question for the regulator, from the standpoint of protecting consumers who purchase insurance coverage, is whether, come what may, the Company has the solid financial footing necessary to meet its obligations to pay claims.

Indeed, a detailed framework for determining whether an insurer has that financial footing has been developed over the years by the National Association of Insurance Commissioners (NAIC). The NAIC’s standards focus on *minimum* solvency levels for insurers – i.e., the smallest amount of cash or net assets insurers can reasonably keep on hand without imperiling their subscribers. The Blue Cross and Blue Shield Association (BCBSA) likewise has developed *minimum* solvency standards for its members. A Blue insurer’s licensure, and its use of the mark, depend on maintaining these minimum solvency standards. Notably, the

¹ D.C. Code § 31-3506.

NAIC and BCBSA standards are designed to ensure *solvency* and are not intended as a framework for determining optimal – much less maximum – levels of reserves.

In short, the main point of insurance is subscriber protection, and the notion that an insurer can offer its subscribers *too much* in the way of financial protection is at odds with historical conceptions of insurance regulation. Indeed, only a small handful of states have statutory frameworks for determining when financial strength – measured by reserves – is excessive. One of these states is Maryland, a neighboring jurisdiction, where the Legislature has empowered the Commissioner of the Maryland Insurance Administration to review whether a non-profit insurer's reserves are excessive, and, if so, to order a plan from the insurer to distribute any excess only to current subscribers through rate reduction, modification or other means. Such a finding has never been made under this Maryland law.

It is of particular note that the Maryland Commissioner is currently reviewing GHMSI's level of reserves. That review is due to be completed within the next few months. This raises the distinct possibility that the parallel reviews conducted by Maryland and the District will reach different conclusions, leaving GHMSI in the untenable position of being subject to conflicting orders, and pitting regulators in one jurisdiction against those of another.

The District's review occurs in the midst of significant financial market turmoil and the most painful economic downturn since the Great Depression – a downturn that has made plain how seemingly invulnerable institutions can fail overnight. Under these circumstances, it seems odd to inquire as to whether GHMSI is offering its subscribers *too much* in the way of financial protection through its reserves. Notably, GHMSI is the only insurer subjected to this inquiry under the MIEAA.

Finally, it is also impossible to ignore the very real possibility of significant insurance and health care reform at the federal level. This could change the landscape in fundamental ways – and could impose substantial new costs on insurers. No one, including the Company itself, knows the final form or the extent to which federal health care reform will impact the finances of the Company. In the face of the potential risks associated with federal reform, it is critical that GHMSI be in the position to protect against these unknowns with strong reserves.

Historical Context Specific to the District of Columbia

GHMSI is unique among all Blue Cross and Blue Shield Plans in the United States in that it was created by an Act of Congress, which established its purpose in a Congressional Charter. This Charter empowers the Company to “enter into contracts with individuals or groups of individuals” for the purpose of providing them with health insurance coverage. The Company was established by this Charter as a non-profit that exists for the “benefit of . . . [its] certificate holders [i.e., subscribers].”

For much of the past decade, the District of Columbia has asserted in various ways and on numerous occasions that the Company has, in addition to its duty to its subscribers, an additional set of obligations beyond those set forth by Congress – namely, a duty to use subscriber funds to underwrite community programs and otherwise serve the general public by promoting health care access and improvement. District officials have asserted, in the course of regulatory and legislative hearings, that the funds GHMSI holds as

reserves for the protection of subscribers could and should be made available for this general community purpose. District officials also have repeatedly asserted that the Company's reserves are too large – i.e., exceeding the amount reasonably needed for the protection of subscribers and other business purposes – and that the Company is hoarding “surplus” unnecessarily while not contributing enough to the community.

Interestingly, during the most intense period of review on this issue in 2005, the then-Attorney General for the District of Columbia and the Commissioner of the DISB both held that GHMSI could fulfill its community obligations by serving its subscribers – in essence, by fulfilling the mission given to it by the Congress.

For its part, the Company has historically expressed the view that its mission, clearly established by the Congress, is to serve its subscribers – period. To be sure, the Company also has made clear that in the sound business judgment of its Board of Trustees, it can and does support worthy community programs to enhance the public health. Indeed it has done so generously, giving more in grants to community organizations *than all of its competitors combined*. But it sees the need for a balance here since doing too much in community giving unduly burdens subscribers as they struggle to afford their coverage.

Indeed, it is clear that GHMSI subscribers, when paying their premiums, do not expect that material portions of those premiums – or the reserves accumulated from those premiums for their protection – could be used for purposes other than their benefit and protection based on the order of a local government jurisdiction. This concern about subscriber expectations is especially acute in this era of rapidly rising health care costs, that has left health care unaffordable for many. This crisis of affordability is the cause of an intense current national debate. The Company “lives” this reality daily.

The MIEAA, in short, is the culmination and embodiment of a decade-long effort by some in the District to deem GHMSI's reserves “excessive” so that the Company could be compelled to distribute the excess to the general public. Under this view, existing GHMSI subscribers can be made to shoulder not only their own costs, but those of others who are not subscribers. For more detailed information on the history of this issue, please refer to **Attachment A**.

It is against this history and context that the September 10 hearing arises. This report presents key facts and GHMSI's views on the central questions before the Commissioner:

- Are GHMSI's reserves excessive as a whole?
- How does one calculate the portion of GHMSI's reserves that are “attributable” to the District? Is there a sound basis for attribution and the concept of excess at all?
- How does one then determine whether this portion is “excessive” or “unreasonably large” or “inconsistent with the community health reinvestment” obligation imposed on GHMSI by the MIEAA?
- If excess were to be found, what would be the basis for this conclusion and to whom would the excess then go?

The answers to these and related questions are of vital interest to the Company; the Blue Cross and Blue Shield Association; the District; the neighboring jurisdictions and Congress, which chartered the Company.

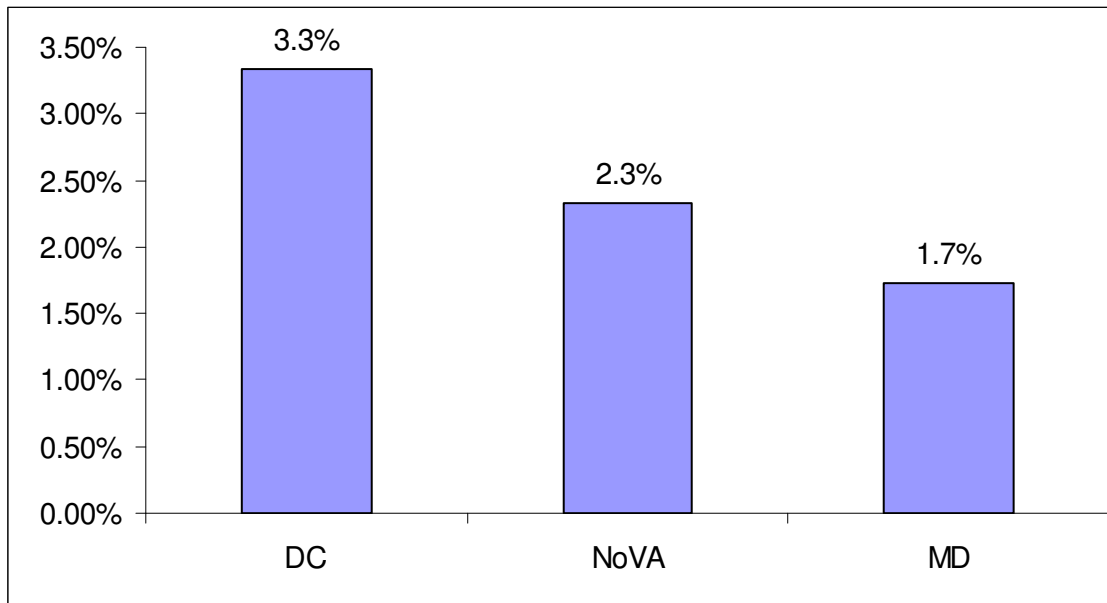
Some Key Facts

In discussing the questions set forth above, it is critical to understand a few basic facts about GHMSI's business:

1. While domiciled in the District of Columbia, GHMSI's enrollment is overwhelmingly located outside of the District. Only 1 in 10 subscribers actually lives in the District. There is no other Blue Cross and Blue Shield Plan in the country with a geographic footprint or subscriber distribution like this. It is an odd circumstance of history and geography that the jurisdiction with the smallest enrollment plays such a key role in controlling – through regulation and legislation – the nature and quality of insurance available to subscribers outside its borders. This creates obvious sensitivities and concerns on the part of neighboring jurisdictions. To read more about the breakdown in GHMSI's enrollment, please refer to **Attachment B**.
2. Since people largely seek health care services close to where they live, most GHMSI subscribers obtain their care in Maryland and Virginia. This is reflected in their claims, and those claims – based on costs driven by the Maryland and Virginia health care markets – in turn affect premiums. It is the difference between what subscribers pay in premiums, less what they incur in claims, that built the reserves held by GHMSI today (together with investment returns on the assets held in reserve). Hence, most of GHMSI's reserves were built from subscriber related transactions and experiences occurring outside of the District.
3. Approximately two-thirds of GHMSI's enrollment is comprised of federal employees and self-insured accounts. A major portion of GHMSI's reserves is developed by and for the support of the remaining third – individual subscribers and small and medium-sized employers headquartered in the District. When premium taxes are imposed by the District and “community health reinvestments” are demanded, it is precisely these individuals and small/medium-sized groups who bear the burden – not the large self-insured accounts or federal employees.²
4. GHMSI, alone among all payers in the District of Columbia, is required by District law to offer products on which it loses substantial amounts of money. These losses (now approaching \$5 million annually and climbing), together with District taxes on premiums, already put a far greater burden on individual subscribers and small/medium-sized groups than do the laws and regulations of neighboring jurisdictions, as shown in Chart A below. Any giving by the Company to worthy health promotion efforts in the community (“community health reinvestment”) further adds to these burdens. And, unlike Maryland, where community giving is in lieu of premium taxes, any giving in the District is in addition to premium taxes.

² Premium taxes and other levies do not apply to insurance written on behalf of the federal employees or self-insured accounts.

**Chart A – 2008 GHMSI Percentage of Premium Revenue
(Excluding FEP) Spent on Community Reinvestment Activities³**



GHMSI’s Reserves are Not Excessive

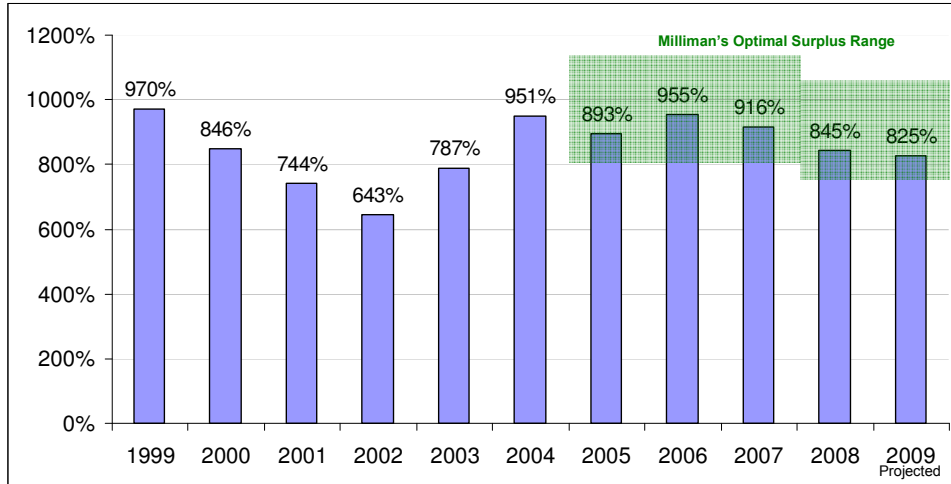
In carrying out its fiduciary duties, the GHMSI Board of Trustees has not made its judgments about the adequacy and level of reserves in a vacuum nor has it relied solely on the opinions of the Company’s own actuaries. Instead, the Board has turned to leading, independent experts for advice in setting appropriate levels of reserves and never has permitted the Company to exceed the ranges prescribed by those experts.

As presented in the report GHMSI submitted to the Commissioner on July 31, 2009, GHMSI has maintained levels of reserves over the past decade that have been within or below the bottom half of a target Risk-Based Capital (RBC) range recommended by Milliman, Inc., one of the nation’s pre-eminent actuarial consulting firms. Milliman recommended this target range after considering the full nature and scope of the risks GHMSI faces. For more detailed information on the purpose of maintaining reserves and the risks GHMSI faces, please refer to **Attachment C**.

Further, GHMSI has recently had the reasonableness of this range confirmed by The Lewin Group, another pre-eminent actuarial and health care consulting firm. This constitutes a “second opinion” as called for from time to time by Board policy on this subject to assure the most appropriate result. The target RBC range is shown below in Chart B. For a detailed discussion of the optimal reserves range recommended by Milliman and adopted by GHMSI’s Board of Trustees, please refer to **Attachment D**.

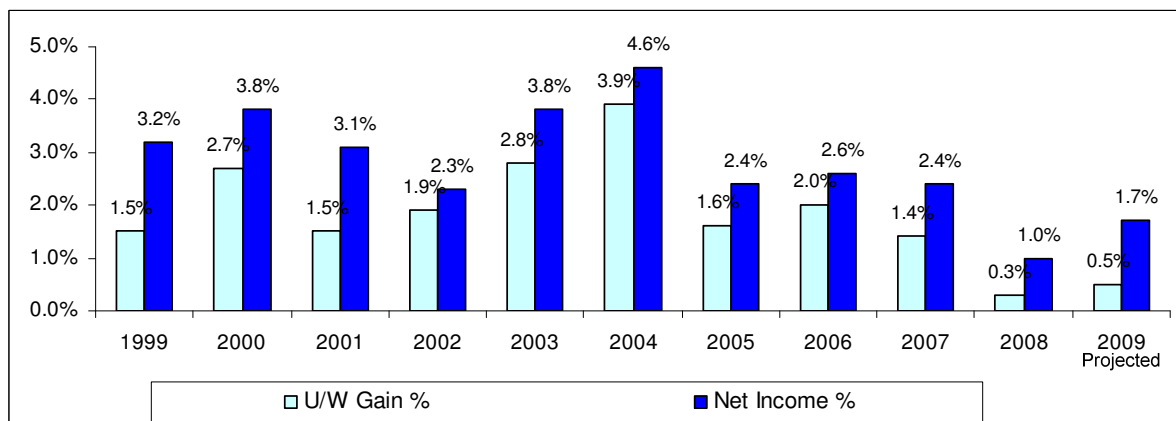
³ See page 28 for a fuller explanation as to why the percentage of community health reinvestment activities by GHMSI in the District may be as high as 7-8% for 2009 onward

Chart B – GHMSI Historical RBC Ratio with Milliman Recommended Revenue Ranges



The Company, under Board oversight, has operated consistently with extremely thin operating margins that have been tailored to maintain GHMSI's position in the target RBC range, as shown in Chart C. As is readily apparent, the Company's reserves position has been declining in recent years and is projected to decline slightly again in 2009. To understand why GHMSI's reserves are not "unreasonably large," please refer to **Attachment E**.

Chart C – GHMSI Historical Margins from Underwriting and Total Income as a Percentage of Revenue



The two outside actuarial advisory firms used by the GHMSI Board of Trustees provide actuarial services to a large number of Blue Cross and Blue Shield Plans and other insurers throughout the country. More detailed background information on both Milliman and The Lewin Group is included in a packet of references which is available upon request. In particular, the firms reached the following conclusions:

- Milliman's December 2008 Report recommends that GHMSI strive for an optimal range between 750 percent and 1050 percent of RBC. This recommendation was subsequent to Milliman's August, 2005 report where Milliman recommended that GHMSI strive for an optimal range between 800-1100 percent.
- Milliman's August 2009 report concludes that any attribution of GHMSI surplus by jurisdiction is artificial. However, if it must be calculated, the approach should be based upon residency of the subscribers which would result in 11.6 percent of 2008 year end GHMSI surplus or \$79.5 million.
- Lewin's August 2009 report concludes that Milliman's recommended range, as well as the process to determine it, is reasonable and further concludes that any attribution of surplus should accrue to subscribers.

Portion of GHMSI Reserves Attributable to the District is Not Excessive

The requirement placed on the Commissioner by the MIEAA is to determine whether the "portion" of GHMSI's reserves "attributable to the District" is excessive. Neither the Company nor its external, independent advisers could find any basis in legal, regulatory or industry standards for "attributing" a portion of a company's reserves on a geographic basis. In fact, the MIEAA mandate to do so raises a number of issues and problems.

First, reserves are indivisible. That is, reserves are held for the benefit of all of GHMSI's subscribers, wherever they are located. Thus, any steps to reduce the level of reserves purportedly "attributable" to a particular jurisdiction, actually reduces the protection available to subscribers in *all* jurisdictions. Further, the reserves – as well as the earnings on them – are held in assets that are not geographically divisible.

