CareFirst Is Not Meeting Its Charitable Obligation To Citizens of the National Capital Area

A supplement to DC Appleseed's report, *CareFirst: Meeting Its Charitable Obligation to Citizens of the National Capital Area*, issued December 6, 2004

Submitted to the District of Columbia Commissioner of Insurance, Securities, and Banking, April 8, 2005

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I. Introduction

In December 2004, DC Appleseed released a report entitled "CareFirst: Meeting Its Charitable Obligation to Citizens of the National Capital Area." The purpose of the report was to explain and establish three important principles concerning Group Hospitalization and Medical Services, Inc. (GHMSI), CareFirst's nonprofit affiliate serving residents in the National Capital area:

1. GHMSI has a legal obligation to engage in charitable, community benefit activities;

2. The governing legal standard requires GHMSI to spend the maximum possible amount on charitable activities, consistent with remaining competitive and financially stable;

3. Under that standard, GHMSI can afford to expend at least two percent of its earned premium for community benefit each year at current levels of premium simply by forgoing further surplus buildup. The amount GHMSI could have spent in 2004 on community benefit was \$41 to \$61 million. The amount GHMSI actually spent on community benefit in 2004 was only \$1.5 million. In 2005, it could afford to spend \$44 to \$66 million.

Three significant events followed the release of DC Appleseed's report. First, CareFirst announced its 2005 community benefit plan for its four affiliates—GHMSI, CareFirst of Maryland, CareFirst Blue Choice, and Blue Cross Blue Shield of Delaware. We discuss the elements of this plan in the Q and As below.

Second, the D.C. City Administrator, Robert Bobb, asked the D.C. Attorney General to evaluate the legal contentions in DC Appleseed's December 2004 report. The AG issued his analysis in a March 4, 2005 memorandum. We discuss that analysis in the Q and As below.

Finally, the DC Insurance Commissioner, Larry Mirel, held a hearing on March 24, 2005, which addressed essentially two questions: What is GHMSI's charitable obligation? And what should the company be doing to meet that obligation? DC Appleseed greatly appreciates the effort of the Commissioner through this hearing to clarify the positions of the parties and members of the public. In fact, the hearing succeeded in illuminating GHMSI's legal position, *which categorically denies any charitable legal obligation whatsoever*. On the other hand, the hearing failed to illuminate CareFirst's new community benefit plan, including its claim that it is going to confer charitable benefits by foregoing rate increases that it otherwise would impose.

At the hearing, GHMSI insisted that the congressional declaration in its federal charter that it is a "charitable and benevolent" institution is a meaningless anachronism. Three conclusions follow from this, according to GHMSI. First, GHMSI has no legal obligation to engage in community benefit activities at all. As the *Washington Post* reported, GHMSI says that "neither its nonprofit status nor the language of its unusual federal charter imposes any special community responsibility on the District-based affiliate of CareFirst BlueCross BlueShield" (March 25, 2005, p. A07). Second, while GHMSI plans to engage in some community benefit activities in 2005, the company says it is not required to do so and regulators may not review these activities. Further, the company says it is not effectively owned by the public. Apart from its legal position, GHMSI claims, finally, that the company needs a surplus significantly larger than that

of any of its competitors and this need precludes it from engaging in substantial community benefit activities. Significantly, as explained in this supplemental memorandum, GHMSI has failed to establish *any* of its contentions.

Our original report and the supplementary material below show that: (1) GHMSI has a legal obligation to engage in substantial community benefit activities; (2) GHMSI's obligation requires it to spend the maximum amount possible meeting that obligation, consistent with remaining competitive and financially stable; and (3) the company has not shown that it is meeting that obligation.

Accordingly, we believe that the D.C. Insurance Commissioner, the D.C. Attorney General, and the D.C. Council need to clarify (1) GHMSI's charitable obligation, (2) the standard GHMSI must meet to fulfill this obligation, and (3) the oversight process to be followed by District officials to ensure that that obligation is met. These measures are particularly urgent in light of the fact that GHMSI has now denied any charitable obligation to the citizens of the National Capital area, and has declined to avail itself of the opportunity presented by the Commissioner to offer information explaining its claimed new community benefit program.

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II. Questions & Answers

1. Does GHMSI have a charitable obligation to citizens of the National Capital area?

GHMSI does have a charitable obligation to citizens of the National Capital area. The Attorney General of the District of Columbia and DC Appleseed are in agreement about this [*See* Memorandum from District of Columbia Attorney General Robert Spagnoletti to City Administrator Robert Bobb dated March 4, 2005 ("AG Memorandum") at 2 (explaining GHMSI's "charitable mission")]. Nevertheless, GHMSI testified at the March 24 hearing that it has no charitable obligation at all, and should be treated by District regulators as any for-profit health insurance company. GHMSI also testified that the Attorney General's opinion supports the company in this view. This is simply not correct.

