



**DC APPLESEED TESTIMONY FOR MARYLAND INSURANCE
ADMINISTRATION SURPLUS HEARING
NOVEMBER 19, 2009**

Introduction

Good morning, Commissioner Tyler. Thank you for holding this hearing concerning the surplus of CFMI and GHMSI, and for giving me an opportunity to testify. My name is Walter Smith, and I am the Executive Director of the DC Appleseed Center for Law and Justice.

As you know, DC Appleseed has believed for some time that CareFirst has not been meeting its nonprofit obligations to citizens in the National Capital area. Our concern began when the company in 2002 attempted to sell itself to WellPoint for many hundreds of millions of dollars less than the company was actually worth. Our view on this issue was confirmed when your predecessor, Steve Larsen, denied the company's attempt to convert to for-profit and the Maryland legislature addressed CareFirst's failure to focus on the community it is chartered to serve by reconstituting CareFirst's board of trustees.

Our concern about the company has continued even following these events. Our December 2004 report showed that the company had built and was maintaining what we believe to be excess surplus that could and should be devoted to reducing premiums and helping more people obtain access to affordable coverage. Indeed, shortly after we issued our December 2004 report, the company announced a new community benefit program of approximately \$100 million dollars, mostly in the form of premium increases that were lower than it might otherwise have charged.

In response to our report, the DC Insurance Commissioner held a hearing in the spring of 2005 addressing whether the company could and should reduce its surplus to address the many community health care needs in the National Capital area, including reducing premiums and increasing subsidized coverage. As you know, the DC Insurance Commissioner determined in the fall of 2005 that the company should significantly reduce its surplus and that such a reduction would in no way harm the company's financial strength and stability.

At the time of the Commissioner's determination, the part of the company the Commissioner was addressing -- GHMSI -- had a surplus of approximately \$500 million. However, rather than reducing its surplus as directed by the Commissioner, the company

has instead *increased* its surplus by nearly another \$200 million over the last 4 years. As of December 31, 2008, GHMSI reports a surplus of \$687 million. Moreover, rather than increase its community benefits spending as the DC Commissioner urged, GHMSI has in fact dramatically *reduced* its community benefit spending from its reported high-water mark in 2005.

In the wake of GHMSI's failure to follow the DC Insurance Commissioner's direction, two important things happened in the District of Columbia: First, the DC Attorney General brought suit against the company in the Federal District Court, contending that the company's excess surplus violated both local DC law and the company's federal charter. Second, the DC Council passed new legislation enforcing the federal charter by directing the DC Insurance Commissioner to examine the surplus of the company and to direct a spend-down of any excess found by the Commissioner. The Attorney General's office agreed to dismiss its lawsuit without prejudice while awaiting the outcome of the Insurance Commissioner's determination.

Significantly, the DC Council's legislation is modeled largely on Maryland's law, with one important difference. That difference -- owing to the Council's concern that GHMSI did not measure its accumulated surplus against the company's federal charter obligation -- is that District law requires that GHMSI's surplus be set at a level that commits the "maximum feasible" amount to community health reinvestment, "consistent with financial soundness and efficiency."

We are here today because we believe that GHMSI's surplus does not meet that standard; nor do we believe that the Invotex report fairly and effectively applies that standard.

In the time that is allowed me today, I would like to make five points to you about the Invotex report. Taken together, I hope these five points will help persuade you, first, that the surplus ranges for CFMI and GHMSI that Invotex endorses should not be accepted. And second that, in the case of GHMSI, only a significantly lower range, and a ceiling set toward the low end of that range, will meet the legal standard and adequately balance the public's overriding interests in that surplus -- specifically, that the company's surplus should maximize community benefits, while maintaining its financial soundness and efficiency.

Here are the five points I urge you to consider: 1) the caveats Invotex itself offers for its report call into question whether the report should form the basis for your own independent review of the surplus issue; 2) Invotex's own analysis of comparable companies calls into question the surplus levels it endorses for GHMSI; 3) in effect, Invotex concludes that CFMI's should raise its premiums dramatically to reach the needed level of surplus—a result that is so counter-intuitive as to reinforce doubts about

the report's methodology; 4) the results reached by Invotex are inconsistent with the persuasive analysis in the Pennsylvania Insurance Commissioner's decision; and 5) perhaps most importantly, Invotex, as was true of Milliman, takes no account of either the company's nonprofit obligations or the legal standard that governs those obligations.