Second, the dictionary definition of "attribute" is to "belong to" or to be "caused by" or to be "resulting from." In the absence of any other established regulatory framework for calculating the amount attributable to the District, we believe one must look for guidance to the Company's Congressional Charter which empowers GHMSI to "enter into contracts with individuals or groups of individuals." It also expressly instructs the Company to issue "appropriate certificates evidencing such contracts." These certificates are issued to subscribers, not employer groups.

As noted earlier, GHMSI's reserves have been slowly built and maintained over the years by accumulating the extremely small difference's between premiums paid by or on behalf of subscribers and the claims and administrative expense paid on their behalf by the Company pursuant to their certificates of coverage. As noted above, the amount of the premiums and the size of the claims reflect the health care costs of the areas in which the subscribers live.

So, for the exclusive purpose of attribution under the MIEAA, it is the belief of the Company that the appropriate method for determining that portion of GHMSI's surplus "attributable to the District" is to base the analysis on subscriber residence. This is a non-standard approach to a non-standard requirement, but for the reasons described above and in greater detail in the attached reports, it is the most equitable, fair and workable solution.

In effect, by looking at the difference between premiums collected and claims paid, one can get at the source of the GHMSI reserve and determine who it belongs to as well as who created it.

Using this approach, approximately 11.6 percent of GHMSI's reserves are "attributable" to the District. This is approximately equivalent to the District's share of enrollment based on residency. A summary of the basis for this conclusion is presented in the attached reports of Milliman and Lewin and **Attachment G**, which include a discussion of the applicability of residency in this particular context.

Third, as to whether the portion of the reserves "attributable" to the District is excessive, one faces a number of challenges. The standard approach to assess the size of reserves – the Risk-Based Capital (RBC) methodology – cannot be employed because it is inherently designed to measure a company's aggregate reserve, not a portion of it. Even if it could be used, RBC requirements go up as the size of the relevant subscriber population goes down. This means that the target range established by Milliman for GHMSI as a whole would certainly be insufficient for the small part of the reserves that is attributable to the District. As Milliman has observed:

[W]e can state that any range that is appropriate for the District of Columbia portion of GHMSI would be higher, when expressed as a percentage of the applicable benchmark, than the optimal surplus target range that we recommended for GHMSI as a whole. **See Milliman Report Attached as Exhibit A.**

Moreover, RBC was specifically designed by NAIC to determine *minimum* solvency standards for health insurance companies, not recommended ranges of reserves for a healthy company, much less to identify what might be considered excessive on a portion of those reserves. For a detailed analysis of the issues regarding the attribution question, please refer to **Attachment G**.

Finally, the MIEAA specifically requires the Commissioner, in "determining whether the surplus of the corporation that is attributable to the District is excessive," to "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."⁴ The portion of GHMSI's year-end 2008 reserves "attributable" to the District is approximately \$79.5 million based on the residency approach outlined above. Taxes, community giving and current open enrollment losses for 2009 for the District are expected to total approximately \$17 million. This is a very considerable portion of the reserves "attributable" to the District.

Moreover, the Company's annual obligations, as set forth in the MIEAA, are expected to increase significantly in the near future. The Company expects to implement a new "public-private" partnership that the Company estimates will add at least another \$7 million to \$8 million annually to this \$17 million total. This new program has been the subject of recent discussions between the Company and the District Council and has been embodied in proposed legislation that will be the subject of a hearing in mid-September and is expected to go to a second reading sometime this fall.

Significantly, as currently drafted, that legislation provides that if the Company and the District fail to reach agreement on a public-private partnership, the Open Enrollment mandate provisions of the MIEAA – which have been temporarily suspended – would take effect. The Company estimates that the cost of complying

⁴ D.C. Code § 31-3506.

with those Open Enrollment provisions would range from \$20 million to \$30 million annually (in terms of losses that GHMSI would incur by offering the enhanced open enrollment product). Factoring in these costs, the sum of all of GHMSI's obligations are enormous in relation to the amount of reserves "attributable" to the District.

It is very clear, therefore, that the problems inherent in attribution are great and the likelihood of excessiveness on the portion of the reserves "attributable" to the District is nil. In fact, in light of GHMSI's considerable existing and expected obligations, were the District to impose additional burdens on GHMSI's reserves, GHMSI would be forced to pursue higher premiums on individuals and small/medium-sized groups in the District, seek financial support from GHMSI's reserves attributable to other jurisdictions, or seek financial support from CareFirst of Maryland, Inc. under the terms of the CareFirst intercompany agreement.⁵

GHMSI's Reserves are not Inconsistent with its Community Health Reinvestment Obligations"

Because GHMSI's reserves are not "unreasonably large," and because under the Act the reserves cannot be "excessive" unless they are "unreasonably large," the Commissioner need not go any further. But, in any event, GHMSI's reserves also are not "excessive" for a second, independent reason: They are not inconsistent with the corporation's statutory community health reinvestment obligation.

GHMSI's statutory obligation is to "engage in community health reinvestment to the maximum feasible extent consistent with financial soundness and efficiency." D.C. Code § 31-3505.01. "Community health reinvestment," in turn, is defined 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). Thus, the question for the Commissioner is whether GHMSI is doing what it can, consistent with maintenance of an appropriate level of reserves, to safeguard the public health for the benefit of its certificate holders. The answer to that question is "yes." The Company's community health contributions are very substantial – running into the tens of millions of dollars each year.

GHMSI's method of community giving varies by the three jurisdictions in which it operates. In Maryland, the majority of giving is "in lieu of" taxes which would otherwise be due. In Virginia, a portion of premium taxes are exempted in exchange for the provision of an Open Enrollment program in the GHMSI service area. In the District, GHMSI pays premium taxes (originally intended to fund Healthy DC although a portion of the funds have recently been redirected to the District's general fund), provides an Open Enrollment program, and continues to give generously to the community. Chart D below shows, on a percentage basis, the disproportionately large share of community reinvestment that occurs in the District of Columbia.

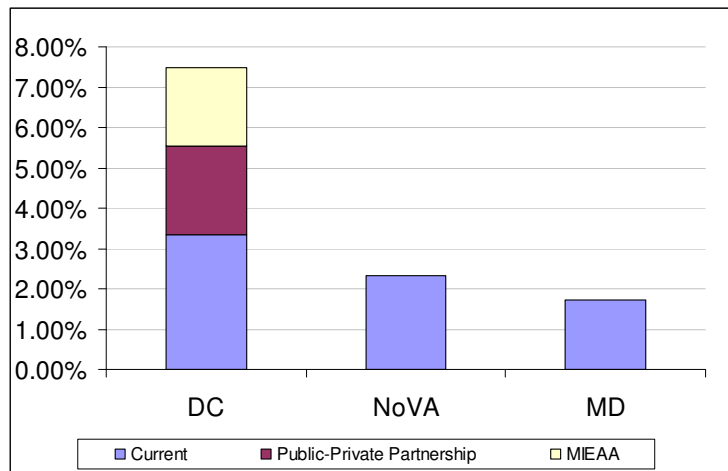
Stated another way, when taxes, giving, subsidies and all forms of community investment are put on an "apples-to-apples" basis, GHMSI already provides far more to the District than its proportionate share (i.e. 10 percent of GHMSI's enrollment resides in the District, but approximately 45 percent of all GHMSI community

⁵ The CareFirst intercompany agreement provides that GHMSI and CareFirst of Maryland, Inc. will provide support to one another in the event of, among other things, an insufficiency in the level of reserves held by one of them.

investment goes to the District today). This is before the impact of the public-private partnership is felt and/or the full impact of the MIEAA Open Enrollment requirements.

Chart ___ below shows the level of GHMSI’s current community investment and the amounts that would be added by the public-private partnership contemplated in the current pending legislation as well as the potential full effect of the MIEAA’s mandates on open enrollment.

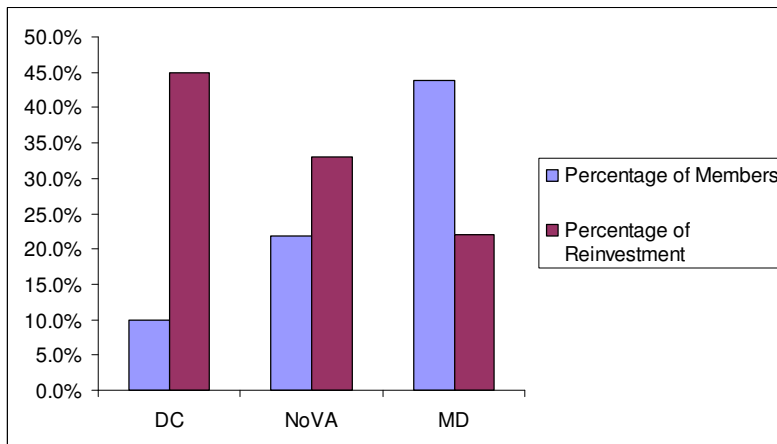
Chart D – GHMSI Percentage of Premium Revenue Invested in Community Health Reinvestment Activities Post- MIEAA*



*Excludes FEP revenue

Chart ___ below, shows the proportion of GHMSI membership in each jurisdiction compared to the level of total community investment in each jurisdiction inclusive of taxes, giving, subsidies and mandated losses.

Chart E – GHMSI Community Giving By Jurisdiction, 2008



For more information on GHMSI's community health reinvestment and other ways that the Company contributes to the community, please refer to **Attachment F**.

Any Excess Reserves Should be Returned to Subscribers

If, despite all of the reasons and difficulties outlined above, the Commissioner were to find that GHMSI's reserves "attributable" to the District were in fact excessive, the question that then must be answered is: Who gets this excess?

We believe that any legitimate excess (which we do not believe exists) is the subscribers' money and should be returned to them. In effect, it means they were overcharged and are due a refund. In this case, since the portion "attributable" to the District was based on residency, any excess must be returned to the source from which it came or to which it is "attributed": D.C. residents who are subscribers. Returning any excess to subscribers is also consistent with the Congressional Charter of GHMSI which commands GHMSI to serve for the "benefit of its subscribers." To do otherwise would violate the Congressional Charter. Notwithstanding all of the issues inherent in attempting to attribute a portion of the reserves, there is actuarial soundness in returning any excess to its rightful source.

Notably, the MIEAA permits GHMSI to fully satisfy its community health reinvestment obligations by returning any excess to current subscribers in the form of rate reduction or rate relief. The legislation now pending in the District Council repeals this provision, which had been added to the MIEAA to make it consistent with GHMSI's Congressional Charter obligations and to allay significant concerns raised by neighboring jurisdictions during the legislative deliberations.

Conclusion

The import of this report is clear: Neither the Company nor its independent advisers believe there is any basis to conclude that GHMSI is operating with excessive reserves. Although levels of reserves have fluctuated over the last decade, they have never exceeded the upper end of a carefully established target range based on the advice of a pre-imminent actuarial firm. Indeed, the reserves have been steadily declining. They are appropriate for a healthy company that plays a vital role in the District and the surrounding region.

The attempt to establish a portion of the GHMSI reserves that is “attributable” to the District is ill considered and does nothing to change the fact that the reserves are not “owned” in whole or part by the District; nor are they dedicated to the District any more than they are to other jurisdictions (Maryland and Virginia) in which GHMSI operates. They are shared by all subscribers and all jurisdictions for the protection and benefit of all.

In fact, the reserves that GHMSI holds today have been mostly built by subscribers who live outside of the District who have a right to the protection and the investment yields from these reserves that are today held for their benefit. If a District regulatory process were to determine that GHMSI has excessive reserves in the face of sound actuarial analysis to the contrary and then order the disposition of such alleged excess to the community at large, this constitutes nothing less than a confiscation or taking of subscribers’ funds at a time when subscribers – especially individuals and small groups – are struggling to pay premiums as it is. This would be a gross misuse of District government power.

Attachment A

Historical Perspective

GHMSI HAS FACED REPEATED ATTEMPTS TO REDEPLOY ITS ASSETS TO BENEFIT NON-SUBSCRIBERS

As established in its 1939 Congressional Charter, GHMSI operates, and is required to operate, for the benefit of its subscribers. Although GHMSI's Charter is clear,⁶ there have been certain individuals and groups, most notably the D.C. Appleseed Center for Law & Justice, a non-profit public policy advocacy group, that began insisting as early 2002 that GHMSI was failing to meet its obligations under its Congressional Charter as a "charitable and benevolent" institution. In a series of reports, including the Appleseed website, which argued that GHMSI should contribute 2 percent to 3 percent of its direct premiums (\$67 million to \$100 million by 2008, by its estimates) annually for the public's benefit. Appleseed asserted that GHMSI's assets (e.g., its financial reserves):

belong to the public. And, unlike for-profit insurance companies, GHMSI *exists* to serve the public...Think of it this way: if GHMSI were a for-profit company, its profits and surpluses would benefit the Company's shareholders. In this case, residents of the National Capital Area are the Company's shareholders -- and the Company is withholding the public's benefits.

Appleseed's goal to redirect GHMSI funds for the benefit of the greater community was most recently reaffirmed in an interview in the *Washington Business Journal*, in which Appleseed Executive Director Walter Smith was quoted saying, "With the economic downturn, the health care needs of Washington, D.C., area residents are quite high. A company with the assets of CareFirst could underwrite public education on obesity or efforts to prevent diabetes."⁷ The report published by Appleseed in late 2004 prompted then-Commissioner of Insurance of the DISB Lawrence Mirel to conduct a public hearing to examine "the charitable and benevolent missions of GHMSI/CareFirst, the District's Blue Cross/Blue Shield health insurer. The Public Hearing will be held to receive testimony from GHMSI, Appleseed and the public regarding Appleseed's charges." In advance of Commissioner Mirel's March 2005 hearing, then-D.C. Attorney General Robert Spagnoletti issued his own advisory opinion in response to Appleseed's assertions. He concluded that GHMSI could meet the requirements of its Congressional Charter by providing health insurance to its subscribers.⁸ Mr. Spagnoletti wrote, "GHMSI may fulfill its obligations as a 'charitable and benevolent institution' through the provision of health plan services to paying subscribers," adding "GHMSI may seek to promote better public health by using its profits exclusively to enhance the quality, benefits, affordability, or accessibility of its health plans."

The subsequent public hearing convened by Commissioner Mirel addressed the following questions: "(1) Whether GHMSI has a legal obligation to engage in charitable activities beyond what it is currently doing? (2) If so, what is the nature of that obligation and who should be the beneficiaries of it, and (3) Assuming there is such an obligation, how much charitable activity is appropriate, consistent with GHMSI's obligations to its policyholders and its need to remain solvent?" Based on that hearing, Commissioner Mirel confirmed that "GHMSI has a legal obligation under its charter to operate as a non-profit charitable and benevolent institution." He added, however, "The evidence before us strongly indicates that the provision of health insurance to its subscribers (and the offering of health insurance on a generalized basis) constitutes charitable activity under GHMSI's charter, and the Department so finds."⁹ The matter of GHMSI's reserves has prompted *The Washington Post*, on two occasions (*CareFirst and the Law*, Thursday, May 19, 2005; *Assault on a Health Insurer: CareFirst shouldn't be a piggy bank for District politicians*, Saturday, October 18, 2008) to editorialize on the matter of to whom the reserves of GHMSI belong, and on both occasions recognized that the reserves belong to the subscribers and the decision regarding GHMSI's level of community health reinvestment lies with GHMSI's board.

⁶ See attached copy of GHMSI's 1939 Congressional Charter.

⁷ "D.C. Leaders Going After CareFirst's Reserves Again," *Washington Business Journal*, August 21, 2009.

⁸ See highlighted Spagnoletti advisory opinion, March 4, 2005.

⁹ See Mirel report, May 15, 2005

Despite such indisputable conclusions by the District's top legal adviser and insurance regulator, there have been no fewer than five separate legislative attempts by members of the D.C. Council as well as litigation initiated by the current Attorney General which have sought to redirect for public purposes those reserves held by GHMSI for the protection of its subscribers. Indeed, in a story in *The Washington Post* announcing his lawsuit against GHMSI, D.C. Attorney General Peter Nickles asserted that the Company is "required to put \$100 million into the community." Although that litigation was dismissed, the current review of GHMSI's reserves occasioned by the Medical Insurance Empowerment Amendment Act of 2008 appears to be the latest attempt by the District of Columbia to tap for its own purposes those reserves built by, and maintained for the protection of, GHMSI's subscribers.

