JUNE 25, 2014 GHMSI SURPLUS REVIEW
PUBLIC HEARING
R&A TESTIMONY

Good morning. My name is Neil Rector, and I am a Senior Consultant with Rector & Associates, Inc. (R&A), an insurance regulatory consulting firm. Our firm is staffed by experts in insurance regulation and financial solvency matters and provides services to insurance regulators and companies on a wide variety of financial condition issues.

I have more than 30 years of experience in the insurance industry, including serving as the Deputy Director for the Ohio Department of Insurance. Since I founded R&A 23 years ago, the firm and I have worked on a wide variety of projects pertaining to insurance and insurance regulation, including serving as the appointed supervisor for financially troubled insurers on behalf of various departments of insurance. I know first-hand how disruptive it can be to policyholders and others when an insurance company gets into financial trouble. While at R&A, I have also served as the Team Leader on Accreditation Review Teams on behalf of the National Association of Insurance Commissioners. In that position, I have been physically on-site and have reviewed the financial solvency oversight operations of the vast majority of US insurance regulators. I have testified twice before Congress about the US insurance financial solvency system. I have also travelled internationally to help non-US insurance regulators in China, Poland, Hungary, Slovenia and Brazil either establish an insurance regulatory agency or train their regulatory staff.

I believe it was my broad background in insurance regulation, and particularly in matters pertaining to what constitutes appropriate regulatory oversight of insurance company financial solvency, that prompted the D.C. Department of Insurance, Securities and Banking (the DISB) to ask me to lead the DISB's examination of the surplus position of Group

Hospitalization and Medical Services, Inc. (GHMSI) required by D.C. Official Code § 31-3506(e).

Sitting beside me here today are several other people who were heavily involved in the review. Next to me is Sarah Schroeder, Principal of R&A and our President, and Jim Toole and Robert Stewart of FTI Consulting, whom I'll introduce a bit later.

The scope of our work, as requested by the DISB, consisted of the following:

1. An analysis of the standards to be used when reviewing GHMSI's surplus position in accordance with D.C. statutes and regulations and with the 2012 decision of the D.C. Court of Appeals in *D.C. Appleseed Center for Law & Justice, Inc. v. DISB* (referred to as the Court of Appeals Order);

2. Reviewing the projection model used to analyze GHMSI'S surplus position;

3. Determining the appropriate standards to be used to analyze GHMSI's surplus position;

4. Analyzing an appropriate amount of surplus GHMSI should maintain to satisfy the appropriate standards; and

5. Analyzing GHMSI's community health reinvestment expenditures during 2011 and 2012; its projected community health reinvestment expenditures during 2013; and its anticipated community health reinvestment expenditures for 2014 and future years.

At the DISB's request, we also reviewed and considered materials and other input provided by D.C. Appleseed Center for Law and Justice, Inc. (Appleseed) and by United Health Actuarial Services (UHAS), an actuarial consulting firm engaged by Appleseed to help in its analysis.

To be clear, our role in the consideration of GHMSI's surplus has been to act as an advisor to the DISB by analyzing the standards and methodology to be used in reviewing GHMSI's surplus position. R&A is not the final decision-maker with respect to whether GHMSI's surplus position satisfies the standards prescribed by DC statutes and regulations and the Court of Appeals Order. Instead, our task has been to convey to the Commissioner our findings and recommendations in the form of our written report and related supplemental responses to questions posed by or through the

Commissioner and his staff. The Commissioner is the final arbiter with respect to whether GHMSI's surplus position meets the required standards.

As I alluded to earlier, to assist with our work, R&A engaged the services of FTI Consulting (FTI). Jim Toole and Robert Stewart of FTI are here today on behalf of their firm.

Before I describe our work and findings, Jim will provide information about his firm and background, as well as address some issues that have been raised relating to the work we performed and the documentation of our work.

Good morning. My name is Jim Toole, and I am a Managing Director at FTI Consulting, a business advisory firm that provides a full range of actuarial services to insurance companies and insurance regulators. I am a Fellow of the Society of Actuaries, a Chartered Enterprise Risk Analyst and Member of the American Academy of Actuaries.

I have over 25 years of experience in the insurance industry, including a variety of roles with leading consulting firms and insurance companies. I acted as the health actuary for the Hawaii Insurance Division for six years in a contractual relationship with the state of Hawaii. I served as the chair of the Health Section of the Society of Actuaries, which coordinates and funds research and education activities on behalf of over 3,500 U.S. and Canadian health actuaries. In 2009, I was awarded a Chartered Enterprise Risk Analyst designation as a result of my leadership in the field of Enterprise Risk Management. I recently completed a three year term on the Board of Directors of the Society of Actuaries.