As the Attorney General stated in his March 4 opinion (p.4), "unlike a for-profit company, GHMSI *exists* to serve the public. It does not 'satisfy' its obligation to the public simply by meeting a statute's minimum threshold for good corporate citizenship." Rather, the company "must operate as a charitable and benevolent institution, consistent with operating for the benefit of its present and future subscribers. It cannot fulfill this mission simply by allocating a specified percentage of premiums or earnings to distinctly 'charitable' activities. Rather GHMSI is to *devote its entire operation* to serving, directly or indirectly, the purposes for which it was chartered" (p.2) (emphasis supplied). In other words, as the Attorney General stated in his conclusion (p.8), "As a 'charitable and benevolent institution' that seeks to serve a public health

mission, *GHMSI has an obligation* to use its profits and excess surplus to serve the purpose of promoting health in its service area" (emphasis supplied). All of this supports DC Appleseed's previous analysis and directly contradicts GHMSI's stated views at the March 24 hearing.

As DC Appleseed has shown, and the Attorney General has now confirmed, there is no sound legal basis for refusing to accord the "charitable and benevolent" language in GHMSI's charter its plain meaning. The retention in GHMSI's charter of the "charitable and benevolent" clause cannot be attributed to congressional inattention, and the 1986 legislation that resulted in Blues organizations' loss of tax-exempt status did nothing to disturb the charter declaration that GHMSI is to be charitable and benevolent. While the legislative history of the repeated amendments to GHMSI's charter is sparse, the repeated expressions of congressional purpose are that GHMSI has a special status as a benevolent and charitable, public-service corporation.

The Attorney General's analysis looks not only to the GHMSI charter, but also to District of Columbia law, which declares GHMSI, as an entity regulated under the Hospital and Medical Services Corporation Act, to hold its assets in trust for the benefit of the public and for the "charitable purposes" described in its charter [*See* D.C. Code §§ 44-601(1)-(2); *see also* AG Memorandum at 1, 2, 4 ("GHMSI's assets belong to the public" and "GHMSI exists to serve the public")]. Appropriately, the Attorney General also relies on the common law of charitable trusts applicable to entities such as GHMSI [*Id.* at 2].

There are additional authorities establishing that GHMSI has an obligation to the public in its service area. District law requires GHMSI to provide an open enrollment product and to provide "health-related educational support for residents of its service area" [D.C. Code §§ 31-3514(a) and (i)]. Section 14-102 of the Maryland Insurance Code states that, as a nonprofit health service plan, CareFirst and its affiliates, including GHMSI, must, among other things, "assist and support public and private health care initiatives for individuals without health insurance" and "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." These provisions are consistent with all of the elements in GHMSI's federal charter. And, although GHMSI's analysis submitted to DISB states that it does not have a charitable obligation, Article II, section 1 of GHMSI's own bylaws recognize that the purposes and objectives of GHMSI "shall be," among several other things, "to cooperate, consolidate, or contract with [others] interested in promoting and safeguarding the public health."

2. Did GHMSI's March 24 presentation establish that it has no charitable obligation?

GHMSI's March 24 presentation failed to establish that it has no charitable obligation. To the contrary, GHMSI's own analysis is very helpful in showing why the company *does* have a charitable obligation. As GHMSI observes, the provision of hospital and medical insurance did not begin as a commercial enterprise, but as a community service directed at meeting an unmet public health need (as GHMSI puts it, "providing a necessary service to the community . . . that otherwise would go unmet") [GHMSI Analysis at 5]. As explained in the IRS General Counsel Memorandum that GHMSI cites [GHMSI Analysis at 6 n. 3],

> "Blue Cross" [organizations such as GHMSI] originated in the period of the depression and at that time constituted the only means by which necessary medical care could be provided to the lower-income populace. These operations also served to protect the hospitals from undue financial risks. Therefore, they originally fulfilled a very serious social need that probably justified their being exempted from the burden of federal income taxation.

[GCM 39763 (October 13, 1988)]. As GHMSI asserts, the relatively novel activity of providing third-party payment for hospital services for people unable to pay large hospital bills on their own "was considered to be an activity that in and of itself was 'charitable' in nature" [GHMSI Analysis at 5; *see also id.* at 13, 14 (when the GHMSI Charter was enacted, the provision of health insurance was considered to be a charitable endeavor)].

Thus, as GHMSI's own analysis shows, Congress chartered GHMSI to conduct charitable activities designed to meet *unmet public health needs*. This is confirmed by the fact that the original charter authorized GHMSI not only to sell health insurance policies to meet the serious social need of lower-income people that existed in 1939, but also to "cooperate, consolidate, or contract with individuals or groups or organizations interested in promoting and safeguarding the public health" [GHMSI Charter, § 2(c)]. Even if Congress's explicit designation of GHMSI as a "charitable and benevolent institution" was only to "provide the underpinning of GHMSI's exemption from taxes" [GHMSI Analysis at 12 n. 6], that was because Congress was chartering an organization for purposes that it deemed to be charitable and "worthy of exemption from taxes" [*Id.* at 13].