Attachment B

GHMSI's Subscriber Base

GHMSI IS A NON-PROFIT HEALTH SERVICES PLAN CHARTERED TO OPERATE FOR THE BENEFIT OF ITS SUBSCRIBERS

The Company's subscriber base can be divided into three categories: (i) individuals and small/medium sized groups that buy insurance products from the Company; (ii) self-insured programs where the Company serves as a health benefits administrator for a large group but bears certain performance risks; and (iii) the Federal Employee Health Benefit Plan (FEP), through which the Company bears a portion of the insurance risk collectively assumed by all Blue Cross and Blue Shield Plans throughout the country.

GHMSI's total enrollment of approximately 1,000,000 subscribers is broken down as follows: 32 percent fully insured members, 33 percent self-insured subscribers and 35 percent FEP subscribers, as shown below:

Chart F – GHMSI Enrollment

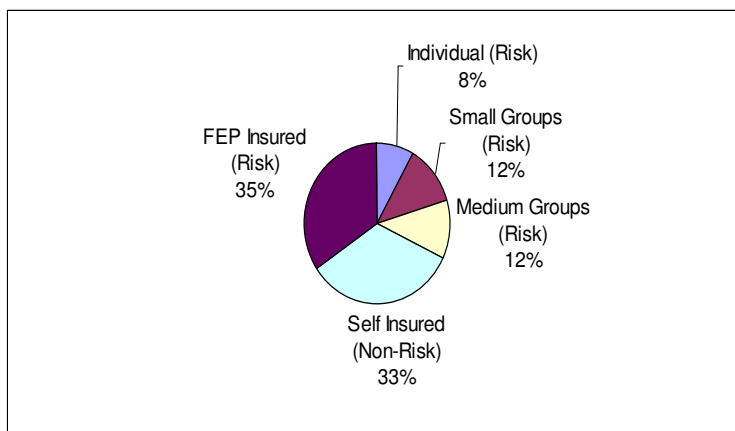
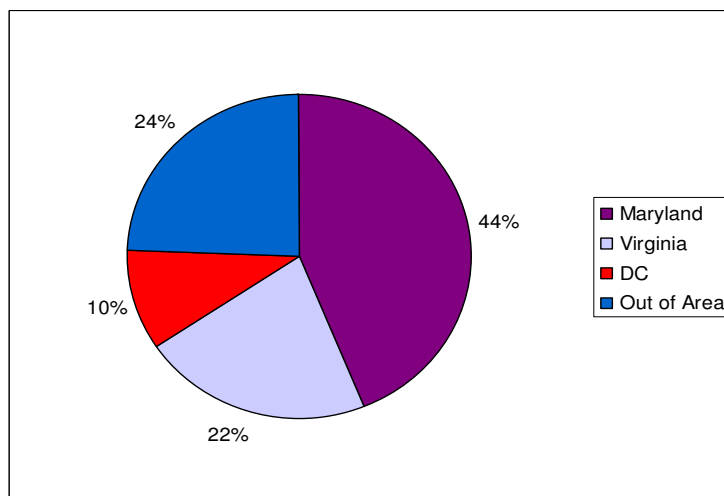


Chart G – GHMSI Members by Residence



Approximately 90 percent of GHMSI's members reside outside of the District, as the chart below demonstrates. These non-District residents contribute substantially to GHMSI's reserves through the premiums paid by them or by their employers on their behalf.

Attachment C

Purpose of Reserves

GHMSI HOLDS RESERVES TO ENSURE THAT IT CAN MEET ITS OBLIGATIONS EVEN IN THE FACE OF UNEXPECTED ADVERSE EVENTS

Health insurers, including GHMSI, are legally required to hold substantial sums in “reserve” to guard against risks, both anticipated (those the Company can identify with reasonable certainty through actuarial and other analyses) and unanticipated. Indeed, insurers can be penalized if their reserves fall below mandated minimum levels. Failure to maintain robust reserves can expose an insurer to the risk of business failure and/or inability to pay customer claims – a worst-case scenario against which prudent insurers are careful to guard, especially in a business climate that places unprecedented pressure on the financial viability of companies of all types.

A. Reserves Protect GHMSI Against A Variety Of Risks and Contingencies

GHMSI’s reserves are held to protect against a wide variety of risks and contingencies associated with the Company’s insured business, financial undertakings and government obligations. The first category of risks – those related to the core business of the Company – includes:

- 1) Unforeseen catastrophic events, such as epidemics, natural disasters and acts of terrorism;
- 2) Unforeseen trends or fluctuations in health care costs;
- 3) The amount of unpaid claim liabilities;
- 4) The speed and certainty of subscriber payments, both individual and group; and
- 5) Guaranteeing performance for large, self-insured groups, which now demand significant monetary concessions from GHMSI if it misses certain administrative performance targets.

As Milliman observed in its December 2008 report to the D.C. Council, catastrophic events are particularly important to guard against for by their very nature they will have “very severe adverse financial consequences” if and when they do arise. “Failure of the insurer to provide protection against such risks...means that the Company is exposed to ruin or incapacity from such an event. More importantly, it means that the Company does not maintain the resources to protect its subscribers and members...against catastrophic loss should such an event occur.”¹⁰ In light of the well-publicized concerns about the spread of the H1N1 (“swine”) flu later this year and this region’s particular risk of further terrorist attacks, it is especially critical that GHMSI plan for catastrophic events.

Health insurers also must guard against a wide variety of risks unrelated to their insured business. First – and particularly relevant in the current economic climate – reserves must be sufficient to guard against fluctuations in interest rates and portfolio asset values. The sort of steep decline in asset values the market has suffered in the last 12 months has the potential to quickly draw down an insurer’s reserves and imperil its financial stability. Likewise, insurers must have the reserves necessary to respond to competitive changes in the health insurance market requiring new and/or different products, capabilities and services. As Milliman explained in its December 2008 report, “today in most areas of the country the health insurance market is increasingly dominated by aggressive and highly competitive regional and national managed care companies. In order to remain viable, a health insurer must anticipate and respond to this ever-changing competitive environment. Doing so requires substantial capital resources and surplus.”¹¹

Nor are these the only non-claim-related demands on reserves. Other substantial costs that are met through reserves include GHMSI’s commitment to community health. Each year, the Company, in keeping with the policy established by its Board, gives to a wide variety of worthy organizations engaged in activities that improve the general health of the community. This amounts to millions of dollars annually, as we discuss in

¹⁰ Milliman December 2008 Report at 13.

¹¹ *Id.* at 9.

detail below. The only source of funds available to GHMSI for this giving is reserves. In addition to these efforts, the Company must make regular costly infrastructure upgrades, which, as Milliman has observed, enable “[h]ealth insurers [to] stay near the forefront in terms of the effective integration of communication, information processing and computing technology. This requires capital investment, which has become virtually continuous with the rapid development and obsolescence of technology.”¹² The heavy financial burden of these upgrades must be funded from GHMSI’s reserves; the Company has no other source from which to fund such investments. In fact, consistent with Milliman’s observation, GHMSI is currently engaged in a multi-year, multi-million dollar effort to upgrade enrollment and claims processing systems which will improve customer service and provide new and innovative ways of managing health care quality and cost all for the benefit of subscribers.

Finally, health insurers must have sufficient reserves to meet the obligations of local and federal government-mandated programs, which impose additional burdens on GHMSI costing literally tens of millions of dollars. Reserves must allow the insurer to respond to a government mandate and meet these requirements – all without putting its ability to make claims payments at risk.

The recent District legislation directed at GHMSI is a case in point. GHMSI is required by District law to offer products that produce known losses and to pay subsidies to help vulnerable populations gain better access to health care. These requirements are placed on GHMSI alone; they apply to no other payer. The latest (and pending) mandate being contemplated by the Council of the District of Columbia in draft legislation will impose losses to GHMSI of at least \$12 million annually – and potentially much more. The source that supports these losses? GHMSI’s reserves.

B. As A Non-Profit, GHMSI Obtains Reserves Only From Premiums and Must Rely On Its Reserves For All Its Investments and Upgrades

As a non-profit health services plan, GHMSI obtains the funds to build and hold reserves from a single source: the premiums paid by subscribers, whether directly or through their employer groups. GHMSI does not sell stock or count the excess of the market value of stock over tangible net worth as equity value to which the Company can turn for capital should the need arise. Since GHMSI has no stock, it has no access to the capital markets.

GHMSI accordingly builds reserves the only way it can – principally from the difference between what it collects in premiums and what it expends in claims and operating expense to conduct its business. This is GHMSI’s only source of capital. Earnings on these reserves, which are conservatively invested on behalf of subscribers (approximately 80 percent of all investments are in the form of fixed income instruments), accumulate and add to reserves in normal economic times.

Building Reserves From Premiums Is Gradual

GHMSI’s operating margins, meaning underwriting gains and net income, have historically been extremely narrow. Underwriting gains (the difference between premiums and total member claims and administrative expense) have averaged between less than 1 percent and 3 percent annually over many years. GHMSI’s annual contributions to reserves (net income) have averaged between 1 percent and 4 percent, including investment income. This low margin is much lower than the underwriting margins of for-profit companies, which generally hover in the 6 percent to 10 percent range. These margins are subject to swings that are natural in the health insurance business; historically, underwriting results of health insurers have been subject to trends in which multi-year underwriting loss periods are commonplace.

Given the small margins it derives from underwriting risk and investment earnings, it takes GHMSI years to build up reserves. But, as the past year has shown, reserves painstakingly built up over long periods of time can decline precipitously when adverse financial market trends combine with adverse claim trends. Over the past decade, GHMSI’s reserves have fluctuated more than 50 percent from high to low as the various factors influencing the reserves have been felt.

Absent Robust Reserves, GHMSI Faces a Severe Competitive Disadvantage.

GHMSI operates in one of the most competitive health care marketplaces in the country. Virtually all of its competitors are multi-product line, multi-regional, for-profit insurers able to issue stock or debt. GHMSI’s

¹² *Id.* at 10.

largest not-for-profit competitor is a national payer with diversification across most of the country. “The capital resources of these larger competitors tend to be enormous. Such resources enable them to invest in new, leading-edge technologies and to aggressively build and contract with provider networks. It gives them negotiating clout, risk-spreading capacity and funding for market acquisition. A large scale of operations also enables them to spread overhead costs more effectively over a broader base.”¹³

In contrast, GHMSI is a single-product-line, single-region insurer with no diversification. If it were to run into capital shortages or other trouble with the risks it bears, it has no ready source other than its reserves from which to draw. No government program provides a safety net or backup to GHMSI’s resources. It must stand on its own. Its history includes at least one episode in the early 1990s where its very existence was threatened. GHMSI was constrained to borrow \$60 million from other Blue Plans so it could continue to serve its certificate holders and remain in business.

GHMSI also faces a landscape in which health care is increasingly expensive, with the effect that an insurer’s ability to ward off financial trouble through premium increases is greatly curtailed. Health care cost increases have reached the level where most individuals and employers are struggling to pay premiums. If GHMSI were to need to materially replenish reserves, it would have to add greater margins to its premium rates – further exacerbating the health care affordability problem and reducing GHMSI’s competitiveness. GHMSI, in other words, would be between a rock and a hard place; it would have no way to raise capital except through premium increases, but premium increases would drive its customers to larger competitors. Given this dilemma, GHMSI must maintain a level of reserves that protects its certificate holders by (i) allowing GHMSI to make necessary upgrades and capital investments while (ii) sustaining affordability by moderating otherwise required premium increases.

GHMSI Is Limited in Its Ability to Raise Money to Pay for Federal Mandates

Moreover, the nation may be entering an era of fundamental insurance and health care reform driven at the federal level which could change the landscape in fundamental ways – and could impose substantial new costs on insurers. One core idea in the reform debate illustrates this: There is widespread support for the proposal that all insurance companies would be required to issue policies without regard to the health status or pre-existing conditions of the prospective member. GHMSI strongly supports this idea. But no one knows the full impact or downstream consequences of such a requirement – only that it could produce losses that would cut deeply into the reserves of GHMSI.

¹³ *Id.* at 9.

Attachment D

Optimal Reserves Range

GHMSI'S RESERVES FALL WITHIN, AND HAVE LONG FALLEN WITHIN, OPTIMAL RANGE

A. Regulators Require Insurers To Maintain Reserves Above Minimum Levels

Because a lack of reserves would imperil both an insurer and its customers, governmental and industry regulators require insurers to maintain a certain minimum level of reserves at all times. Most pertinent here are two figures. First, the Blue Cross and Blue Shield Association ("BCBSA") sets a 375 percent risk-based capital ("RBC") "Early Warning Monitoring" threshold. If an insurer's reserves fall below that level, the insurer is subject to monitoring for potential lack of financial soundness. Second, various regulators, including the BCBSA and the District, set a 200 percent RBC minimum to guard against even more severe undercapitalization.

It is important to understand the meaning and import of these minimum RBC levels, and so we discuss them in some detail here.

What is RBC?

The RBC mechanism provides for the calculation, by detailed formula, of a benchmark or reference value that can be used to establish minimum reserves and solvency standards. The key number the RBC method produces is called the RBC "Authorized Control Level," or "RBC-ACL." Put simply, the RBC-ACL methodology examines an insurer's size, structure and insurance and business risks and produces a baseline number quantifying how much capital it has on hand to protect against claims risks and other expenses. The RBC formula does *not* attempt to calculate how much capital an insurer needs for innovation and infrastructure upgrades required for ongoing business viability and success. Thus, the RBC-ACL cannot be the end of the story. Instead, "[i]n developing an optimal range for a Company's surplus, as opposed to a minimum threshold for solvency monitoring, surplus needs for matters not contemplated in the RBC formula must be considered and addressed."¹⁴

In GHMSI's case, an RBC-ACL of 200 percent equates to just about 2½ *weeks'* worth of insured (including Federal Employee Health Plan) member claims and expenses for GHMSI and its proportionate share of BlueChoice.¹⁵ An RBC-ACL of 800 percent equates to approximately 10 weeks of such claims and expenses.

The 375 Percent and 200 Percent RBC Benchmarks Are Minimum Floors, Not Targets

The BCBSA and the District have adopted RBC benchmarks of 375 percent and 200 percent to serve as a "red flag" when an insurer is under-reserved and at risk of claims payment default or cessation of business. Upon triggering the 200 percent of RBC-ACL threshold, a domestic insurer must formally notify the DISB Commissioner of the corrective actions it plans to take. Direct regulatory interventions are triggered if surplus drops to even lower percentage levels. As for the BCBSA, meanwhile, the BCBSA begins stringent oversight of any licensee that falls below the 375 percent RBC-ACL threshold. Any plan that falls below the 200 percent RBC-ACL benchmark is stripped of the right to use its Blue Cross Blue Shield trademark. As Milliman observed, "[t]he loss of trademark due to inadequate financial strength would likely be a catastrophic event."¹⁶

To be quite clear: These RBC benchmark levels set an *absolute minimum*, not an optimal target number, for an insurer's reserves. The 375 percent and 200 percent figures are not viewed by the Company, the BCBSA or any regulator as reasonable, prudent or optimal levels of reserves; they represent levels to be avoided, not levels to be achieved. An insurer with reserves in the range of 375 percent would not be appropriately cushioned against a panoply of risks; it would instead be flirting with a level of reserves so low as to trigger

¹⁴ *Id.* at 18.

¹⁵ *Id.* at 20.

¹⁶ *Id.* at 21.

increased scrutiny of its business by regulators and, as a Blue plan, potential stripping of its trademark altogether.¹⁷

In its December 2008 report, Milliman explained why an insurer's optimal RBC range will always be substantially higher than the regulatory minima established to ward off imminent financial disaster:

The focus of oversight and regulatory bodies on adequate minimum surplus levels is understandable and appropriate. These bodies bear responsibility for monitoring the continuing solvency of the health plans under their jurisdiction, and for taking actions before impending insolvency and closure. . . . The proper focus of a financially healthy non-profit Blue Cross Blue Shield Plan, however, is on achieving and maintaining an optimal ongoing surplus level. Such a level is intended to (i) ensure the continuing viability of the Company, (ii) inspire warranted confidence by group customers, subscribers and providers, (iii) enable the development of competitive yet adequate premium rates for customers (rather than needing to be excessively high, because of inadequate surplus to back them), and (iv) provide funding for long-term development costs and investments. Such a focus by Company management is prudent and appropriate. [Thus] [a]n optimal ongoing operating range for a company's surplus level clearly will be higher than the minimum level used by regulators and oversight bodies as a benchmark for warning signals against insolvency and necessary intervention.¹⁸

In keeping with this common-sense analysis, Milliman has developed a target range for GHMSI's reserves of 750 percent to 1,050 percent of RBC-ACL. This target range is designed to ensure that GHMSI's RBC-ACL will remain above the 375 percent minimum RBC threshold even in the midst of a particularly adverse business cycle.