I am a frequent speaker at industry meetings, seminars, and universities and have written and edited articles for numerous industry publications. I served as lead editor of the textbook "Insurance Industry Mergers and Acquisitions" that was published by the Society of Actuaries (the SOA) in the spring of 2005. I served as lead researcher on an SOA research project to analyze the potential impact of a pandemic on the U.S. life and health insurance industries, and chaired an SOA research project oversight group estimating the economic measurement of medical errors in the US medical system.

FTI was asked by R&A to assist its staff in its analysis of GHMSI's surplus position. We played a similar role in the 2009 review of GHMSI's surplus

position. As a result, we already were familiar with the mechanics of and issues relating to the Milliman projection model.

For purposes of this review, we function as an integrated part of the R&A team. Generally, our only communications regarding the project that occurred independently from the rest of the R&A team were with Milliman and GHMSI actuaries to discuss technical aspects of the projection model.

At R&A's request, we reviewed the structure of the Milliman projection model and the values and assumptions used to construct the model. We provided R&A with written documentation of our analysis and recommendations. Finally, we reviewed and provided input with respect to the R&A Report and related documents prior to finalization and publication of the Report and related documents.

At the very beginning of the review, a threshold question that had to be addressed was whether to use the Milliman projection model as the base model—subject to adjustments—or whether to use a different projection model as the base. There are, of course, other projection models that exist in the market we could have used. We also could have used our own model.

After considering the matter, and discussing it with R&A and the DISB, we collectively decided to use the Milliman projection model as the base model. However, the decision was also made to supplement the work done there by testing it against the results of our own independently-constructed model, which we developed for validation testing purposes. We felt that this mix—using the Milliman model as the base but testing it against results from our model—provided the right balance.

It is important to emphasize that the decision to use the Milliman projection model as the base did not mean that we were being deferential to Milliman or GHMSI, or that GHMSI was being advantaged. Projection models are essentially calculators and should produce similar results if similar assumptions are used. If a given model is properly constructed, it ultimately isn't all that important whose model you use. Rather, the important decisions pertain to the numbers put into the model—in other words, the assumptions selected for the model to run. Our team retained full control over the selection of assumptions, and we validated the results generated by the Milliman model by comparing them to the results generated using our own independently-developed model.

Why did we decide to use Milliman's projection model as the base? Well, even though a projection model is essentially a calculator, it is a very complex calculator and one that needs to be tailored to the task at hand. Since Milliman had already developed its projection model, and since we were already familiar with it from the 2009 review, using a different model as the base model would have complicated the review without adding much benefit. As I mentioned, what drives the result is the choice of assumptions that go into the calculations, not the projection model itself, so we felt that keeping the model a constant would allow us and others to focus more clearly on what was really important—the assumptions—rather than be drawn into a discussion about this or that aspect of any particular calculator.

However, as I mentioned previously, we supplemented that work by also using a projection model we developed independent of Milliman. Why? The answer again relates to the fact that projection models are very complex. What we didn't want to happen was for there to be an internal kink in the Milliman model—some aspect to it—that wasn't easy to see but that would cause the calculations to skew to GHMSI's advantage even if the assumptions selected were the correct ones. We felt the best way to detect whether that was happening—a way to "validate" the Milliman model—was to run essentially the same assumptions on a model that we had constructed independent of Milliman using a similar, but somewhat different, forecasting methodology. If we achieved essentially the same results using our model than what was reached using the Milliman model, we knew that the Milliman model was running properly. Using that approach, we were able to validate the Milliman model and its surplus findings and key assumptions against appropriate historical experience.

Another topic we considered before we began our review was whether to evaluate the operating results and RBC levels of other health insurers for comparative purposes. In other words, we considered whether it would be helpful to try to identify insurers that might be considered GHMSI's "peers" and to compare their financial results and surplus profiles to GHMSI's. We had performed such a "peer group analysis" in connection with the 2009 review, and we needed to know whether to perform a similar review this time.

Before making a decision regarding the matter, we discussed it with GHMSI, Milliman, Appleseed and UHAS. All of those entities agreed at the beginning of the project that such a comparison would not be helpful because GHMSI's operations and market are different enough from those of other insurers—even from those of other Blue Cross Blue Shield insurers—

that any such comparison would not provide helpful information. The view seemed to be that attempting such a comparison would consist of comparing an apple to oranges. Given the views of GHMSI, Milliman, Appleseed and UHAS, and its own, the DISB told us not to do such a comparison this time.