1. The Invotex report is not independent.

In our view, in order for the Commissioner to rely on the Invotex report, that report should be 1) based on a wholly independent and expert actuarial analysis; and 2) performed by a firm that clearly has the experience and expertise to conduct such an analysis. Meaning no disrespect to the authors of the Invotex report, we do not believe the report meets these requirements.

We say this primarily because of concessions that Invotex itself makes in the report. As Invotex forthrightly acknowledges on page 68 of the report, its proposed surplus ranges for GHMSI and CFMI "carry with them certain caveats." For us, the two most important caveats identified by Invotex itself are that the report's surplus estimates "are based on Milliman's model and their work as well as on the assumptions that were developed and agreed upon by Milliman and CareFirst."

We believe the stakes in this proceeding are much too high for the Commissioner to premise his surplus review on an analysis that largely defers to the company and its actuary, rather than offering an independent analysis. We are aware, of course, that the Invotex report appears to challenge certain of the Milliman and CareFirst assumptions, but those challenges are very much at the margins. The fact is that Invotex did not develop its own model for assessing surplus, nor did it do any analysis to validate that model.

Invotex apparently accepted without question the key underlying assumption of the Milliman model -- that surplus should be measured against an assumed three or four-year severe downturn cycle that has no clear historical basis. Indeed -- as acknowledged by Invotex at page 68 of its report -- its "ranges have been developed" on the basis of "perceived risks that ... have not been observed historically." In our view, the Commissioner's assessment of surplus for GHMSI and CFMI should be based on reliable historical data. As is shown in the attached work from our own actuarial experts, Actuarial Risk Management (ARM), when actual historical data are used to measure perceived risks, it can be shown with 99.99% certainty that a much lower surplus range will protect the company from the risk of it surplus falling to 375% or 200% RBC. (Attachment 7-ARM Rebuttal, at 11).

It is not clear to us why Invotex did not construct its own independent model or conduct its own independent analysis of the appropriate surplus ranges for the company. In addition, according to its website, Invotex has no direct experience in conducting this kind of analysis, nor does it appear to have any full time actuaries on its staff.

For us, the combination of these caveats -- along with the other questions we address below -- raises serious doubt whether the Invotex report can form the requisite independent, credible analysis the Commissioner needs in order to decide this very important issue.

2. Invotex has produced a completely counter-intuitive result for CFMI.

We agree with Invotex's conclusion that CFMI's surplus range should be higher than that for GHMSI. In our view, based on the work of ARM, an appropriate surplus range for GHMSI is 450% to 525 % RBC. (Attachment 7 - ARM Rebuttal, at 21). CFMI's current surplus is at 503% RBC. Although we have not separately assessed CFMI's surplus, the relationship between our proposed range for GHMSI and CFMI's current surplus level seems appropriate.

Surprisingly, however, Invotex (having adopted Milliman's model) concluded that CFMI's surplus should be dramatically higher -- between 825% to 1075% RBC, compared with its current (2008) level of 503% RBC. If Invotex is correct, then CareFirst has grossly underfunded CFMI's surplus and should approximately double its surplus -- from \$394 million in 2008 to at least \$647 million, or to as much as \$843 million. Assuming that CFMI is currently as efficient as it can be, such an increase could come only from increased premiums. If correct, Invotex's conclusions suggest that CFMI should increase its health premiums across the board by 19 to 34 percent, even before accounting for medical trend and other factors that underlie rate increases. We suggest that the astonishing surplus that Invotex recommends for CFMI calls their report, with respect to both CFMI and GHMSI, seriously into question.

3. The Invotex peer analysis is unpersuasive.

A third factor calling the Invotex report into question is its examination of certain "peer companies" in order to justify its recommended surplus ranges for GHMSI and CFMI—although our concern here is only with the appropriateness of the analysis as it applies to GHMSI. We believe that Invotex's peer group analysis actually undercuts its recommended surplus range for GHMSI. We say that for two reasons.

First, as we showed in our own analysis submitted to the DC Commissioner, GHMSI is clearly at the upper-end of surpluses held by comparable BlueCross BlueShield

companies (see attached statements from Deborah Chollet and ARM). The average RBC of Invotex's selection of comparable companies is 678% RBC. (Invotex at 42) —much higher than the RBC ratio of the companies selected by either Dr. Chollet (500%) or ARM (573%). (Attachment 4 - Chollet Statement, 8.31.09 at 5; Attachment 3 - ARM Report 8.31.09 at Appendix B). Nevertheless, it is hard to see how Invotex's figure confirms its recommended surplus range for GHMSI of 700% to 950% RBC, much less GHMSI's current 845% RBC.