B. GHMSI's Policy on Reserves

GHMSI seeks to hold only that amount of reserves that is reasonable and prudent to account for all of the various risks, contingencies and demands the Company faces or may face. The Board of Trustees of the Company has adopted a formal policy position on this subject. The essence of this policy is that the Company strives to operate with levels of reserves in an optimal range. If reserves are below or are heading below the bottom of the range, premium rate margins are increased to bring reserves back into the range. If reserves are too high or heading too high, rates are moderated or rate increases are delayed to bring the reserves down. GHMSI generally evaluates its reserves on a three-year horizon in order to accommodate natural fluctuations in the business. Moderation is the key. Slow build-up of margins when reserves are low is the goal in order to avoid large premium spikes.

In the absence of clear regulatory standards and methodologies for determining an optimal reserves range, the GHMSI Board has historically sought outside expert actuarial advice on a yearly basis. By 2005, the Company sought this advice not solely to assure that reserves stayed above the required minimums, but with the notion of establishing an optimal range (floor and ceiling) that could provide the foundation for the policy framework described above.

To accomplish this, the Company retained Milliman's expert actuarial services. Milliman works with insurance companies, managed care organizations, Blue plans, long-term care insurers and disability insurers. The firm's strategic advice is grounded in details, and their technical work always references the business imperatives at the direction of the GHMSI Board. They provide us with outside experts in this discipline with a broad view of the issues facing the industry to help our Board manage through change: diversification, consolidation, global competition, consumerism and technology. Milliman developed an actuarial model, explained more fully below, that initially determined the Company's optimal reserves level – given its various risks and demands over a multi-year period – to be between 800 percent and 1,100 percent of RBC. A second review, completed in late 2008, modified the optimal range to between 750 percent and 1,050 percent of RBC.

¹⁷ Neither the NAIC nor the BCBSA has established standards for what constitutes *too much* reserves. The entire focus of both organizations has been on the solvency of insurers and on establishing methodologies for ascertaining *minimum* solvency – not desired or optimal (much less “maximal”) solvency.

¹⁸ *Id.* at 22.

C. Milliman's Methodology

Pages 26-56 of Milliman's December 2008 report explain the actuarial process that under-girded the development of GHMSI's target reserves range. While one cannot fully understand the models used by Milliman without substantial grounding in actuarial science, the analysis essentially proceeded as follows:

First, Milliman examined GHMSI's historic performance to determine the Company's range of underwriting performance and how it either conformed to or departed from assumptions. As Milliman explained, underwriting results of health insurers have been characterized historically by marked underwriting cycles; periods of industry-wide underwriting gains have been followed by periods of losses, and then again by periods of gains. While specific patterns have varied by Company and by market segment or region, market-wide results historically exhibited a consistent six-year underwriting cycle – three years of gains followed by three years of losses – throughout the 25-year period from the mid-1960s to the end of the 1980s.

GHMSI has experienced these same cyclical forces, and indeed, GHMSI has experienced three distinct adverse cycles – periods of years during which GHMSI suffered net underwriting losses – during the period since 1980.¹⁹ Put another way, there have been three downturns during which GHMSI paid out more in claims and administrative expenses than it brought in through premiums, thus cutting deeply into the Company's reserves as it dipped into them to pay the difference. The three adverse cycles for the combined GHMSI operation produced cumulative underwriting losses that ranged from 12 percent to 45 percent, averaging about 25 percent.²⁰

Second, Milliman identified and quantified all the key risks and contingencies that impact different aspects of GHMSI's financial performance. Milliman identified GHMSI's most important risks and contingencies as "(1) Rating adequacy and fluctuation; (2) Unpaid claim liabilities and other estimates; (3) Interest rate and portfolio asset value fluctuations; (4) Overhead expense recovery risk; (5) Other business risks, including ASC business; (6) Catastrophic events; and (7) Provision for unidentified development and growth."²¹ GHMSI faces a heightened risk in some of these categories due to the current business cycle and to the Company's location in the D.C. area. As Milliman explained:

[D]ue to the previously-mentioned financial downturn many insurers are experiencing significant reductions to their asset portfolios, and those with defined benefit pension plans may be facing material additional funding requirements. These circumstances could be exacerbated if other adverse events, such as unanticipated acceleration in medical costs, were to occur at the same time. In addition to these concerns, the fact that GHMSI's service area is the nation's capital clearly magnifies the importance of providing for the terrorism risk.²²

Third, Milliman employed an actuarial simulation model to determine the probability of different financial outcomes with different degrees and expressions of the key risks, both alone and in various combinations.

Fourth, and finally, Milliman compared and analyzed the simulation model results to actual historical results to develop a range of potential outcomes.

By necessity, this summary oversimplifies the complex process and analysis undertaken by Milliman. Its actuaries consider the interaction of all of the above variables, their probability and degree of occurrence, as well as possible adverse impacts. The result is a range that provides the Company with reasonable assurance that a single major catastrophic event, or the interconnected string of a number of less catastrophic events over a multi-year period, would not likely cause it to dip below BCBSA monitoring levels or, worse, below the 200 percent loss-of-trademark level.

This methodology, it should be emphasized, is not the simple "stacking up" of contingency reserves for a list of possible disasters (e.g., HIV, swine flu, etc.). Proper reserves levels cannot be rationally calculated in that way. Instead, Milliman follows proper actuarial practice by employing a sophisticated probabilistic and interactive model that is tested against historical results. Nor is the analysis focused solely on the risks inherent in medical underwriting. Instead, Milliman considered all categories of risk, including business, asset and financial-market risks. The last year alone illustrates how important these calculations are, as the

¹⁹ Milliman December 2008 Report at 27.

²⁰ *Id.* at 32-33.

²¹ *Id.* at 39.

²² *Id.* at 44.

adverse financial market and economic and health care trends all interacted simultaneously to cut into the Company's reserves.

D. Milliman's RBC Target Range

Having conducted the full actuarial analysis, Milliman recommended to GHMSI in 2005 that the Company seek to maintain RBC-ACL in an "optimal range" between 800 percent and 1,100 percent. In 2008, Milliman ran the analysis again with updated data and offered GHMSI the revised recommendation discussed in its December 2008 report – namely, that GHMSI strive for an optimal range between 750 percent and 1,050 percent of RBC-ACL. That range is designed to allow GHMSI to withstand a realistic sustained period of underwriting losses without its reserves falling below the 375 percent BCBSA Early Warning Monitoring threshold.²³ In order to further validate Milliman's recommendations, GHMSI engaged a separate evaluation by The Lewin Group, which confirmed the reasonableness of Milliman's recommended RBC range.

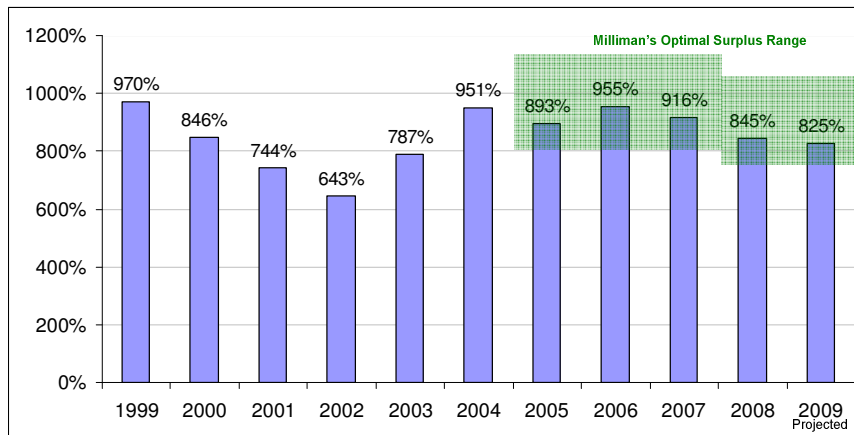
GHMSI by necessity must aim for an RBC *range*, not an exact figure. The insurance industry is cyclical and uncertain, and insurers cannot immediately correct for new information because their premiums typically are "locked in" for a period of months. Thus, for example, an insurer that realizes it is losing money due to unusually high medical claims relating to a flu outbreak must simply absorb the loss until the time comes to set premiums for the following year. For that reason, "[c]orrective actions...are unlikely to yield results until the subsequent year."²⁴

An insurer's reserves, in short, fluctuate during the course of the business cycle. The "proper" level of reserves for an insurer accordingly is not a precise number, but instead an optimal range that the insurer strives to stay within. If an insurer's reserves begin to creep toward the top of the range, the insurer can take careful steps, such as reducing premiums or holding them steady in the face of rising medical costs, to lower the percentage. And, when the insurer's reserves begin to drop toward the floor of the range, the insurer can take steps, such as raising premiums, to ensure it does not become under-reserved. Either way, it is important to note that a non-profit insurer like GHMSI cannot quickly replenish reserves once drawn down. GHMSI relies entirely on premiums to build reserves and, as a matter of business reality, it cannot (and has no desire to) drastically increase premiums on its certificate holders in response to a severe decline in reserves. This makes it especially important for GHMSI to maintain proper reserves levels at all times.

E. GHMSI's Reserves Have Been Within Or Even Below Milliman's Optimal Range For Many Years, And Are Now Toward The Lower End of That Range

The chart below, which GHMSI first provided to the Commissioner in its July 31 summary report, shows GHMSI's reserves levels for each year in the last 10 years expressed as a percent of RBC. It also shows the ranges recommended by Milliman and GHMSI's position within those ranges. Importantly, the chart demonstrates that, for at least a decade, GHMSI has never been above – and has sometimes been below – the RBC range recommended by Milliman.

Chart H – GHMSI Historical RBC Ratio with Milliman Recommended Ranges



²³ *Id.* at 54-56.

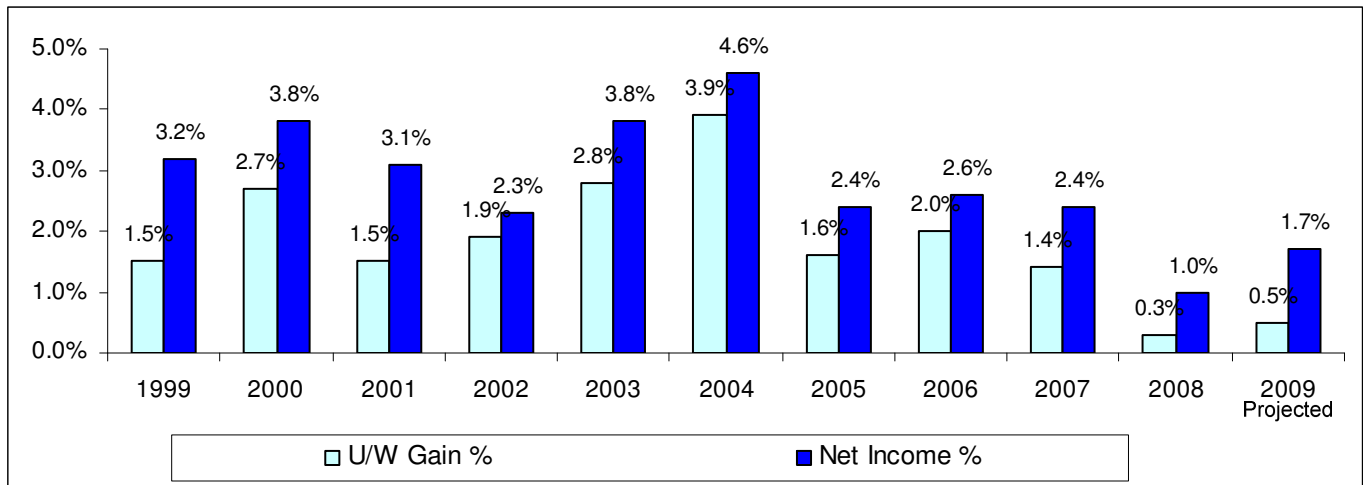
²⁴ *Id.* at 27.

GHMSI, indeed, has been in the lower half of the optimal range throughout the decade – except for a period early in the decade when it fell considerably below the optimal floor. And, GHMSI has been declining in its position in the range over the last several years. This reflects the generally poor condition of the economy and the financial markets as well as the continued strong upward climb of health care costs in this region. Nothing in the experience of the current year suggests a change in this position or trend. On the contrary, based on our latest projections, GHMSI's reserves are expected to drop to 825 percent of RBC-ACL by year end. Put another way, the Company's reserves amount to about \$740 per insured member – a fraction of the cost of one day's stay in the hospital.

F. True to its Goal of Remaining Within the Optimal Range, GHMSI Tailors its Underwriting Margins to Maintain a Consistent Level of Reserves

The chart below, which also was included in GHMSI's July 31 summary report, shows GHMSI's underwriting margins during the last 10 years as well as the total net income of the Company including underwriting results and investment returns. As is clear from the chart, GHMSI has constantly striven to manage its reserves consistent with its policy, working to increase its margins in years when the level of reserves fell below the optimal range and reducing margins once reserves climb back within that range.

Chart I – GHMSI Historical Margins



Due to concerns about premium levels in these difficult economic times and a desire to continue to maximize affordability, the Company has not sought to effectuate margin increases in the last several years and expects to operate with extremely thin margins in 2009. If the reserves fall below the floor of the optimal range, the Company will have to reconsider the level of its margins. Should such a drop occur, any restoration to the optimal range would be attempted over a multi-year period so as to minimize rate fluctuations for premium-paying subscribers.

Attachment E

GHMSI's Reserves are Not "Unreasonably Large"

IF GHMSI'S RESERVES FALL WITHIN THE TARGET RANGE, THEY CANNOT BE "UNREASONABLY LARGE"

We now apply these facts about GHMSI's business and its reserves to the Act. The first crucial point is that because GHMSI's reserves are within the optimal range recommended to the Company by actuarial experts – and indeed are toward the bottom of that range – the Commissioner should conclude that they are not "unreasonably large." And because the reserves are not "unreasonably large," they cannot be "excessive" under the terms of the Act.

A. The Analysis Required by the Act

The relevant portion of the Act provides:

[T]he Commissioner shall review the portion of the surplus of the corporation that is attributable to the District and shall issue a determination as to whether the surplus is excessive. The 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 [community health reinvestment] obligations* under [section 6(a)].

D.C. Code § 31-3506(e) (emphasis added). In this case, the Commissioner has interpreted "greater than the appropriate risk-based capital requirements" to mean greater than the 375 percent and 200 percent minimum RBC thresholds and thus concluded that GHMSI's reserves met the first prong, above. But, as we have explained, having reserves greater than the bare regulatory minima simply means GHMSI is not in immediate financial danger; it says nothing about whether GHMSI's reserves are sufficient, much less excessive. Indeed, in the DISB Order leading to this proceeding, the Commissioner made clear that "the term 'appropriate'...is not meant to suggest that the statutory and BCBSA minimum RBC levels cited above should be deemed advisable for GHMSI or that they are adequate or sufficient to meet GHMSI's insurance and other needs." See, 2009 Group Hospital and Medical Services Adequate Surplus Determination at 3. Quite right, for all of the reasons discussed above. Under the Act, therefore, GHMSI's reserves cannot be deemed "excessive" unless they are "unreasonably large" and "inconsistent with the corporation's [community health reinvestment] obligations." We address both of those conjunctive requirements in turn.

B. GHMSI's Reserves Are Far From "Unreasonably Large"

Milliman's considered actuarial recommendation to GHMSI calls for reserves to fluctuate in an optimal RBC-ACL range between 750 percent and 1,050 percent. GHMSI has not exceeded the top end of this range for at least a decade,²⁵ it has been below the floor of that range for several years during the same period, and over the past several years its reserves have crept downward into the bottom third of the range, to 845 percent in 2008, with a further drop to 825 percent expected at year-end 2009.

It is also critical to note that neither the NAIC nor the BCBSA has established standards for what constitutes *excessive* reserves. The entire focus of both organizations has been on the solvency of insurers and on establishing methodologies for ascertaining *minimum* solvency – not desired or optimal (much less "maximal") solvency. In fact, BCBSA guidelines offer the concept of a "subscriber safety net." A plan that has an RBC

²⁵ GHMSI's Board has an explicit policy requiring the Company to reduce reserves when they climb too high within the actuarially prescribed range; the Board in the past has invoked that requirement when it has concluded, in its business judgment, that a reduction in reserves was appropriate.

ratio of 800 percent is deemed to have met the BCBSA requirement that the plan make explicit arrangements for the payment of claims and the continuation of its insured subscribers' coverage in the event of insolvency. However, BCBSA acknowledges that a plan may have a need for capital beyond this level. The fact that 45 of the 50 states have chosen not to regulate maximum levels of reserves reflects their recognition of the importance of maintaining sufficient reserves that are well above the minimum RBC thresholds required under the NAIC guidelines.

GHMSI's reserves also have been falling steadily. In the 2007-2008 period alone, an economic recession and an unfavorable underwriting cycle combined to reduce GHMSI's reserves by \$67 million from year-end 2007 to year-end 2008 and RBC levels from 916 percent to 845 percent – a decline in RBC of 71 percentage points in RBC in just *one year*.