Lastly, I'd like to address certain references in Mr. Shaw's report regarding the Actuarial Standards of Practice and Code of Conduct. In his report, Mr. Shaw indicates that, in his view, the Milliman Report and the R&A Report are actuarial communications that fail to adhere to the Actuarial Standards of Practice. He claims that Milliman, R&A, and FTI did not provide sufficient documentation, as required by Actuarial Standards of Practice #41.

I have several responses here:

First, the Actuarial Standards of Practice apply only to individuals; they do not apply to firms. As a result, contrary to Mr. Shaw's statements, the Actuarial Standards of Practice do not and cannot apply to Milliman, R&A, or FTI.

Second, the Actuarial Standards of Practice apply only to individual actuaries who are members of one of the five US-based actuarial organizations. The authors of the R&A Report, Neil Rector and Sarah Schroeder, are not actuaries, nor do they purport to be actuaries, and they are not members of any actuarial organization. In my opinion, the R&A Report meets the standards of ASOP #41. However, the report is not required to do so since the Actuarial Standards of Practice do not apply to the R&A Report.

Third, contrary to Mr. Shaw's characterization, ASOP # 41 does not set out specific disclosure requirements, and certainly not the items claimed by Mr. Shaw in his report. ASOP #41 provides guidance to actuaries with respect to actuarial communications. It is descriptive, not prescriptive.

Beyond these somewhat technical responses, it also is clear to me that, as a substantive matter, Mr. Shaw has been given information sufficient to allow him to analyze and understand our work, consistent with the intent of ASOP # 41. Mr. Shaw's 61-page report sets out in detail his analysis of the structure of the model; the assumptions used by both Milliman and R&A; and his own conclusions with respect to GHMSI's surplus needs using different assumptions.

It seems clear to me that any material differences between Mr. Shaw's conclusions and ours pertain to the assumptions selected rather than because

Mr. Shaw did not have sufficient information to understand the model or the work we did.

At this point, I'd like to turn the discussion back to Neil so that he can further describe the analysis done by both R&A and FTI.

Thanks, Jim.

As part of our examination and as requested by the DISB, we analyzed the projection model used by Milliman in its work as GHMSI's consultant. Milliman documented its work in a May 31, 2011 public report titled "Need for Statutory Surplus and Development of Optimal Surplus Target Range". In addition, Milliman provided us with Technical Materials related to its May 31, 2011 Report. We also received from Milliman and GHMSI additional written materials concerning the model, and we also reviewed and considered materials provided by Appleseed and by Mark Shaw, a consulting actuary with UHAS.

At the outset, staff from our firm and FTI met on two separate occasions with key staff from GHMSI, Milliman, Appleseed, UHAS and others to discuss the structure of our work, the Milliman model, and the standards to be used by the DISB and R&A in the analysis of GHMSI's surplus. During those meetings, Appleseed and UHAS provided input into the appropriate structure and standards to be used for the examination. We listened carefully to that input and took that input into account.

Based on those meetings, we had subsequent discussions with Milliman and GHMSI, during which we requested and received additional information regarding GHMSI's surplus and the Milliman model. Upon completing our analysis, we issued our Report dated December 9, 2013.
Subsequent to the issuance of our Report, Appleseed and UHAS submitted a series of questions to the DISB regarding our analysis and recommendations. To gain a better understanding of the questions, we participated in several conference calls with their representatives, and with representatives from the DISB, GHMSI and Milliman. Through the DISB, we provided over 30 pages of written responses to Appleseed's and UHAS' information requests. DISB's responses to those questions appear on the DISB's website and will be made a part of the record for this hearing.

Before getting into a more detailed discussion of our particular findings, I would like to provide an overview of the projection modeling methodology that much of our work was based on.

At its core, the Milliman projection model uses a statistical approach to determine how much surplus GHMSI needs to start with to stay above a certain RBC threshold level at a certain degree of probability over a 3-year period of time. For example, the model could determine how much surplus GHMSI would need to start with in order to have no more than a 2% chance of falling below a 200% RBC threshold level within 3-years.

The model involves a complex statistical modeling process called "stochastic testing." It calculates 500,000 gain and loss possibilities based on combinations and permutations of various assumptions, and then ranks those possibilities from the most favorable gain outcome to the least favorable loss outcome. From that, it is possible to determine the amount of money GHMSI has a given chance of losing. The loss amount determined as a result of this process is then used to calculate how much money GHMSI would need to start with in order to stay above the selected RBC threshold level at the selected degree of probability during the modeled 3-year period.