Moreover, Invotex acknowledges that GHMSI has increased its surplus over the 2001-2007 period at a rate that is almost twice that of the peer companies – by 175% vs. 94%. (Invotex at 41). Again, because Invotex's peer group comparison shows, if anything, that GHMSI's surplus level and growth exceed those comparable companies, it is hard to see how Invotex's peer company analysis justifies its recommended surplus range.

4. The Invotex report departs from the well-reasoned decision of the Pennsylvania Insurance Commissioner.

In its report, Invotex appears to endorse the decision of the Pennsylvania Insurance Commissioner concerning the appropriate surplus ranges for the Pennsylvania Blues. Thus, on page 72 of its report, Invotex says that “the Pennsylvania approach... appears to be effective, easy to administer, and a transparent means to balance the goals of financial soundness and community responsibility.” However, as we read the Pennsylvania decision, the Insurance Commissioner rejected the Milliman model upon which the Invotex report is based.

As we explained in our submissions to the DC Insurance Commissioner (see our attached August 31 cover memo and August 31 Covington & Burling memo), Commissioner Koken rejected Milliman's approach for several reasons. First, she concluded that an economically efficient level of surplus is one at which “a Blue Plan does not face solvency issues from *routine* fluctuations in factors such as underwriting results and returns on its investments.” (In Re: Applications of Capital BlueCross, Highmark Inc., Hospital Service Association of Northeastern Pennsylvania d/b/a Blue Cross of Northeastern Pennsylvania and Independence Blue Cross for Approval of Reserves and Surplus, Misc. Dkt. No. MS05-02-006, at 34 available at http://www.ins.state.pa.us/ins/lib/ins/whats_new/2004bc/BCBS_DETERMINATION.pdf (hereinafter, “Pennsylvania Decision”)). Accordingly, she reasoned, while any number of extreme or adverse contingencies might be imagined, they should not be the predicate for establishing surplus levels. Rather, she concluded:

their low probability of occurrence or unforeseeable or catastrophic nature recommend that they are most efficiently prepared for through a combination of

government, industry-wide, societal and individual company specific initiatives. The reality is, no individual insurer can or should be permitted to collect or accumulate enough premiums to cover any and all catastrophic events no matter how remote or unforeseeable. (Pennsylvania Decision, at 12).

Furthermore, the Pennsylvania Insurance Commissioner rejected Milliman's contention that an appropriate surplus level should be calculated solely by estimating the impact of an imagined downturn for the company. Rather, she said, such an approach improperly ignores "differences in underwriting volatility associated with size and diversity" (Pennsylvania Decision, at 13) and other factors related to the company; it also ignores important benchmarks such as the surplus levels of other comparable companies and surplus standards set by the BlueCross BlueShield Association. In the latter category, Commissioner Koken (and later Commissioner Mirel) pointed to the fact that the BCBSA treated an upper range of 800% RBC as one where it may be presumed "that the Plan is sufficiently strong to meet its obligation to it insureds well into the future." (Pennsylvania Decision, at 22).

In the Pennsylvania case, as here, Milliman considered none of these other factors. Rather, in Pennsylvania, as here, Milliman premised its case on assuming an unprecedented adverse cycle for the company. Using that assumption, Milliman projected a surplus range of 650% to 950% RBC for Highmark. (Highmark, Inc. – Need for Statutory Surplus and Development of Optimal Surplus Target Range, Milliman USA, Inc. March 21, 2004 at 54, available at http://www.ins.state.pa.us/ins/lib/ins/whats_new/2004bc/Highmark.pdf). The Pennsylvania Commissioner determined instead that the range should be 550% to 750% of RBC. (Pennsylvania Decision, at 37). Thus, the Commissioner found that Milliman's proposed range was too high by 15% (at the low end of the range) to 17% (at the high end).

Although the Invotex report embraces the Pennsylvania decision, we think the report does not apply that decision. Rather, in our view, the Milliman model--which Invotex largely adopted here--is at odds with the Pennsylvania approach and produces surplus recommendations that are far higher than the Pennsylvania approach would produce.