On these facts, there is no rational reason to conclude that GHMSI's reserves are "unreasonably large." Such a conclusion would ignore the fact that GHMSI's reserves are in line with national averages and would force GHMSI to reject the expert advice of its own actuary – advice aimed at ensuring that GHMSI never faces a situation where it cannot make good on its promises to pay its customers' health care benefits.²⁶ The Commissioner should find that the reserves are not unreasonably large and accordingly that they are not excessive under the Act.

C. The "Unreasonably Large" Calculus Also Must Take Into Account GHMSI's Tax Payments And Open Enrollment Expenses

For all of the reasons cited, the Commissioner should conclude that GHMSI's reserves are not unreasonably large. But, if the Commissioner has any doubts on that issue, the balance is tipped in GHMSI's favor by the Company's tax expenditures and open enrollment losses. These expenditures are massive and growing, and they require GHMSI to exercise special care in maintaining a level of reserves sufficient to meet their demands.

Under the Act, "[i]n 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, including premium tax paid and the corporations' contribution to the open enrollment program." D.C. Code § 31-3506(f). In 2008, GHMSI paid more than \$29 million in federal, state and local income, property, premium taxes and in lieu of premium taxes in Maryland. Indeed, GHMSI paid nearly \$7.4 million in District of Columbia premium taxes in 2008.

In addition to these expenses – all of which must be covered out of premium revenue – GHMSI spends millions of dollars a year to offer District residents an "Open Enrollment" product. The Open Enrollment program provides health care coverage to District residents who, because of medical condition or prior health history cannot qualify for commercially available coverage. GHMSI is the only health insurer mandated by law to offer an open enrollment product in the District. In effect, this makes GHMSI the District's insurer of last resort.

Last year, GHMSI incurred losses of \$3.1 million on this product; its losses in 2009 are projected to approach \$5 million. It is important to note that GHMSI cannot offset these losses in any way. Before 2005, losses on the Open Enrollment product could be used to offset a portion of the premium taxes GHMSI owed to the District. But, under recent revisions to the law, GHMSI pays the same 2 percent tax on indemnity premiums as is paid by commercial, for-profit insurers who are immune from the statutorily imposed obligations and losses that GHMSI faces. As such, a portion of GHMSI's reserves go to cover losses incurred on the Open Enrollment product. This additional drain on the Company's reserves offers yet another reason why GHMSI's reserves are prudent, not "excessive."

²⁶ Indeed, it is worth noting that, even if GHMSI's reserves *exceeded* the top of the optimal range, that would not necessarily mandate a finding that the reserves are unreasonably large. As explained above, reserves corrections by necessity occur over a period of years, and an effort to cut back on reserves by reducing underwriting margins does not take effect overnight. Thus, the analysis of GHMSI's reserves should be measured over a period of years to account for normal fluctuations. To deem GHMSI's reserves unreasonably large in the aggregate, DISB must determine that GHMSI's aggregate RBC levels not only exceed the top of the optimal range but will *remain* above the top of the range on a sustained basis.

D. The Commissioner Should Examine GHMSI's Reserves In the Aggregate To Determine Whether They Are "Unreasonably Large"

We pause to note that this discussion has proceeded as if the proper focus is on GHMSI's entire, Company-wide surplus and whether it is "unreasonably large." In fact, one reading of the Act's text suggests that the focus *not* train on GHMSI's entire surplus, but instead only on that "portion of the surplus of the corporation that is attributable to the District" and whether *that portion* is unreasonably large. In other words, the Act might be interpreted to contemplate that the Commissioner will determine an appropriate RBC range for the portion of the GHMSI's reserves "attributable to the District."

Such a figure, however, is literally impossible to calculate in an actuarially sound manner: An appropriate RBC range cannot be calculated on a subset of a Company's service area. As explained in the Milliman report filed in conjunction with this Pre-Hearing Report, RBC methodology is specified by the National Association of Insurance Commissioners, is inextricably tied to the whole of an insurance entity's investments and assets, and cannot be isolated and calculated as to a geographic subset of those assets; no knowledgeable expert could rationally so conclude.²⁷

GHMSI's reserves, like those of any multi-jurisdictional insurer, are used to protect and cover subscribers in all jurisdictions as needs arise. See Milliman Inc., *Evaluation of GHMSI Surplus Attributable to D.C.* 3 (Aug. 28, 2009) ("All members [of GHMSI] are protected by the same surplus, without regard to their line of business, type of product, age, gender, geographic location, or other classification."). Moreover, the assets that make up GHMSI's reserves are held in investments that are not jurisdictionally separable. For these reasons, evaluation of the appropriateness of reserves must be performed at an entity-wide level. The notion of segregating or dividing reserves in the manner contemplated by D.C. law is inconsistent with all applicable insurance regulatory standards. One rather unique feature of GHMSI is that the plan is headquartered in a jurisdiction in which only 10 percent of its certificate holders reside. We are unaware of a similar scenario in any other jurisdiction in the United States.

The Commissioner accordingly should evaluate the appropriate RBC for GHMSI as a whole and use that as a proxy to determine whether the portion of the reserves attributable to the District is "unreasonably large." Because reserves are not divisible, if GHMSI's reserves in whole are not unreasonably large, by definition the reserves attributable to any single geographical area – including the artificially calculated "portion...attributable to the District" – cannot be unreasonably large, either. And, GHMSI's reserves are far from "unreasonably large" but have been within the optimal range, and they are declining further still.

²⁷ GHMSI identifies this established fact about the nature and limits of RBC calculation even though an imaginary "RBC subset" calculation would in all likelihood be favorable to the Company. If one *were* (despite the experts' conclusions) 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. 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.

Attachment F

GHMSI and the Community

GHMSI'S RESERVES ARE NOT "INCONSISTENT WITH THE CORPORATION'S COMMUNITY HEALTH REINVESTMENT OBLIGATIONS"

Because GHMSI's reserves are not "unreasonably large," and because under the Act the reserves cannot be "excessive" unless they are "unreasonably large," the Commissioner need not go any further. But, in any event, GHMSI's reserves also are not "excessive" for a second, independent reason: They are not inconsistent with the corporation's statutory community health reinvestment obligation.

GHMSI's statutory obligation is to "engage in community health reinvestment to the maximum feasible extent consistent with financial soundness and efficiency." D.C. Code § 31-3505.01. "Community health reinvestment," in turn, is defined 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). Thus, the question for the Commissioner is whether GHMSI is doing what it can, consistent with maintenance of a conservative level of reserves, to safeguard the public health for the benefit of its certificate holders. The answer to that question is "yes." The Company's community health contributions are very substantial – running into the tens of millions of dollars each year – and easily outpace the contributions made by (and the contributions required of) other insurers in GHMSI's service area.

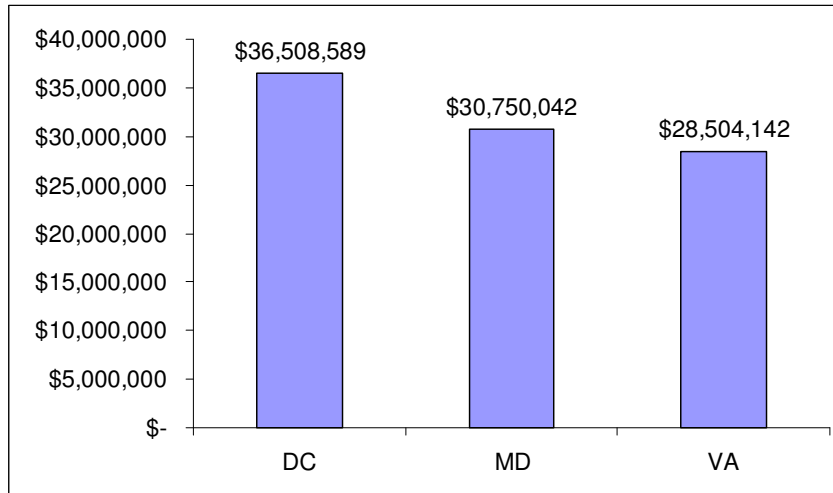
GHMSI's community health reinvestment is based on the same four tenets for funding public health initiatives used by CareFirst as a whole. It aims to improve health care affordability and access by reducing costs, increase patient quality and the standards of care for subscribers and non-subscribers alike, close gaps in health care delivery by addressing racial and ethnic disparities, and encourage health and wellness in the diverse communities CareFirst (and GHMSI) serve. The Company takes pride in the success it has achieved in safeguarding the public health.

In recognition of the importance of CareFirst's community mission, CareFirst BlueCross BlueShield in 2005 launched the CareFirst Commitment initiative and continues to expand its impact. The initiative is overseen by a special Board Mission Oversight Committee, which monitors all of CareFirst's corporate giving activities.

For the CareFirst corporation as a whole, more than \$130 million was contributed in the form of premium taxes, open enrollment losses, subsidies and corporate giving throughout Maryland, the District of Columbia and Northern Virginia from 2005 through 2008 to keep health care affordable for our subscribers and to improve health care accessibility, quality, and safety for the many communities we serve through the region. In 2008, CareFirst committed nearly \$40 million to catalytic programs, partnerships, public programs and charitable causes under the CareFirst Commitment initiative. Nearly \$20 million of which was dedicated to GHMSI.

CareFirst employs an evaluative framework to guide its community giving that is focused on certain priorities. The most intense focus of giving is to expand access to health care by subsidizing health coverage for many of the region's most vulnerable residents. CareFirst also seeks to act as a catalyst in developing systemic improvements in health care delivery in ways that benefit all in the community. A third area of giving is in targeted programmatic initiatives undertaken by qualified charitable, non-profit community organizations that focus on specific health improvement opportunities, such as reducing childhood obesity and reducing cardiovascular risks in older men. Over the past several years CareFirst has funded all manner of health care related programs that are having a direct impact on raising the quality and access to health care in the District and the region. A copy of CareFirst's most recent community report is attached as can be found in a supplemental packet of references, available upon receipt.

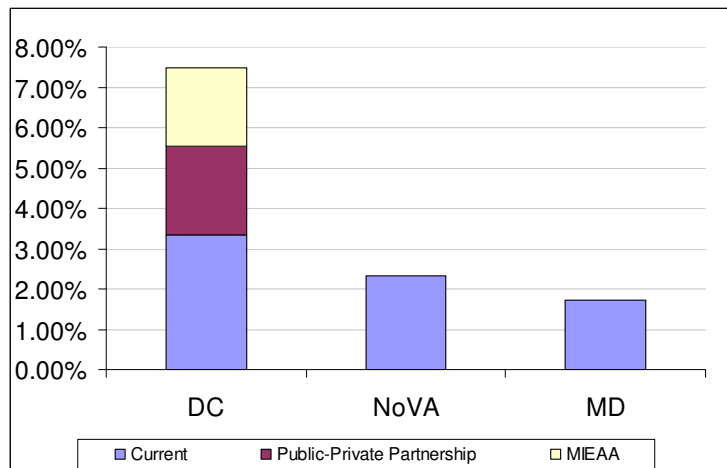
Chart J – GHMSI Community Reinvestment, 2006 to 2008



All of the commercial insurers in the region *combined* do not equal this level of giving. It is important to note that the cost of this giving is borne directly by the Company's certificate holders, who have a right to expect wise stewardship of their premium and fee dollars as well as effective efforts on our part to keep costs as low as possible.

The figures for community reinvestment presented in Chart H include GHMSI's contribution to the District through the D.C. Open Enrollment program, which as discussed above costs GHMSI millions of dollars a year on a net basis. This year, the program is projected to produce about \$5 million in losses, which the Company must subsidize through its reserves. And, as noted above, GHMSI expects to enter into a public-private partnership with the District under which it is expected to sustain millions of dollars of additional losses to fully satisfy the Act's community health reinvestment obligations. For some time now, GHMSI has engaged in good faith discussions with the District Council to support a program that would increase insurance coverage in the District and we are hopeful that this public-private partnership will begin operating in January of 2010. Chart I reflects the significant increase in the percentage of premium revenues GHMSI will spend on community reinvestment activities under the proposed partnership and open enrollment program.

Chart K – GHMSI Percentage of Premium Revenue Invested in Community Health Reinvestment Activities Post- MIEAA*



*Excludes FEP revenue

GHMSI, in sum, has been a regional leader in participating in programs and community giving to benefit both its subscribers and others in the community. These initiatives come at a steep cost to GHMSI – some \$36 million in 2008, and an anticipated \$45 million in 2009. And, importantly, GHMSI's reserves have been steadily dropping toward the floor of its optimal RBC range as it continues making these substantial community contributions. To place still more community-health obligations on GHMSI in these circumstances would be to force the Company to pay for those obligations out of its reserves and then replenish the reserves the only way it can: by raising premiums on its subscribers. Given that fact – and given the fact that it can take years to replenish depleted reserves – the only logical conclusion is that GHMSI's reserves are *not* "inconsistent with the corporation's [community health reinvestment] obligation under [section 6(a)]." D.C. Code § 31-3506(e)(2). It follows that they cannot be deemed "excessive" under the Act.

Attachment G

“Attributable to the District”

PORTION OF RESERVES “ATTRIBUTABLE TO THE DISTRICT” IS THAT SHARE BUILT FROM PREMIUMS PAID BY DISTRICT RESIDENTS

If, despite all the evidence to the contrary, the Commissioner finds that GHMSI’s reserves in whole are excessive, the Commissioner then must oversee a determination of how “the excess” should be disbursed. D.C. Code § 31-3506(g)(1). “The excess” referred to in the statute, however, is not to be measured as a percentage of GHMSI’s entire, company-wide reserves. It is, instead, a percentage of the “portion of the surplus . . . attributable to the District.” D.C. Code § 31-3506(e)(1). To explain by way of example, if GHMSI’s company-wide reserves totaled \$10 million, the portion attributable to the District was \$1.2 million, and the Commissioner determined that the reserves needed to be reduced by 10 percent, the “excess” in question would be \$120,000, not \$1 million.

This complication of the Act means that if the Commissioner finds reserves are “unreasonably large,” he must delve into a nearly unanswerable question: What portion of GHMSI’s reserves is “attributable to the District?” As we explain below, this inquiry makes very little sense as an actuarial matter. Reserves are an undifferentiated whole, and they may be used to pay unexpected claims and other costs as they arise anywhere in an insurer’s service area. But, to the extent the analysis is even possible, reserves “attributable to the District” must mean the portion of the reserves that stems from, and would be used to pay the claims of, GHMSI certificate holders who are District residents.

A. Attribution of Reserves By Jurisdiction Is Inconsistent With Sound Actuarial Practice

In light of the manner in which GHMSI’s reserves are used and invested, the lack of industry precedent, and the consequences of attribution by jurisdiction, sound actuarial practice counsels against attempting to attribute a portion of GHMSI’s reserves to the District. First, all of GHMSI’s reserves, like those of any multi-jurisdictional insurer, are used to protect and cover subscribers in all jurisdictions, as needs arise. Specifically, as noted in the supplemental Milliman report filed in conjunction with this Pre-Hearing Report, “All members are protected by the *same* surplus, without regard to their line of business, type of product, age, gender, *geographic location*, or other classification.” Milliman Inc., *Evaluation of GHMSI Surplus Attributable to D.C.* 3 (Aug. 28, 2009) (emphasis added). Thus, any attempt to attribute reserves by jurisdiction would be, at best, “artificial,” ignoring the actual nature and purpose of the reserves. *Id.* at 4. Moreover, as indicated above, GHMSI’s reserves are invested on behalf of all subscribers, and the assets used for those investments are not jurisdictionally separable.

In fact, according to the supplemental Milliman report, there is no precedent anywhere in the nation for the jurisdictional allocation of reserves; the concept of “attribution” in this context is inconsistent with any traditional insurance methodology. *Id.* at 3, 6 (“The concept of attributing accumulated surplus to geographic jurisdictions within the same company is not one that we have seen employed in the health insurance industry and we are aware of no precedent for this process.”).

Finally, because reserves are not divisible, the taking of reserves by any single jurisdiction would come at the derogation of subscribers in the other jurisdictions served by GHMSI. The subscribers in the benefiting jurisdiction would be “double dipping”; they would have exclusive access to a portion of the reserves attributed to them, while also enjoying the benefit of the protection derived from the balance remaining in the reserves. At the same time, subscribers in the other jurisdictions would bear the burden, having less protection available to meet their needs. As explained in the supplemental Milliman report,

If the portion determined to be attributable to D.C. were found to be excessive and therefore used for other purposes, the protection afforded to all policyholders, including those in Maryland and Virginia, would be diminished. Likewise, if the regulators in Maryland or Virginia were to determine that the surplus attributable to their respective jurisdictions was to

be expended for a designated purpose, the protection of all policyholders, including those in the District, would be affected.

Id. at 3. Therefore, if GHMSI is placed at risk by such taking, it would be required to seek financial support from GHMSI's reserves attributable to other jurisdictions, or seek financial support from CareFirst of Maryland, Inc. under the terms of the CareFirst intercompany agreement. Accordingly, CFMI subscribers in Maryland and Virginia would, in this way too, effectively be forced to subsidize the cost of coverage for GHMSI subscribers in D.C.