As Jim mentioned earlier, the result is really driven by the assumptions selected. Because the model generates the calculations automatically, it is important to get the key assumptions right. Consequently, a significant part of our work consisted of carefully reviewing and adjusting the key assumptions underlying the projection modelling process, including the probability and severity distributions assigned to the key assumptions. Our work in this area was time-consuming and difficult. There was almost never a clear "right" or "wrong" answer. It was a matter of judgment.

In using our judgment to select assumptions, we selected assumptions based on what we believe are the risks and opportunities inherent in GHMSI's future operations, including the possible effects of health reform. In some instances, our choices were consistent with GHMSI's historical results. However, in many instances, and particularly those impacted by the risks of health reform, the assumptions selected were quite different from GHMSI's historical experience because we anticipate health care reform will cause certain aspects of GHMSI's operations to be different in the future than they have been in the past.

It is also important to emphasize that the assumptions were selected based on what was known regarding health care reform at the time our review was performed. Any future analysis of GHMSI's surplus would of course need to update those assumptions based on the most current understanding of how health care reform will impact GHMSI.

Further detail about the financial projection modelling process, and about our work, are set out in our Report and in the responses to Appleseed's and UHAS' questions I referred to above.

To summarize: the projection model uses a statistical approach to determine how much surplus GHMSI needs to start with to stay above a certain RBC threshold level at a certain degree of probability. I mentioned a few minutes ago the example of how much surplus GHMSI would need not to have more than a 2% chance of falling below a 200% RBC threshold level. However, the model could calculate how much surplus GHMSI needs relative to RBC threshold levels other than 200% and degrees of probability other than 2%. So we also had to make determinations regarding which RBC threshold levels to measure and the degree of probability of crossing those thresholds.

In making those decisions, we focused on the statutory standards as interpreted in the 2012 Court of Appeals Order. In that Order, the Court of Appeals indicated that there are two determinations the DISB must make in connection with the surplus review:

1. Whether GHMSI has engaged in community health reinvestment to the maximum feasible extent consistent with financial soundness and efficiency; and

2. Whether GHMSI's surplus exceeds appropriate RBC requirements and is unreasonably large and inconsistent with GHMSI's community health reinvestment mandate.

The Court of Appeals also indicated that, as a matter of law, the two determinations must be made in tandem, not *seriatim*, to give full effect to the statute.

Our understanding is that the first determination—whether GHMSI has engaged in community health reinvestment to the maximum feasible extent consistent with financial soundness and efficiency—requires GHMSI to engage in community health reinvestment right up to the edge of where doing more would present an inappropriate risk of GHMSI becoming financially unsound or inefficient. In other words, could GHMSI give more in community health reinvestment expenditures without becoming financially unsound or inefficient?

Our understanding is that the second determination—whether GHMSI's surplus exceeds appropriate RBC requirements and is unreasonably large

and inconsistent with GHMSI's community health reinvestment mandate—goes to whether GHMSI has excess funds (in other words, an unreasonably large surplus, more than it needs), so that such excess funds could be used to fund community health reinvestment.

As I indicated, the Court of Appeals Order made clear that, as a matter of law, the two determinations must be made in tandem rather than in *seriatim*. The two determinations, therefore, have to be read together. In other words, "excess surplus" under determination # 2 is any surplus exceeding what GHMSI needs not to become financially unsound or inefficient as described in determination # 1. Similarly, GHMSI's obligation pursuant to determination # 1 to engage in community health reinvestment to the "maximum feasible extent" means that any "excess surplus" as described in determination # 2 is to be used for community health reinvestment rather than for other purposes.

To read the two determinations in tandem requires us to look for a target amount of surplus that complies with the statutory requirements by being neither too high nor too low. If GHMSI's surplus is above that target amount, GHMSI has not satisfied determination # 1 since it has not engaged in community health reinvestment right up to the edge of what it can do without presenting an inappropriate risk of becoming financially unsound or inefficient, and, under determination # 2, it has excess surplus. However, if GHMSI's surplus is below that target amount, it has gone beyond engaging in community health reinvestment to the maximum feasible extent since it has entered the territory of having an inappropriate risk of becoming financially unsound or inefficient.

It is also important to note that determination # 1 mentions both "financial soundness" and "efficiency," and we considered both aspects in our analysis. Our December report highlighted the "financial soundness" phrase, consistent with the fact that the bulk of our Report pertained to financial results calculated pursuant to the projection model. However, we also concluded that GHMSI could adhere to the RBC surplus target and benchmark range set out in our Report without becoming inefficient. In that regard, we also were aware that GHMSI now is subject by law to certain medical loss ratio requirements that would cause it to return a portion of its surplus to subscribers if it does not operate within the legal limits of efficiency as set out in the law.