5. The Invotex report takes no account of the governing legal standard

In its report, Invotex states (p.12) that CFMI and GHMSI have the statutory mission under Maryland law to:

- (1) provide affordable and accessible health insurance to the plan's insureds and those persons insured or issued health benefit plans by affiliates or subsidiaries of the plan;

(2) assist and support public and private health care initiatives for individuals without health insurance; and

(3) promote the integration of a health care system that meets the health care needs of all the residents of the jurisdictions in which the nonprofit health service plan operates.

And yet nowhere in its report does Invotex attempt to incorporate the described statutory obligation in its analysis. This is also true of Milliman. In fact, Milliman's representative testified at the recent hearing before the DC Insurance Commissioner that his studies and recommendations concerning GHMSI's surplus "were not done in view of this specific statute at all." (DISB Hearing Transcript, September 10, at 197, *available at* <http://disb.dc.gov/distr/frames.asp?doc=/distr/lib/distr/pdf/witnesslist/0910disb.pdf>).

The specific statute that Milliman referred to was the DC Council's recent enactment setting the standard for GHMSI's surplus. That statute requires GHMSI's surplus to be consistent with its community health reinvestment obligation. (*See* Medical Insurance Empowerment Amendment Act of 2008, D.C. Law 17-369, Sec.2(e) now codified at D.C. Code § 31-3506 (e)). That obligation in turn requires GHMSI to "engage in community health reinvestment to the maximum feasible extent consistent with financial soundness and efficiency." (Id., Sec. 2(c), now codified at D.C. Code § 31-3505.01). Neither Milliman nor Invotex account for this standard. Rather, both simply compute an "optimal" surplus for GHMSI and whatever is left over GHMSI supposedly will commit to community reinvestment. We submit that this analytical framework is backwards and serves to undermine the surplus ranges Milliman and Invotex have recommended.¹ This framework also fails to apply a key principle adopted in the Pennsylvania decision – that at some point "successive dollars of surplus" bring only a "marginal reduction in risk," and that "marginal reduction in risk" must be balanced against "the benefits of using these same surplus funds in an alternative fashion." (Pennsylvania Decision, at 15).

In its actuarial analysis, ARM computes a "financially sound and efficient" surplus for GHMSI, which would allow GHMSI to maximize its community health reinvestment. ARM makes the calculation on the basis of GHMSI's own historical data for the past 14 years, rather than the imagined and unprecedented catastrophic downturn that Milliman and Invotex assume. ARM's approach produces a much lower surplus range for GHMSI -- 450% RBC to 525% RBC -- a range that faithfully implements the requirements of the

¹ As earlier noted, the "maximum feasible/financial soundness and efficiency" standard is the only significant difference between Maryland's surplus law and DC surplus law. And in our view, Maryland must apply the more stringent DC standard in examining GHMSI's surplus. (*See* Attachment 2 - Covington Memo 11.18.09).

Pennsylvania decision in that it is based on actual historical income fluctuations of the company.

In our view, for the reasons stated, the Commissioner should reject Invotex's recommended surplus range for GHMSI. However, even if the Commissioner accepts that range, we submit for the reasons advanced in the attached Covington & Burling memo that the "maximum feasible" requirement in District law requires that the surplus be set near the low end of that range.

In fact, Invotex's own report would support this view. As Invotex says (p.68), "in a statistical sense, if CFMI and GHMSI are operating within their respective appropriate range of surplus, there is a low probability that risks will manifest themselves to such a degree that will cause either plan's surplus to fall below the 375% BCBSA RBC requirement and even lower risk that either plan's surplus would fall below the 200% current ACL RBC requirement."

In other words, Invotex appears to conclude that any level of surplus within its recommended range would ensure the financial soundness and efficiency of the company. That being so, only at the low end of the range for GHMSI can GHMSI engage in community health reinvestment to the "maximum feasible extent." Accordingly, even if Invotex's range were accepted, GHMSI's surplus should be reduced from 846% RBC to approximately 700% RBC. This is not a trivial matter: this reduction equates to over \$100 million. Such an amount applied to the considerable healthcare needs of the citizens of the National Capital area would be of great benefit.

Conclusion

DC Appleseed appreciates the attention that both Maryland and the District of Columbia have paid to this important issue. Given the region's present economic circumstances and the difficulty so many citizens are having in obtaining access to affordable healthcare coverage, the need for this attention has never been greater. We look forward to working with you and the DC Commissioner to ensure that GHMSI is all that is envisioned in statute: a company that is financially efficient and strong, and engaged in community health reinvestment to the maximum feasible extent.