For these reasons, evaluation of the appropriateness of reserves should always be done at an entity-wide level.

B. To the Extent Attribution of Reserves Ever Need Be Attempted, It Should Be Driven By the Residence of GHMSI's Certificate Holders

Background

While we firmly believe that it is inappropriate to “attribute” reserves by jurisdiction, if such “attribution” of reserves nevertheless is attempted, we would argue that one must look to whom the reserves belong or who built them – in other words, the subscriber. As discussed earlier, it is the subscriber whose premiums contributed to the reserves and therefore any attribution must be done on the basis of the residency of the subscriber. Both now and historically, the subscriber (or, as specified in GHMSI's Congressional Charter, the “certificate holder” on whose behalf GHMSI is mandated by Congress to conduct its business) is the individual or family that is provided health insurance coverage and on whose behalf GHMSI is organized. Reserves exist solely for the benefit of subscribers. They were built over time from the premiums paid by or on behalf of the subscriber minus medical claims filed and administrative costs incurred. They are held principally to cover the insurance risks associated with current subscribers. This position is clear in the context of Section 2(d) of the MIEAA, codified at D.C. Code § 31-3506(e), that provides that the District's Insurance Commissioner shall review only “the portion of the surplus of [GHMSI] that is attributable to the District and shall issue a determination as to whether the surplus is excessive.”

As explained below, the phrase's plain meaning, the statutory context, the applicable cases and the MIEAA's legislative history all point in the same direction: Surplus is “attributable to the District” if it stems from, and is being held in reserves to pay the claims of, GHMSI certificate holders who are District residents.

The law specifies that the calculation of reserves must be tied as precisely as possible to those who built those reserves – i.e., the individual subscribers whose premium payments and claims experience contributed to producing the reserves GHMSI holds today. Thus, “attribution” of reserves to the District must be focused on who built the reserves.

Congressional Charter Supports – Indeed Requires – Residency as Basis for Attribution

The need to determine attribution based upon residency would hold for any insurer. But, it is especially compelling as it applies to GHMSI, which not only is the only insurer covered by the MIEAA's unique provisions but which also operates under a Congressional Charter that explicitly creates obligations running from the Company to the *individual certificate holder* – not to the employer groups that facilitate coverage.

The Charter provides that GHMSI is “empowered...to enter into contracts with *individuals or groups* of individuals,” but as mentioned above, the “groups” are not the certificate holders. Instead, the Charter expressly instructs GHMSI to “issue *to such individuals* appropriate certificates evidencing such contracts.”²⁸ This verbiage is important for two reasons. First, it strongly suggests that Congress contemplated a direct link between individual certificate holders and GHMSI's premium income, such that any surplus would necessarily be “attributable” to a jurisdiction based on the premiums the individuals in that jurisdiction had paid. To the extent that is so, the doctrine of federal preemption forecloses any attempt to calculate surplus “attributable to the District” on a *situs* basis. *In Armstrong v. Accrediting Council for Continuing Educ. and Training, Inc.*,²⁹ the court held that state law is preempted when it “actually conflicts” with federal law;

²⁸ Charter § 2 (emphasis added).

²⁹ 168 F.3d 1362, 1369 (D.C. Cir. 1999).

similarly in *California Fed. Sav. & Loan Assoc. v. Guerra*,³⁰ the court held that state law “must give way” to federal law when “the state law stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress.”

But, aside from the preemption argument, the Charter further supports the notion that the phrase “attributable to the District” mandates an analysis based on residency. The Charter, of course, is part of the statutory context that informs the interpretation.³¹ Section 2 of the Charter only underscores what the words “attributable to” already provide by their terms: that GHMSI’s surplus is generated by, and exists to provide for, the individual certificate holder, and that accordingly it is the legal residence of those individual certificate holders that provides an appropriate methodology for apportioning the Company’s surplus.

The Relevant Case Law Mandates a Residency-Based Approach

In the District, “[t]he text of an enactment is the primary source for determining its drafters’ intent,”³² but context is also crucial to the inquiry: “Statutory construction is a holistic endeavor, and, at a minimum, must account for a statute’s full text, language . . . , structure, and subject matter.”³³ Here, both text and context mandate that surplus be “attributed” based on residency, not technical *situs* of the group contract.

Beginning with the text, the MIEAA requires that only “the portion of the surplus...that is attributable to the District” be considered.³⁴ The word “attribute,” in turn, is defined to mean “regard as *belonging to or being caused by*.”³⁵ Courts interpreting the word “attributable” have emphasized the notion of ownership as “belonging to” and causation as “caused by”. In *Braunstein v. Commissioner*,³⁶ for example, the Supreme Court interpreted “attributable to” in the phrase “gain attributable to such property” as “merely confin[ing] consideration to that gain caused or generated by the property in question.”³⁷ Likewise, the Federal Circuit understands “attributed to” to mean “due to, caused by, or generated by.”³⁸ The Second Circuit put the matter starkly: In *Benedek v. Commissioner*,³⁹ the court was asked to determine whether gain was “attributable to” certain property.⁴⁰ The court wrote, “There appears to us to be no special mystery about the word ‘attributable’ as it is used in the statute. The question to be answered is ‘where did the money come from?’ The answer will ordinarily be the source to which the gain is ‘attributable.’”⁴¹

Applying these definitions of “attributable to” in the unique context of the MIEAA leads to the clear conclusion that attribution should be calculated based on the residency of the certificate holder. After all, an insurer’s surplus is “caused by” premiums paid by, or on behalf of, certificate holders. Likewise, to the extent an insurer’s surplus “belongs to” anyone, it belongs to the subscribers, in the sense that it is held to pay for future claims made by those subscribers. In *Maryland Casualty Co. v. United States*,⁴² the court describes reserves as “a fund with which to mature or liquidate...future unaccrued and contingent claims” and *Jones v. United States*,⁴³ the court observes that insurers must “maintain high levels of cash capital and surplus so that the insurers’ ‘creditors,’ the policyholders, would be adequately protected.” The MIEAA’s proponents in the D.C. Council certainly thought as much. As discussed below, they clearly believed (i) that the surplus was “caused by” and “belongs to” GHMSI’s certificate holders and (ii) that those very premises under-girded the legislation. See *infra* at 35, which discusses comments of Councilmember Catania.

Importantly, the only court of which we are aware that has reached the question presented here – who “causes” insurance surplus, and to whom does it “belong”? – squarely held that it is caused by and belongs

³⁰ 479 U.S. 272, 280-281 (1987).

³¹ See *District of Columbia v. Beretta, U.S.A., Corp.*, 872 A.2d 633, 652 (D.C. 2005).

³² *Stevenson v. District of Columbia Bd. of Elections & Ethics*, 683 A.2d 1371, 1376 (D.C. 1996).

³³ *Beretta*, 872 A.2d at 652 (quoting *United States Nat’l Bank of Oregon v. Independent Ins. Agents of Am.*, 508 U.S. 439, 455 (1993)) (alteration in *Beretta*).

³⁴ D.C. Code § 31-3506(e).

³⁵ Compact Oxford English Dictionary of Current English (3d ed. 2005) (emphasis added).

³⁶ 374 U.S. 65 (1963).

³⁷ *Id.* at 70.

³⁸ *Electrolux Holdings, Inc. v. United States*, 491 F.3d 1327, 1330-31 (Fed. Cir. 2007) (citations omitted) (construing 26 U.S.C. § 6511(d)(2)(A)).

³⁹ 429 F.2d 41 (2d Cir. 1970).

⁴⁰ *Id.* at 43.

⁴¹ *Id.*

⁴² 251 U.S. 342, 350 (1920).

⁴³ 659 F.2d 618, 620 (5th Cir. 1981).

to individual subscribers. In *NEA-Coffeyville v. Unified School District No. 445*,⁴⁴ a school district's group health insurer held a surplus stemming from the school district's premium payments and was contractually obligated to refund it. The Court was asked to decide to whom the refundable surplus belonged – the district, which had created the group plan, or the teachers, who were the individual subscribers. The Court held that, “as a matter of community standards of fairness and decency,” the surplus belonged to the individual subscribers because it had been caused by them:

“Regardless of whether the teachers or the District actually paid for the group health insurance, there is no dispute that the divisible surplus was created by the actions of the subscriber-teachers in filing fewer and/or smaller claims than were anticipated when BCBS set the premiums. The divisible surplus is wholly a product of their actions rather than anything that may be attributed to the District...We conclude that in the absence of a contract provision addressing the rights of the parties in this situation, those whose conduct generated the refund, the teachers, are entitled to the refund.”⁴⁵

The same principle applies here. There is a direct link between an insurer's surplus and the payments made by its certificate holders. The surplus “is wholly a product of their actions,”⁴⁶ and its *raison d'être* is to pay their medical bills. Since “the money come[s] from” the certificate holders, *Benedek*,⁴⁷ it rightfully is attributable to each jurisdiction in a proportion that reflects the payments made by the certificate holders in that jurisdiction.

Similarly, the D.C. Circuit construed a District law with nearly identical “attributable to” language and held that the law *required attribution based on subscribers' place of residence* in cases where the company's business revolved around income from and services to subscribers. Those holdings compel the same result here.

The cases in question addressed a D.C. statute that imposed a 5 percent franchise tax on corporations doing business in the District. The statute provided that the income on which the 5 percent tax should be imposed was “that portion of the net income of the corporation . . . as is *fairly attributable to any trade or business carried on or engaged in within the District* and such other net income as is derived from sources within the District.”⁴⁸ In *District of Columbia v. Evening Star Newspaper Co.*,⁴⁹ the D.C. Circuit considered what portion of the *Evening Star's* income was “fairly attributable” to its business within the District—and he settled squarely on a calculation based on the residency of the newspaper's customers. Writing for a unanimous panel, he explained that “[i]t is apparent that all revenues” of the newspaper “rest ultimately upon circulation and readership.”⁵⁰ He therefore concluded that net income had to be “apportioned between District and non-District sources” and that that should be accomplished by the location of subscribers, such that if “20% of the newspaper's circulation is outside the District and the balance within the District, then 80% of the ‘operating net income’ would be the amount attributable to the District and subject to the tax.”⁵¹

Three years later, the Circuit had occasion to elaborate on *Evening Star*. In *Broadcasting Publications, Inc. v. District of Columbia*,⁵² again writing for a unanimous panel, Judge Burger explained that *Evening Star* stood for the proposition that, in order to determine what portion of income is “fairly attributable” to District operations, one had to “examine [the] Taxpayer's total activity and select that function which fairly reflects the geographical sources of income.”⁵³ “In that case,” he wrote, “we concluded that the essence of the newspaper business, for franchise tax purposes, is the dissemination of news, *i.e.*, the distribution of newspapers.”⁵⁴ “Allocation of income” therefore had to be made “according to the situs of subscribers.”⁵⁵

These decisions point the way to a residency-based approach here. The “essence” of GHMSI's insurance business is the collection of premiums from, and the eventual payment of claims to, its subscribers (*i.e.* its

⁴⁴ 996 P.2d 821 (Kan. 2000).

⁴⁵ *Id.* at 832.

⁴⁶ *Id.*

⁴⁷ 429 F.2d at 43.

⁴⁸ D.C. Code § 47-1580 (1951) (emphasis added).

⁴⁹ 273 F.2d 95 (D.C. Cir. 1959).

⁵⁰ *Id.* at 102.

⁵¹ *Id.* at 103.

⁵² 313 F.2d 554 (D.C. Cir. 1962).

⁵³ *Id.* at 559.

⁵⁴ *Id.*

⁵⁵ *Id.*

certificate holders).⁵⁶ Just as in *Broadcasting Publications*, then, it is the “situs of *subscribers*” – not the situs of contracts entered into by those subscribers’ employers – that best describes the source, and the eventual destination, of GHMSI’s surplus.⁵⁷ It is at their legal residence that the certificate holders subtract from their net worth to make premium payments; it is at their legal residence that they eventually will be benefited by claims payments. Because the residency of GHMSI’s certificate holders most “fairly reflects the geographical sources” of the surplus,⁵⁸ it is that measure that should be employed to calculate the portion of the surplus attributable to the District.⁵⁹

A Plain Reading of the Statute Requires That Attribution be Based upon Residency

Statutory context requires the same result.⁶⁰ Section 2(d) of the MIEAA, codified at D.C. Code § 31-3506(g)(2), provides that if GHMSI’s surplus were to be deemed excessive and unreasonably large, GHMSI could draw down the excess “entirely [by] expenditures *for the benefit of current subscribers* of the corporation.” (emphasis added). GHMSI’s “subscribers” are its individual certificate holders.⁶¹ Section 31-3506(g)(2) therefore contemplates a direct link between GHMSI’s surplus and payments made by individuals. Read together with the text of Section 31-3506(e) – as it must be under well-settled principles of statutory construction – the provision makes clear that the calculation of surplus “attributable to the District” must focus on the individuals who pay their premiums, and receive the benefits of any surplus, where they live.

Location or *Situs* of Employer Contracts Is Irrelevant to Determining Attribution

For the same reasons of text and context, the phrase “attributable to the District” cannot be properly read to mean “attributable to *contracts that have their legal situs* in the District.” As an initial matter, that construction involves adding words to the statute – a fundamental statutory-interpretation taboo.⁶² But, in any event, the surplus generated by premium payments made by (or on behalf of) Maryland and Virginia residents who happen to work in the District cannot be said to “belong to” the District.⁶³ As discussed above, the surplus is held to pay the medical claims of *certificate holders*, not of their employers. The money paid out as claims effectively enriches those certificate holders – at their legal residences – by assuming their obligation to pay medical or related bills. It would be the merest legal fiction to say that money held for a Maryland resident, and eventually paid to settle medical bills that otherwise would draw down his or her personal wealth in Maryland, and overwhelmingly paid to Maryland providers, “belongs to” the District just because that Maryland resident works in the District. The law is to the contrary.⁶⁴

⁵⁶ See Black’s Law Dictionary 802 (7th ed. 1999) (defining insurance as an agreement by which the insurer “commits to do something of value” for the insured “in return for a premium payment”).

⁵⁷ 313 F.3d at 559 (emphasis added).

⁵⁸ *Id.*

⁵⁹ To be sure, tax law has evolved in the half century since *Evening Star* was decided, and courts now employ a multi-factored test to determine how much tax a corporation should pay in a given jurisdiction. But that evolution of tax doctrine does not undermine the persuasive force of Judge Burger’s decisions in this case. *Evening Star* and its progeny are relevant here not as cases reflecting modern tax law, but as the leading cases in the District on what it means to say funds should be “attributed to” a given jurisdiction.

⁶⁰ See *Gondelman v. DCRA*, 789 A.2d 1239, 1245 (D.C. 2002) (“[W]e construe statutory provisions ‘not in isolation, but together with other related provisions.’”) (quoting *Olden v. United States*, 781 A.2d 740, 743 (D.C. 2001)).

⁶¹ See GHMSI Charter § 2 (directing GHMSI to “issue to such individuals appropriate certificates” evidencing their contracts of insurance).

⁶² See *United States v. Curtis*, 755 A.2d 1011, 1017 (D.C. 2000).

⁶³ See Oxford English Dictionary of Current English, *supra*.

⁶⁴ This is so even though a certificate holder’s employer may pay a portion of his premium as part of the employee’s ancillary benefits. The *NEA-Coffeyville* court faced identical facts and dismissed the employer’s payments as irrelevant, holding that to the extent the insurer ends up holding a surplus, it is because the employees have not made claims seeking disbursement of the money. See *NEA-Coffeyville*, 996 P.2d at 832.

Legislative History Makes Clear the Intent to Consider Residency

Because the language of the MIEAA is clear, and is only reaffirmed by case law construing a closely analogous provision, there is no need to consult the legislative history.⁶⁵ But, in any event, the legislative history further supports GHMSI's position. On December 2, 2008, Councilmember Cheh explained the newly added "attributable to the District" language as follows:

[T]he committee print for the bill initially required the Mayor to review the company's entire surplus and determine what percentage of premium revenues must be devoted to community health reinvestment.

Under the amendment, the Commissioner of DISB...instead of looking at CareFirst's entire surplus, will review only that portion of the surplus, quote/unquote, "attributable to the District." *This addresses concerns raised by the Maryland congressional delegation about the fairness of the bill* and actually captures our intent in any event from the original bill.⁶⁶

Members of the "Maryland congressional delegation," in turn, had expressed their belief that "reserves belong solely to CareFirst subscribers" and that "any excess reserves should be required to be given directly back to the...individuals who have paid into CareFirst." See, Letter from Sens. Barbara A. Mikulski and Benjamin L. Cardin, *et al.*, to Hon. Vincent C. Gray at 1 (Dec. 15, 2008). The Maryland legislators had further expressed concern that aspects of the MIEAA would "tak[e] money away from the Marylanders, Virginians, and Federal Employees who are CareFirst beneficiaries." *Id.* The "concerns raised by the Maryland congressional delegation about...fairness," in short, centered on ensuring that GHMSI certificate holders resident in Maryland did not subsidize, through their premium payments, the mandates of the MIEAA. Given that Councilmember Cheh explicitly identified this concern as the driving force behind the "attributable to the District" amendment, the "attributable" language is best interpreted to require apportionment of surplus based on the residency of GHMSI's certificate holders.