So the two determinations set out in the Court of Appeals Order, when read together, have prompted us to look for the point where surplus above that

number is excess and is evidence that the requirement to give to the maximum feasible extent has not been honored, and yet where surplus below that number is not excess and in fact is evidence that GHMSI has given more than what a maximum feasible effort to give would lead to.

So that's the number our work was geared toward finding.

How did we go about finding it? First, we looked at two different RBC thresholds—200% RBC and 375% RBC—and evaluated what the impact on GHMSI would be if it reached those thresholds.

Those thresholds were not chosen arbitrarily. The 200% threshold was chosen because it is defined under insurance law as the "company action level"—a level that signals to regulators that an insurance company is at significant financial risk, requiring mandatory action by the company under heightened regulatory oversight. The 375% threshold was chosen because it is the Blue Cross and Blue Shield Association's early warning level.

It would be best if GHMSI did not cross either threshold, but that leaves open the question of what is the appropriate percentage chance GHMSI should be allowed to risk in crossing them. For example, should GHMSI have enough surplus so it has no more than a 2% chance of crossing the 200% RBC threshold? No more than a 1% chance? Would holding surplus in an amount equivalent to having a 5% or 10% chance of crossing that threshold be acceptable?

There are no "right" or "wrong" answers here. It is a matter of judgment. And, ultimately, it is a matter of the DISB's judgment. However, the DISB has asked for our thoughts and recommendations regarding the issue, and we provided those in our Report.

It is important to point out that we made the choice of what thresholds to guard against, and the percentage chance allowed to cross them, before we ran any calculations. We did this on purpose. We wanted input from Appleseed, UHAS, GHMSI and Milliman on those issues before making our decisions, and we knew that we had to get their input before numbers were run. Otherwise, we thought it would be impossible for those entities to separate their views as to the appropriate thresholds and percentages from an awareness of the impact those choices would have on the final answer. In other words, we wanted to make the rules and then play the game rather than playing the game and then trying to set the rules afterwards.

At the outset, before the numbers were run, everyone agreed that one of the selections should be that GHMSI have no more than a 2% chance of crossing the 200% RBC threshold. GHMSI, Milliman, Appleseed and UHAS agreed to this selection in meetings with us. Appleseed and UHAS documented their agreement in letters to the DISB, which have been made available to the public on the DISB's website and will be admitted into the record for this hearing.

Appleseed, UHAS, GHMSI and Milliman did not agree with each other as to the 375% RBC threshold. GHMSI and Milliman thought there should be no more than a 5% chance of crossing that threshold. Appleseed and UHAS did not believe the 375% threshold should be used at all. However, if it were used, they urged a 75% confidence level relative to it—in other words, that GHMSI protect against a 25% chance of crossing that threshold.

After giving the matter a significant amount of thought, and taking into consideration the views expressed by GHMSI, Appleseed, Milliman and UHAS, we ended up selecting the following: (1) that GHMSI have no more than a 2% chance of crossing the 200% RBC threshold and (2) that GHMSI have no more than a 15% chance of crossing the 375% RBC threshold. As a technical matter, these were expressed in our Report as "confidence levels" that the threshold not be crossed, rather than as percentage chances that it would be crossed. In other words, we selected that (1) there be a 98% "confidence level" that GHMSI does not cross the 200% RBC threshold and (2) there be a 85% "confidence level" that GHMSI not cross the 375% RBC threshold.

We selected a 98% confidence level relative to the 200% RBC threshold because crossing 200% would be extremely problematic. As I indicated previously, the 200% level itself is designated by insurance regulators as the "company action level" at which insurance companies are required to take action to try to prevent financial insolvency. In fact, regulators often step in even when an insurance company is significantly above the 200% level, and especially when the insurance company is losing money rapidly. The BlueCross BlueShield Association also could terminate GHMSI's BCBS trademarks if GHMSI fell below 200% RBC.

Second, as noted, the projection model calculates the percentage chances of what could happen over a 3-year period of time. So we are not talking, here, of a situation where a company has been hovering in a stable fashion at the 200% RBC level consistently for years. Even if GHMSI were in that

position, it would still be a serious concern because the company could slip so easily from there to insolvency.

But the scenario we are seeking to protect against is significantly worse than that. When Appleseed, UHAS, GHMSI and Milliman all agreed to a 200% RBC threshold at a 98% confidence level, they—and we—were saying, in essence, that GHMSI needs to have enough surplus to protect against a drop from where it is now—with RBC in the 900%s—down to an RBC of 200%, in just 3 years. To put that in dollar terms, the scenario we are seeking to protect against would be one where GHMSI were to lose approximately $700 million of surplus in just 3 years.

You might think that it is impossible for GHMSI to lose that much money that fast. But remember that we are talking about something that has a 2% chance of happening—something that would happen, statistically, twice every 100 years. We tend to forget that calamities that we think could never happen, do happen, including at that level of frequency. For example, just before the Great Recession hit, no one thought we could ever again have any financial catastrophe even approaching that of the Great Depression. But we have now had two such financial catastrophes, in less than 100 years, roughly the same probability we measured relative to GHMSI.

If GHMSI were to lose $700 million in surplus in a 3-year period, we believe it would cause extreme distress in the DC market, even if GHMSI could be pulled out of the nose dive before it becomes insolvent. Employers and individual policy holders would worry about whether their health carrier is collapsing. Given GHMSI's dominance in the DC health insurance market, this would be far more troubling and disruptive in DC than if the loss were by a similarly-sized health insurer with a more modest share of the DC market.

We also think it would be difficult to pull GHMSI out of such a steep nose-dive. Unlike publicly held for-profit health insurance companies, GHMSI does not have the ability to go to the capital markets to obtain funds if needed. Nor does GHMSI have a "parent" company that might have cash available to contribute to GHMSI. Further, although GHMSI in theory could raise its premium rates to offset the losses, there are limits, because of rate regulation and because of market restrictions, on the size of premium increases allowed and the speed with which GHMSI could implement the increases. We think it is very questionable whether GHMSI could do enough, quickly enough, to offset such a huge nose dive over a 3-year period.

For these reasons, we think it is appropriate for GHMSI to hold enough surplus to make it highly unlikely that it would fall to the 200% RBC threshold over a 3-year period of time. What's the right percentage chance? Again, there is no "right" or "wrong" answer. It is a matter of judgment. Ultimately, in our view—and in the view of Appleseed, UHAS, GHMSI and Milliman, at least based on what they all said before we ran the numbers—we decided that there should be only a 2% chance of that occurring. But it is a matter of judgment, and the DISB could certainly decide to select a different probability if it is willing as a matter of public policy to take a different level of risk that GHMSI would fall below the 200% threshold.

Falling below the 375% RBC threshold is not as significant a matter as falling below 200%. At the 375% RBC level, GHMSI would be trending toward trouble, but it would not be yet be in trouble. Further, as noted above, unlike the 200% threshold, there was no agreement between Appleseed, UHAS, GHMSI and Milliman as to the 375% threshold. We ended up selecting 85% as the appropriate probability. In our judgment, we concluded that having a 15% chance of crossing the 375% threshold was appropriate. Similar to the discussion above regarding the 200% threshold, our concern here has perhaps as much to do with the precipitousness of the drop as it does with the 375% level in an absolute sense. In other words, if GHMSI were to fall from where it is now (RBC in the 900%s) down to 375% in a 3-year period, we believe that would be evidence of a serious financial problem at the company. As with the 200% threshold, though, selecting the appropriate probability relative to the 375% threshold is a matter of judgment, and the DISB could certainly make a different selection if it is willing to take a different level of risk that GHMSI would fall below the 375% threshold.

So to summarize: we recommended that the DISB define the target number I referred to previously—the number where GHMSI's surplus is balanced relative to the two determinations—by assigning a 98% confidence level to staying above the 200% RBC level and by assigning an 85% confidence level to staying above the 375% RBC level. Those confidence levels equate to our view that GHMSI should hold enough surplus so that it has no more than a 2% chance—a 1 in 50 probability—of falling below the 200% RBC threshold and no more than a 15% chance of falling below the 375% RBC threshold, each over a 3-year period of time.

If GHMSI has more surplus than what is needed to meet those probabilities, then in our view it has not given to the maximum feasible extent and has

excess surplus. If GHMSI has less surplus than what is needed to meet those probabilities, it has given more than the maximum feasible extent.

As described in our report, applying the model to those two tests resulted in the conclusion that GHMSI should have surplus equivalent to 958% RBC. So that's what we describe in our report as the "surplus target." However, as also described in our report, calculating such a specific number implies a degree of precision that could be misleading. Honing in on such a specific number could cause someone to believe that if GHMSI's surplus is higher or lower than that by even 1 basis point—959% vs 958%, or 957% vs 958%--then GHMSI would either need to put more into community health reinvestment or would need to grow surplus, respectively. That's not accurate. Because of the complexity of the projection model and the imprecision that is inherent in trying to make predictions about the future, it is inappropriate to make those kinds of conclusions based on such razor-thin margins.