The comments of other MIEAA proponents underscore this interpretation. Throughout the hearings, for example, Councilmember Catania linked his concerns about the surplus to District "citizens," observing that the surplus came from "70 years of citizens contributing" premium payments and asserting that "[t]his money belongs to the citizens of the District of Columbia if and when this company is ever sold." *Bill 17-934: Medical Insurance Empowerment Amendment Act of 2008*, Committee on Public Services & Consumer Affairs, at 74-75 (Oct. 10, 2008) (comments of Hon. David A. Catania). Given this focus, it would betray the purposes of the MIEAA – not to mention be unjust – if moneys contributed for decades by *Maryland* and *Virginia* citizens were to become subject to the MIEAA's dictates. The legislative history, in short, points in the same direction as the MIEAA's plain text and the relevant case law. Surplus "attributable to the District" equates to surplus generated from (and payable to) certificate holders who reside in the District.

Ability to Attribute Does Not Negate the Reality That Reserves are Indivisible

In spite of the theoretical ability to attribute reserves and the inherent logic and case law that underlies it, the ability to analytically attribute reserves to a jurisdiction does not change the fact that by virtue of their purpose and nature reserves are indivisible. In fact, the very Charter under which GHMSI operates, the insurance regulatory framework, accepted actuarial practice and the legal framework within which GHMSI operates, dictate that the amount of reserves attributable to D.C. is nothing but an analytical artifact. Nor does this theoretical exercise change the nature of GHMSI's duty to meet all of its obligations to all of its subscribers from the same reserve, regardless of where they live.

Residence-Based Attribution Data For GHMSI

For all of these reasons, "the portion of the surplus of [GHMSI] that is attributable to the District," D.C. Code § 31-3506(e), is the portion generated by premium payments from District residents. As Milliman calculated in their residency-based analysis, the portion of GHMSI's surplus attributable to the District at year end 2008 is 11.6% or \$79.5 million.

⁶⁵ See *Ratzlaf v. United States*, 510 U.S. 135, 147-148 (1994) ("[W]e do not resort to legislative history to cloud a statutory text that is clear.").

⁶⁶ *Bill 17-934: Medical Insurance Empowerment Amendment Act of 2008*, Transcript of Thirty-Seventh Legislative Meeting of the D.C. City Council at 5 (Dec. 2, 2008), which details comments of Hon. Mary M. Cheh (emphasis added).

Exhibit A

Milliman Report Dated August 28, 2009



CareFirst, Inc.

Group Hospitalization and Medical Services, Inc.

Evaluation of GHMSI Surplus Attributable to D.C.

August 28, 2009

Prepared by:

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Evaluation of GHMSI Surplus Attributable to D.C.

I. Introduction

At the request of CareFirst, Inc., Milliman has carried out an analysis of the surplus accumulation of Group Hospitalization and Medical Services, Inc. (GHMSI). This analysis addresses the estimated portion of the accumulated Statutory surplus that is attributable to the District of Columbia (D.C.).

In December 2008 the D.C. Council enacted an amendment to the Hospital and Medical Services Corporation Regulatory Act of 1996, known as the "Medical Insurance Empowerment Amendment Act of 2008". This Amendment Act included a provision that requires the Commissioner of Insurance to determine whether the portion of the surplus of GHMSI that is attributable to D.C. is excessive. We were asked by CareFirst to evaluate what portion of the GHMSI surplus could be considered attributable to D.C.

We have estimated that 11.6% of GHMSI's surplus as of December 31, 2008 is attributable to D.C. This report describes our approach to this evaluation. We believe that the assumptions and methods underlying our analysis are reasonable and appropriate based on the data and other information available and the purpose for which it has been developed.

Limitations

In developing these estimates, Milliman has relied on various descriptions, data, and sources of information provided by CareFirst. We did not audit any of the information we received, although we did review it for general reasonableness. If there should be any inaccuracies in this information, then the results shown may be affected accordingly.

The results presented in this report represent estimates, and are based on the methodology described. Other methods could be expected to produce different results. Further, application of this methodology in future years may produce different results.

Use of Work Product

This material has been prepared for the use of and is only to be relied upon by the management of CareFirst. We understand that CareFirst may wish to share this report with regulators in the District of Columbia and

other jurisdictions in which they are licensed. We hereby grant permission, so long as the document is provided in its entirety. Milliman does not intend to benefit any third party either through this analysis or by granting permission for this report to be shared with other parties.

This report represents the opinions of the authors and does not necessarily reflect the opinions of other Milliman consultants. The authors are Members of the American Academy of Actuaries and meet its qualification standards for performing this type of analysis.

Judgments as to the conclusions contained in our report should be made only after studying the report in its entirety. Furthermore, conclusions reached by review of a section or sections on an isolated basis may be incorrect. The results in this report are technical in nature and are dependent upon specific assumptions and methods. No party should rely upon these results without a thorough understanding of those assumptions and methods. Such an understanding may require consultation with qualified professionals.

II. Background and Role of Surplus

The Medical Insurance Empowerment Amendment Act of 2008 provides that, initially and then on an annual basis, “...the Commissioner shall review the portion of the surplus of the corporation that is attributable to the District and shall issue a determination as to whether the surplus is excessive.” In view of this legislation, CareFirst management asked for Milliman’s assistance in evaluating the portion of GHMSI surplus that could be considered attributable to the District.

Adequate surplus is central to the viability and sound operation of any insuring organization. It is needed to enable a company like GHMSI to ensure that the promises and commitments to its customers, as well as to hospitals, physicians, and other providers, can be met. In addition to providing for the many and varied risks assumed by an insuring organization, surplus is needed to develop new products, maintain service capabilities, respond to regulatory requirements, build infrastructure, and generally operate effectively as a viable ongoing business entity over time.

The surplus is available for the protection of all policyholders and for the sound business operations of the entity as a whole. GHMSI management must continually evaluate and monitor surplus requirements, and make decisions regarding the products and services offered by the company in order to ensure its ability to provide sufficient protection from risks (known and unknown) and contingencies. These decisions are made based on the conditions and operations of the entire company. All members are protected by the same surplus, without regard to their line of business, type of product, age, gender, geographic location, or other classification.

The concept of attributing accumulated surplus to geographic jurisdictions within the same company is not one that we have seen employed in the health insurance industry and we are aware of no precedent for this process. While the attribution of existing surplus arises in the demutualization of an insurance company, in that situation a portion of the surplus is allocated to policyholders as consideration for relinquishing membership rights. Geographic jurisdiction is generally not a direct factor in this allocation process. In any case, the demutualization process represents a unique circumstance where surplus is being allocated over the policyholders / owners of the company for the purpose of reorganizing the company. This is decidedly different from attempting to allocate the surplus of a not-for-profit corporation where surplus is maintained for the ongoing protection of the policyholders.

Given these considerations, we believe that any attribution of GHMSI surplus by jurisdiction is artificial. The surplus is intended to benefit all policyholders. If the portion determined to be attributable to D.C. were found to be excessive and therefore used for other purposes, the protection afforded to all policyholders, including those in Maryland and Virginia, would be diminished. Likewise, if the regulators in Maryland or Virginia were to determine that the surplus attributable to their respective jurisdictions was to be expended for a designated purpose, the protection of all policyholders, including those in the District, would be affected.

Note that our analysis is limited to the surplus of GHMSI and does not include any consideration of the relationship of GHMSI to the holding company CareFirst, because the law applies only to hospital and medical service corporations.

III. Development of Estimated Surplus Attributable to D.C.

We have developed an estimate of the portion of GHMSI surplus as of December 31, 2008 that is attributable to D.C., as summarized in the following table.

Summary of Estimated Surplus Attributable to D.C. (Values in Millions)			
	GHMSI December 31, 2008 Reported Statutory Surplus	Estimated % Attributable to D.C.	Estimated Surplus Attributable to D.C.
Parent Excluding Value of CFBC	\$524.1	13.9%	\$72.8
CFBC Value	162.7*	4.2%**	6.8
Total GHMSI	\$686.8	11.6%	\$79.5
* Full value			
** Reflects GHMSI 40% ownership share			

Note that we have developed separate estimates for the portion of GHMSI surplus that excludes the value of CareFirst BlueChoice (CFBC), a partially-owned affiliate, vs. the portion that represents the value of CFBC. This and other facets of our development are discussed below.

Considerations in Development of Methodology

As mentioned previously, we are unaware of any precedent for the development of surplus attributable to geographic jurisdictions within the same company. In defining the approach that we have utilized, we considered the purpose for which this development is to be used, the characteristics of GHMSI's business, and the limitations of the available historical data. Our objective was to develop a methodology within these parameters that is equitable, and at the same time relatively straightforward and replicable. We believe that the assumptions and methodology we have employed meet this objective, and that they are reasonable and appropriate from both an actuarial and a general financial perspective.

Following is a brief discussion of some of the major considerations in the development of our approach, and the manner in which they have been addressed in our evaluation.

Purpose – The development of estimated surplus attributable to the District has been prepared in response to recent legislation that requires the Commissioner of Insurance to determine whether the portion of the surplus of GHMSI that is attributable to D.C. is excessive. This legislation also states that *“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.”*

Determination of Jurisdiction – We considered two alternative approaches to the determination of how membership, premium, and other financial measures would be attributed by jurisdiction. These were: (a) attribution of values to the jurisdiction in which a given subscriber resides (the “residence” approach), or (b) attribution to the jurisdiction of the situs of the associated contract, meaning the residence of an individual subscriber or the situs of the employer of a group subscriber (the “situs” approach).

While we are not attorneys and cannot offer legal interpretations, it appears to us that the intent of the legislation is to have any distribution of surplus that results from the application of the requirements of the law benefit residents of the District of Columbia. It was our conclusion based on this understanding, that the residence method is the appropriate alternative. If the funds are to be used to benefit only D.C. residents, then it would seem that they should be comprised of amounts that are attributable to only D.C. residents. The situs approach, if used instead, could have the effect of causing surplus that was attributable in part to residents of Maryland and Virginia to be expended on behalf of residents of D.C. only. This would not be equitable, and we concluded that the situs approach would therefore not be appropriate.

Time Period of Evaluation – The estimation methodology that we have employed in developing surplus attributable to D.C. involves the analysis of historical annual changes in surplus values as reported in GHMSI’s Statutory blank. Each year’s change in surplus, due to operating results and other factors, was evaluated in order to attribute an appropriate portion to each jurisdiction. In order to carry out this evaluation it was necessary to supplement the information reported in the Statutory blank with additional data tabulations drawn from GHMSI’s internal reporting and information systems. The approach we have selected is designed to be relatively straightforward, allowing future replication and updating with a reasonable level of effort.

We worked with GHMSI staff to identify the types of information that were required, and the availability of such information by year. While the data available for the most recent five years was fairly comprehensive, for earlier periods the level of detail that could be obtained was more limited. In general, we found that the degree of detail of the information and its level of quality both tended to decline with each additional year, working backward in time.

After analysis and discussions with GHMSI management, we determined that a ten-year period of historical information would be studied, and that this would produce equitable results by offering a reasonable compromise between the desire to incorporate a sufficient historical period of time and the importance of utilizing reliable information.

Therefore our methodology involves the analysis of the reported change in surplus values by year for the period of 1999 through 2008, in order to evaluate which portion of each year’s amount is attributable to D.C. The Statutory surplus value as of December 31, 1998 was then assumed to be attributed by jurisdiction in the same proportions as the surplus accumulated from 1999 through 2008.

Treatment of Affiliates and Subsidiaries – GHMSI owns a 40% share of CareFirst BlueChoice (CFBC), and holds a 100% share in a number of materially smaller subsidiaries, none of which are insuring entities. Given the significant size of CFBC and the materiality of its contribution to GHMSI’s surplus, we carried out a parallel evaluation of the reported annual change in surplus of CFBC and its predecessor (Capital Care, Inc.) for the period of 1999 through 2008. Based on this analysis, we estimated the portion of GHMSI surplus contributed by CFBC and its predecessor that can be considered attributable to D.C. residents.

The annual changes in value associated with other GHMSI subsidiaries were treated as investment returns in our evaluation, and were therefore attributed to jurisdiction based in part on premium income and in part on the attribution of the prior year’s ending surplus value. The subsidiaries of CFBC were treated in a parallel manner in our evaluation of CFBC and its predecessor.

Surplus Target - We have not done an evaluation of optimal surplus levels for GHMSI at the jurisdictional level (and there would be many technical problems with trying to do so). However, we can state that any range that is appropriate for the District of Columbia portion of GHMSI would be higher, when expressed as a percentage of the applicable benchmark, than the optimal surplus target range that we recommended for GHMSI as a whole.

Brief Description of Methodology

The general approach that we employed in our evaluation was to first attribute each year's Statutory underwriting gain/loss (UGL) by jurisdiction in proportion to estimated premium or fee income by jurisdiction of residence. This attribution was made separately for the UGL of each of the three major risk categories – i.e., Risk (excluding FEP⁶⁷), FEP, and Non-Risk. Each of these was considered separately in view of their unique underwriting and risk characteristics, which have resulted in materially differing financial objectives and underwriting results.

The evaluation of premium or fee income by residence necessarily involved an estimation process, because this information is not directly tabulated. Therefore, premium was first attributed to jurisdiction of situs, based on information in the Statutory blank for the Risk segment⁶⁸, and using the distribution of membership by residence for FEP. For the Non-Risk segment the fee income by situs from internal jurisdictional tabulations was utilized. The premium or fee income for each situs jurisdiction was then attributed to jurisdiction of residence based on available membership data, which was cross-tabulated by situs and residence for periods in 2005 through 2008.

After attributing each year's underwriting gain/loss by jurisdiction of residence, the other components of the change in surplus were attributed in proportion to premium and fee income, with the exception of investment returns. Attribution of the annual investment return was based in part on premium income (in recognition of the float generated by the time lag between premium collection and claims payment) and in part on the attribution of the prior year's ending surplus value.

It must be emphasized that while the process described above involved the direct use of detailed data where possible, it also required a significant degree of judgment and estimation due to the limitations on availability of such data. The earlier years, in particular, required some reliance on incomplete data tabulations, and where no applicable data was available, on patterns observed in subsequent years.

IV. Conclusion

In our opinion, the assumptions and methods employed in our analysis are reasonable and appropriate given the limitations of the data and other information that was available, and in view of the purpose for which it has been developed. Further, we believe that the methodology satisfies the objectives of providing an equitable approach to the attribution of surplus, while being straightforward, replicable and easily updated in future years.

We appreciate the opportunity to present the results of our analysis of GHMSI surplus attributable to the District of Columbia. The authors are available to explain and / or amplify any matter presented herein, and it is assumed that the reader of this report will seek such explanation and / or amplification as to any matter in question.

⁶⁷ By FEP, we mean GHMSI's participation in the BCBSA Federal Employee Program offerings within the Federal Employees Health Benefits Program (FEHBP). This does not include the CFBC offering within FEHBP, which is not part of the BCBSA program.

⁶⁸ For 2008 this allocation was based on internal jurisdictional tabulations, because the premium information by jurisdiction in the Statutory blank did not reflect the impact of reinsurance agreements that became effective in 2008 between GHMSI and CareFirst of Maryland, Inc. (CFMI).

Exhibit B

Lewin Group Report Dated August 31, 2009



Background and Methodology

The Lewin Group was retained by CareFirst to perform an independent assessment of the risk based capital range (RBC) suggested by Milliman for CareFirst's subsidiary, Group Hospitalization and Medical Services, Inc. (GHMSI).

This report contains Lewin's findings in response to three key questions addressed as a part of this analysis. Those questions are:

- Question 1: Is RBC an appropriate mechanism for assessing upper limits of insurers' surplus?
- Question 2: Is the approach used and range of RBC set forth by the Milliman report appropriate?
- Question 3: Is the concept of attributing "excess" surplus to a geographic area reasonable? What are potential mechanisms that could be used for attributing surplus in this manner?

Lewin relied on several sources of information to conduct this assessment. First, we relied on our experience in having conducted similar analyses on behalf of states and other health insurers. Second, we used statutory financial statements as the basis for much of our review of GHMSI's financial condition. We have noted instances where our findings were supplemented by interviews and/or information obtained solely through CareFirst. Finally, we used publicly available reports and documents, such as Milliman's December 4, 2008 report to CareFirst executives and the documents publicly available on the DC Department of Insurance, Securities, and Banking (DC DISB) website.