To provide what we believe is better guidance to the DISB, we decided to put a plus or minus band around the surplus target. To arrive at the appropriate band, we reviewed changes in GHMSI's RBC historical levels over the period 1999-2012. Although GHMSI's RBC varied from year to year by 100 or more basis points during the early part of the period, most year to year changes since 2004 have been less than 100 basis points. The average year to year change during the 2004-2012 period was 82.5 basis points. So we selected a range consisting of the target surplus level—958% RBC—plus or minus 82.5 basis points.

To summarize: our recommended target surplus is 958% RBC and our recommended Benchmark Range is 875%-1040% RBC. We are not saying that any number between 875% and 1040% is equally good. Rather, 958% RBC is our best specific conclusion as to the appropriate amount of surplus for GHMSI. That's the number we recommend the DISB require GHMSI to target. If GHMSI's surplus is above that number, we believe GHMSI should start doing things, including increasing community health reinvestment, to move down toward the 958% target. Conversely, if GHMSI's surplus is below 958%, we believe GHMSI should begin taking steps to move up toward the 958% target.

So we recommend the DISB select 958% RBC as the target. However, we also recommend that the DISB be in mostly a watchful mode—evaluating GHMSI's own actions to move toward the target rather than stepping in to

require GHMSI to take action—so long as GHMSI's surplus does not fall below 875% or rise above 1040% RBC.

Those of you who have followed the surplus review of GHMSI for some time will no doubt note that our recommendations here are higher than our recommendations in connection with the review of GHMSI's surplus we did in 2009. In 2009, we recommended a surplus range of 600-850% RBC. This time, as I just indicated, we recommend a surplus target of 958% and a Benchmark Range of 875-1040% RBC. In other words, the high end of our range this time is approximately 190 RBC basis points higher than it was in 2009.

We've talked with the DISB about the reasons for the difference in these ranges. In turn, the DISB provided written materials to Appleseed describing the reasons, and those materials are part of the record here. I refer you there for a more detailed description of the reasons for the difference. However, I will try to highlight some of the most significant aspects here.

As discussed with the DISB and as described to Appleseed, it is difficult to identify and quantify the precise reasons behind the differences in part because we used somewhat of a different approach for the 2009 review than we did for the current review. In the 2009 review, we made our adjustments after Milliman completed the stochastic modeling portion of the process. We took Milliman's stochastic modeling answer and adjusted it. For the current review, however, we made adjustments to the underlying assumptions and the probability and severity distributions that generated the stochastic modeling results. In other words, rather than taking Milliman's answer and adjusting it, this time we adjusted the assumptions that generated the answer. This difference in approach between the two reviews makes it difficult to identify and quantify the impact any individual factor had on the difference in the ranges.

A further complication is that the "answer," to the extent we can determine it, also is significantly different depending on how you try to measure the difference between the results from 2009 and the results of the current review. In other words, the factors that led to differences in the tops of the two ranges are different from the factors that led to the differences in the bottoms of the two ranges and are different again from the factors that led to the differences in individual data points that make up the ranges.

So there is no easy way to attribute a specific percentage point impact to each reason for a difference between the 2009 result and the current result.

Having said that, it seems clear that the biggest reason for the difference is that, because of the timing of when our work was performed, our results in 2009 did not include any potential impact from the Affordable Care Act—the major health reform legislation—whereas our results this time included the effects of ACA.

Certainly ACA provides opportunities to an entity like GHMSI. But it also adds risk, and neither the opportunities nor the risks were factored into the analysis in 2009. In the current review, however, the risks and opportunities attributable to the ACA were carefully considered throughout the entire process and impacted the assumption selections made as part of the stochastic modeling process.

We believe other things contributed to the difference too—differences in approach between the two reviews, changes in what we believed management could do if GHMSI started losing money, changes in the probability or confidence levels tested, etc. So we believe a number of things contributed to the difference, and, as I mentioned, there is extensive information regarding this topic in the DISB's answers to Appleseed's questions that are part of the record of this hearing.

However—big picture—we believe the biggest driver of the difference is that the 2009 review did not factor in the opportunities, risks or uncertainties generated by health reform whereas the current review did.

The final topic I would like to cover is the Commissioner's request that the scope of our review include an analysis of GHMSI's community health reinvestment expenditures during 2011 and 2012; of its projected community health reinvestment expenditures during 2013; and of its anticipated community health reinvestment expenditures for 2014 and future years.

MIEAA defines community health reinvestment expenditures to mean expenditures that promote and safeguard the public health or that benefit current or future subscribers, including premium rate reductions.

GHMSI indicated that it considers its community health reinvestment expenditures to fall into five categories. We believe that three of those categories meet the MIEAA definition of "community health reinvestment," but that two of them do not. I'll start with the three categories that we concluded meet the statutory definition of community health reinvestment.

First, corporate giving.

This category covers such things as program initiatives to support a specific population (for example, the District of Columbia Department of Health Maternal and child Case Management Program) and corporate sponsorships (for example, the DC Chamber of Commerce). At the time of our review, GHMSI indicated that its corporate giving equaled the following amounts for the following years:

2011 -- $3.4 million
2012 -- $3.9 million
Estimated 2013 amount -- $3.5 million
GHMSI indicated that it would be very difficult to predict its corporate giving for 2014 and future years.

I will say that we struggled some as to whether this category met the statutory definition of "community health reinvestment." We aren't completely sure it directly promotes and safeguards the public health or benefits current or future subscribers, as required. However, we recognize that these expenditures do support the DC business community, many of which are current or future subscribers, and support organizations that provide needed health care resources to the DC community. Accordingly, we treated GHMSI's corporate memberships and community sponsorships as community health reinvestment expenditures.

A second category is open enrollment subsidies. Prior to January 1, 2014, the District of Columbia had a program in place that allowed individuals to enroll in commercial products, regardless of the person's health condition or status. Under this program, GHMSI was required to subsidize the cost for of the individual's coverage by charging a lower premium than it would otherwise charge based on the individual's health status. At the time of our review, GHMSI indicated that its open enrollment subsidies equaled the following amounts for the following years:

2011 -- $4.5 million
2012 -- $7.5 million
Estimated 2013 amount -- $9.6 million

Although we concluded that those historic amounts constitute community health reinvestment expenditures within the meaning of the statute, this category essentially is going away since, as a result of health care reform, the open enrollment program no longer accepted new enrollees as of January 1, 2014. Accordingly, GHMSI will only provide open enrollment subsidies in 2014 while any remaining enrollees in the program convert to other coverage available due to health care reform.

The third category is GHMSI's funding of the DC HealthCare Alliance Program. This program provides a full range of health care services to individuals who have no health insurance coverage, including Medicare and Medicaid, and have a limited income. Since 2009, GHMSI has been required to provide funding of $5 million each year for the DC HealthCare Alliance program. Our understanding is that the funding requirement is included in a public-private partnership agreement that will end in 2014.

As I indicated previously, GHMSI provided information regarding two other categories that it believes constitute community health reinvestment, but that we concluded are not community health reinvestment within the meaning of the statute.

The first of those two categories is premium taxes. Based on discussions with the DISB, we did not think that premium taxes meet the definition of these type of expenditures. We didn't think that GHMSI's premium tax payments necessarily are an expense that promotes or safeguards the public health or that benefits current or future subscribers. As a result, we didn't include premium taxes in our Report as part of GHMSI's community health reinvestment expenditures.

The other category GHMSI provided was premium rate reductions. We recognized that the statutory definition of community health reinvestment expenditures references premium rate reductions, and, therefore, that premium rate reductions COULD be community health reinvestment expenditures. However, after talking with DISB staff regarding this category, we understand that premium rate reductions are not automatically community health reinvestment expenditures. Rather, it depends on things such as the reason the rate reductions were made. Here, we were unable to quantify GHMSI's past premium rate reductions as reductions that were intended for community health reinvestment purposes, instead of for other reasons. Accordingly, we did not include the premium rate reduction information that GHMSI provided us in our Report as part of GHMSI's community health reinvestment expenditures.

To summarize: we found that GHMSI's community health reinvestment expenditures for the time periods for which the DISB asked to review were:

For 2011 -- $12.9 million
For 2012 -- $16.4 million
For 2013, an estimated amount of $22.1 million
For 2014, an estimated amount was not able to be provided because of uncertainty regarding corporate giving

I want to close by saying that we are very proud of our work here, and we stand behind it. However, we also encourage you to listen carefully to those who disagree with us. As I have indicated on several occasions in my testimony today, there are no "right" or "wrong" answers on the key items that drive the result.

Our sole motivation in reaching our conclusions has been to try to faithfully carry out the intent of the MIEAA statutes. We recognize, though, that the questions are complex and difficult, and we do not claim a monopoly as to the answers. We are glad you will hear some opposing views so that you will have in front of you a full range of views, which, collectively, should allow you to make the best decision possible based on what the law requires and what is best for the people of the District of Columbia.

We look forward to being of whatever further help you think appropriate.