Question 1: Is RBC an appropriate mechanism for assessing upper limits of insurers' surplus?

To answer this question, it is important to define both surplus and RBC. Surplus is generally defined as an insurer's retained earnings or funds on hand to protect the company and its customers against adverse business conditions and support investment needs. Since surplus amounts do not provide perspective on a health plan's risk profile and organizational structure, state regulators commonly use RBC to assess an insurer's level of risk.

RBC is a measure generally used by regulators to establish the minimum amount of capital appropriate for a health plan to support its overall business operations during a period of adverse conditions. In DC, if RBC drops below 200% an insurer is required to present a plan to the DC DISB for improving its surplus. Blue Cross Blue Shield plans have similar, but more stringent RBC requirements imposed by the Blue Cross Blue Shield Association (BCBSA). The BCBSA requirements generally call for a licensee to maintain an RBC ratio of at least 375% as a threshold below which additional reporting and monitoring with regard to surplus levels is required.⁶⁹

Appropriate use of RBC

RBC was designed by NAIC to help regulators "distinguish adequately capitalized companies from inadequately capitalized companies."⁷⁰ Several reports and commentaries point to RBC's use as a mechanism for monitoring minimum levels of capital required to remain solvent, and not for setting upper limits of surplus. This is due to several reasons, but notably:

1) RBC does not measure the "appropriate" level of surplus for an insurer. The NAIC's RBC formula projects a regulatory minimum amount of capital that is based on a standardized set of RBC factors

⁶⁹ A description of minimum solvency requirements and capital thresholds is contained on pages 17 through 21 of the GHMSI Milliman report, as available on the DC DISB website at <http://disb.dc.gov/distr/cwp/view,a,1299,q,644199.asp>

⁷⁰ Statement on Use of RBC Data from the NAIC. Accessed on August 26, 2009. Mike Barth, "Ranking Insurers by RBC Measures: Still Not Such a Smart Move," NAIC Research Quarterly, April 1995.

applied to specific financial statement values of each company. However, the amount produced is a bare-bones minimum, and most companies carry well in excess of the statutory minimum.⁷¹ How much surplus is required in excess of the minimum is not addressed by the formula and is largely a matter of a plan's unique circumstances rather than a standardized calculation. Surplus management for a health insurance carrier must include consideration of both the *solvency* and *vitality* of the company.

Solvency is addressed, in part, by RBC measurement and other benchmarks. As we note elsewhere, however, RBC measures of solvency are point-in-time calculations. Surplus management and targets set by companies must, in fact, reflect a longer-term perspective to ensure that the point-in-time RBC measures are achieved.

Vitality objectives for companies address changes demanded by the marketplace, regulators, and members in response to an evolving healthcare environment. The history of the U.S. healthcare industry has been marked by continuous change in both the nature of available treatments and the manner in which services are provided by carriers. Companies require capital to react to these changes and develop or modify products and services to best serve its membership. Examples may be market driven (e.g. new and improved claims payment systems) or regulatory (e.g., ICD10 requirements), but typically are required to keep the company competitive and retain vitality in the marketplace.

BCBS plans are uniquely challenged because they lack the ability to sell stock to raise money, an option that is available to their for-profit competitors. Non-profit BCBS plans must fund large capital expenditures for innovation and vitality through either accumulated surplus or certain forms of new debt. Perversely, demands for capital are often likely to occur in a business environment which represents the worst time to incur additional debt. Appropriate levels of surplus must therefore address both solvency and an exercise in anticipating funding for necessary capital expenditures.

2) RBC is extremely volatile and can fluctuate between years for both consequential and inconsequential reasons. The RBC calculation is extremely sensitive to several variables, including underwriting performance, investment income, changes in non-admitted assets and internal accounting mechanisms. For example, the average BCBS companies' RBC ratio plummeted by 104 percentage points last year, primarily driven by the recent economic downturn and the loss of investments in the capital markets. GHMSI also experienced such a loss, in excess of 70 percentage points, as investment income fell by 42% from 2007 to 2008.

3) RBC is generated by a finite set of entries available in NAIC reporting formats and, as such, does not take into account all risks that insurers may face. As a generic formula, every single risk exposure of a company is not necessarily captured in the formula. The formula focuses on the material risks that are common for the particular insurance type.⁷² Examples of risks not included are: pandemics/epidemics (e.g., H1N1 influenza), natural disasters (e.g., Hurricane Katrina) and the implications of broad health reform efforts (e.g., such as those currently being considered by the Obama administration).

4) RBC is a point in time measurement and does not take into account issues associated with surplus planning across a multi-year period. Historical results for health insurance carriers reflect successive years of gains and losses across multi-year periods. These are so common as to be industry-referenced as the "underwriting cycle." Such cycles are not coincidental but are actually cause and effect outcomes created by events which trigger an initial loss and the subsequent business dynamics by which companies react to losses and re-establish appropriate rate levels across their entire book of business.

Such loss cycles are therefore not uniform in length or depth of losses. There are unique characteristics in each company's block of business with regard to the regulatory, competitive, and contractual limitations which might be placed on re-establishing appropriate rate levels. Loss cycles also vary based on the nature of the trigger for initial losses and the overall business and economic environment at that point in time.

Surplus management must focus on levels of surplus required to weather the cumulative impact of the multi-year loss cycles. The RBC measure becomes one test as a surplus floor against which solvency needs to

⁷¹ Ibid.

⁷² Risk-Based Capital, General Overview, July 15, 2009.

be measured at each year-end in modeling the impact of a projected loss cycle. As discussed above, it is also only one factor in such surplus assessments. Additionally, the RBC formula does not necessarily reflect the unique characteristics of the block of business of any given company when considering target surplus under the various loss scenarios.

Therefore, the appropriate use for the RBC is to help regulators provide an “early detection” system to monitor the solvency of an insurer.

The use of the RBC ratio by both health insurers and regulators

In recent years regulators and insurers alike have used RBC beyond its original intent as a measure of minimum financial solvency. Most insurers seem to contend, as GHMSI has done, that an insurer wants to provide an adequate margin of safety so that the company can endure periods of adverse experience without triggering any form of regulatory intervention while maintaining operational vitality and the ability to nimbly respond to unfolding market conditions. As noted above, it is most common for health plans to target surplus levels to cushion against a downturn in the underwriting cycle.⁷³

The use of RBC as a mechanism for regulating the upper limits of an insurer's surplus is much more controversial. For the reasons listed above, the RBC calculation was never designed to regulate the upper limits for insurer surplus.

Regulating the maximum levels of surplus for an individual insurer can lead to several unintended consequences within the market place. If an insurer perceives that it may be accumulating surplus at a faster rate than a regulatory threshold permits, the insurer is incentivized to spend the “excess” surplus before regulatory intervention. For example, all insurers need to have the ability to plan for capital investments (e.g., IT investments) that need to be made in future years. This is particularly true for non-profit insurers, such as GHMSI, since they must either borrow the money or rely on surplus to fund such investments. Capping surplus accumulation makes it difficult for insurers to plan for long-term, future capital investments that are required so the company can remain competitive in the market place.

Additionally, an insurer seeking to avoid the trigger of a maximum regulatory threshold may not be maintaining surplus at an adequate level to remain solvent across several years of poor financial returns, low underwriting cycles, and other conditions mentioned previously. Only two states actively apply an RBC-type formula to monitor insurers' upper surplus limits.⁷⁴

- *Pennsylvania.* In 2005, the Pennsylvania Insurance Department stipulated RBC ratio ranges for all BCBS insurers operating within Pennsylvania. If a BCBS insurer goes above that range, they are required “to provide a plan to the Department illustrating how it will reduce its surplus level back to within its sufficient surplus operating range over a reasonable period of time.”⁷⁵
- *Michigan.* In 2003, Michigan enacted a provision stipulating that the BCBS insurer operating in that state shall not maintain an RBC ratio greater than 1000%.⁷⁶

All other states have either not addressed placing a limit on insurer surplus or have simply chosen not to do so. Based on Lewin's experience in conducting research on this topic, most regulators tend to deal with the

⁷³ James Drennan, “How Much Is Enough? Beyond the Mathematics of Risk Based Capital,” Society of Actuaries meeting, June 2003.

⁷⁴ New Hampshire has a law (Title XXXVII, Insurance, Chapter 420-A, Health Service Corporations, §420-A:22, Annual Review) capping a non-profit health insurer's “contingency reserve fund” at 20% of premium income. The law is not enforced, primarily because New Hampshire's BCBS plan is now a for profit company. Minnesota had a maximum capital level for non-profit BCBS plans in the amount of three months' worth of medical claims expense; however it was eliminated in 2005 with the addition of the NAIC Model Health RBC Act. Hawaii had a law stating that if a non-profit health plan's network exceeded 50% of the prior year's total health care expenditures plus operating costs, the health plan is required to refund the money to clients. That law is no longer in effect.

⁷⁵ Determination and Order issued by the Pennsylvania Insurance Department in February 2005. The RBC ratio ranges are 550-750% for Highmark and IBC and 750-950% for Capital Blue Cross and NEPA.

⁷⁶ The Nonprofit Health Care Corporation Reform Act 350 of 1980, §550.1204a Unimpaired Surplus (added 2003).

issue of surplus accumulation through traditional mechanisms and oversight tools commonly available to state insurance departments, such as rating requirements and restrictions, minimum loss ratios, file and approval for rate increases, and other mechanisms, rather than relying on the RBC calculation.

Question 2: Is the approach used and range of RBC set forth by the Milliman report appropriate?

As previously noted, Milliman has identified a target RBC ratio range that CareFirst executives could use as a mechanism for managing surplus levels to appropriate risk mitigation levels. The Milliman-recommended RBC range is between 750% and 1050% under normal operating circumstances. Lewin was asked to comment on the appropriateness of the range without extensively modeling the underlying aspects of GHMSI's business.

Methodology used to assess Milliman's approach and RBC range

We have modeled surplus as a percent of revenue for many clients and updated our model to review the range of surplus for most non-profit Blue Cross Blue Shield plans. We recognize that different business dynamics will shift optimal ranges for GHMSI either above or below the output suggested by our model. However, the model produces a range that suggests the breadth of the range recommended by Milliman (i.e., 300% point range) is reasonable.

We are also familiar with the modeling concepts Milliman employed. In fact, we have performed similar modeling exercises in other situations with the same general framework and approach. Based on our review of Milliman's report, the Milliman approach was to model the potential "loss cycles" as discussed above. This analysis then develops a range of surplus levels which might be required to weather potential accumulated losses and maintain required RBC and/or surplus levels throughout the loss cycle. The range of surplus required is therefore a function of the assumptions as to what might drive losses, the specific dynamics of repricing business at GHMSI, and the desired probability of weathering a projected scenario.

Findings from assessment of Milliman's approach and RBC range

To review the breadth of GHMSI's proposed range of RBC, Lewin examined the historical surplus levels to quantify historical volatility and fluctuation of surplus for similar non-profit BCBS plans. Our model examines the number of years in a cycle and the magnitudes of surplus change observed historically during underwriting cycles. Using this historical information, the model estimates the RBC level required to remain solvent during potential loss years of an underwriting cycle. By converting the observed gains and losses of the underwriting cycle to a normal distribution, the model allows us to construct scenarios based on the likelihood of a certain magnitude of decline.

Milliman has chosen to set their range to withstand risks occurring between the 90th and 98th percentiles of the loss distribution. We believe that this range in the loss distribution is appropriate, especially given the current economic situation (we note that their report was written in December 2008). The breadth of their range (300%) is reasonable when we independently constructed a range. We believe that the 95th percentile of the loss distribution is prudent for a point estimate, therefore Milliman's range of 90% - 98% can be justified.

The specifics of modeling potential loss cycles require processing a great deal of detail as to the underwriting and contractual characteristics of the blocks of business at GHMSI. Surplus considerations should also be addressed in modeling for capital needs and other issues beyond solvency, as discussed earlier in this letter. We did not run an independent loss cycle modeling exercise, but we are familiar with the approach taken by Milliman and find it similar to our own modeling. We also reviewed the surplus objectives and model parameters as described in the Milliman report. Based on work we have performed elsewhere and review of Milliman work, we are in agreement with the targets and rationale. The actual range would be a function of the assumptions, business modeling, and desired probability of maintaining the surplus target. Overall, our review does not allow us to comment as to whether we would have produced the same range of surplus requirements as shown in the Milliman report. Our review does suggest:

- Given what we know about the type of modeling exercise Milliman undertook, we believe the surplus targets produced represent a reasonable range of expected outcomes.

- We support the use of a wide range of targets such as the 300% (750-1050%) range of potential outcomes that Milliman adopted. This finding is reinforced by both the results of our analysis, as well as the difficulty in managing to a narrow range of RBC given the limitations of the calculation. Events associated with potential loss cycles can have a wide range of impact, and the ability of the company to respond can be confounded by a wide range of environmental factors.
- Models of the type used by Milliman are developed based ranges of likely assumptions which then create a probability-weighted range of potential outcomes. We support Milliman's recommendation that surplus targets should be chosen which represent a 90% to 98% likelihood of occurring among potential projected outcomes. Choices of a target with a 10% probability that surplus becomes inadequate (90% targets) do not represent sufficient assurance that company objectives can be achieved. On the other hand, the range of outcomes is sufficiently broad that achieving 100% assurance will be overly conservative. As previously noted, the case of a BCBS plan in which underwriting gains are the primary source of both surplus and capital needs argues for choosing targets with a higher probability of sufficiency.

Question 3: Is the concept of attributing “excess” surplus to a geographic area reasonable? What are potential mechanisms for attributing surplus in this manner?

Per Section 2(d) of the Medical Insurance Act,⁷⁷ the District's Insurance Commissioner is required to review only “the portion of the surplus of [GHMSI] that is attributable to the District and shall issue a determination as to whether the surplus is excessive.” The answer to this question attempts to address if the attribution of surplus to a specific geographic region is reasonable and mechanisms that might be used to attributing surplus, regardless of the “reasonableness” of the concept.

Reasonableness of surplus attribution

GHMSI is a federally chartered Health Services Corporation that writes healthcare policies in three insurance jurisdictions: Washington D.C., Maryland, and Virginia. As such, GHMSI faces regulations from the three separate jurisdictions; however the company is centrally administered and managed.

Since GHMSI serves three contiguous geographical areas and invests in corporate infrastructure that allows economies of scale which accrue to all three areas, allocating surplus among the three areas is challenging. The infrastructure would be difficult to divide amongst the three areas, and if it was divided up the three separately administered areas would not achieve the operational advantages that a centrally administered organization is able to achieve. Similarly, by maintaining combined surplus that covers all three geographies, GHMSI is able to increase the financial protection afforded to all three. In light of the economies of scale provided to all three areas, it is difficult to attribute surplus (or any plan assets) to specific geographies. Additionally, the surplus and other plan assets have been accumulated over many years, and to attribute them appropriately may require a longer term historical view of the entities.

Potential mechanisms for attributing surplus

Insurance involves the payment of premium in exchange for financial protection afforded to the subscribers who receive the benefits. Bearing this in mind, we believe that any allocation of surplus should accrue to the subscribers. Furthermore, the accumulation of surplus occurs over a long period of time and not necessarily accruing evenly from all policyholders, further complicating the question of allocation.

It is important to note that nothing in the RBC formula anticipates an attribution of surplus within a regulated entity. Risk factors applied in the RBC formula, or other modeling exercises which might be applied to develop target surplus, could very well differ significantly among various geographies. They are not currently anticipated in the development of either the factors or the underlying financial data to which the factors are applied. Since the concept of attribution is not currently anticipated in surplus management, the foundations for modeling process which might accomplish such attribution is therefore even less clear.

In summary, our findings from our analysis across all three questions are below:

⁷⁷ D.C. Code §31-3506(e)

- The RBC calculation was never designed to regulate the upper limits for insurer surplus. RBC calculations should be applied as an element in determining minimum regulatory solvency – consistent with the purpose which they were developed.
- Our review of the development of surplus targets set forth by the Milliman report suggests that the approach and range of potential targets developed is generally reasonable. We have several models we might apply, and exercises such as the loss cycle model that can produce a range of answers based on input assumptions and output parameters. We might, therefore differ as to the precise RBC percentages recommended. However, the model applied is consistent with an approach we might undertake, the outcomes do not differ significantly from those we might expect, and the choice of probability for sufficiency among potential outcomes seems appropriate.
- The attribution of any “excess” surplus to a geographic area is not a straightforward or easily determined outcome. Assuming that such an attribution is warranted, potential mechanisms for attributing surplus do not exist and would have to be developed. However, such logic was not anticipated in current surplus exercises and would have to be extrapolated from basic principles which are underlying minimum RBC determination and development of surplus management targets