Today, in contrast, the sale of health insurance at commercial market rates is *not* a charitable activity [*See* GCM 39763 (October 13, 1988) ("the provision of insurance to the general public at a price sufficient to cover the costs of insurance generally constitutes an activity that is commercial")]. Responding to this reality, Congress in 1986 effectively revoked the federal income tax exemption of Blues organizations, including GHMSI. But Congress did not remove the "charitable and benevolent" designation from GHMSI's charter, and there is no indication that later Congresses strayed from the original intent and policy objective that GHMSI conduct charitable activities to meet unmet public health needs. To the contrary, in 1986 Congress explicitly recognized that providing insurance below cost to charitable recipients was not a commercial insurance activity and it continued to authorize special tax treatment to the extent that companies provided special coverage for high-risk individuals. In 1997, the representatives of Congress who sponsored legislation to amend GHMSI's charter and spoke on the floor of Congress emphasized that its status as a charitable and benevolent institution was to be preserved.

There is therefore no justification for concluding, as GHMSI does, that if the company cannot completely fulfill its charitable mission by selling insurance at market rates, it is relieved of any further charitable public health obligation. First, as discussed below in response to question 3, when an original charitable purpose no longer can be fulfilled, there is an obligation to undertake charitable activities as closely related as possible to the original purpose. Second, GHMSI's charter already authorizes it to fulfill its charitable obligations by different but related means: to

“cooperate, consolidate, or contract with individuals or groups or organizations interested in promoting and safeguarding the public health.” GHMSI can achieve the mission of meeting unmet public health needs if it makes insurance accessible to the uninsured and pursues other activities designed to promote public health.

GHMSI’s position that it does not have a charitable obligation is based entirely on the statement in section 3 of the GHMSI charter that GHMSI is not to be operated for profit but is to be operated for the benefit of “aforesaid certificate holders,” *i.e.*, individuals and groups to whom section 2 of the charter authorizes GHMSI to sell policies of insurance. However, this provision will not bear the weight of GHMSI’s argument that it has no charitable obligation at all. GHMSI admits that its charter permits it to pursue charitable public health activities. It thereby acknowledges that section 3 of its charter does not require the company to operate *exclusively* for the benefit of its current policyholders. The question therefore is whether GHMSI can meet its charter mission of undertaking charitable activities to meet unmet public health needs if it operates exclusively for the benefit of its current policyholders. If GHMSI cannot accomplish a charitable public health mission by providing insurance to current policyholders at commercial rates, then it must find another way, in the circumstances that apply in 2005 and the future, of complying with the original (and unchanged) congressional intent that it undertake charitable activities to promote and safeguard the public health.

It is simply not enough to say, as GHMSI did in its March 24 legal memorandum from Mr. Marks (p.1), that “GHMSI meets its legal obligations when it serves its subscribers….” Of course the company serves its subscribers; every health insurance company does that in one way or another. But GHMSI has a charitable obligation beyond that.

3. Does GHMSI's charitable obligation run only to current subscribers or to others as well?

As both a practical matter and a legal matter, GHMSI’s charitable obligation requires it to promote health by serving the general public in its service area, not just its current subscribers.

The Attorney General’s analysis would apparently allow GHMSI to fulfill its charitable obligation “through the provision of health plan services to paying subscribers …” (p.6). At the same time, the Attorney General made clear (p.8) that “the ‘non-profit’ goal of maximizing benefits for GHMSI’s subscribers should be pursued in a manner that is consistent with the larger ‘charitable’ purpose of *promoting better health in GHMSI’s service area*” (emphasis supplied). The Attorney General furthermore noted that District officials should help GHMSI to “identify unmet healthcare needs” in its service area and develop initiatives that address those needs (p.8). In other words, while the Attorney General concluded that the company’s obligation may technically run only to subscribers, it can and should pursue that obligation through programs that address unmet healthcare needs of the public at large. The following explains why DC Appleseed believes that it would be very difficult if not impossible for GHMSI to satisfy its charitable obligation solely by serving current subscribers, and very difficult for District regulators to test whether GHMSI has been able to do so.

First, for GHMSI to provide economic benefits to its existing subscribers, who can afford to and are paying competitive rates, would not be "charitable" in any reasonable sense of the term. A charitable activity is one that is on behalf of persons who are needy—it must confer a benefit that such persons could not obtain on their own. GHMSI's subscribers to its standard health insurance plans at competitive, medically underwritten premiums demonstrably are able to obtain the benefits of such insurance on their own.

Second, the result of GHMSI improving its competitive offerings and providing a more attractive choice to persons that already can afford health insurance would be taking market share from competing health insurance companies. That goal or result also is not charitable, as it does not promote health by increasing the total number of insured persons. The promotion of health can be a charitable purpose, as the Attorney General points out, but not if it is done is a way that is indistinguishable from the activities of commercial companies.

Third, to test whether GHMSI has met its charitable obligation by providing health insurance policies to subscribers, the Attorney General and DISB would need to distinguish health insurance that is charitable from health insurance that is not. But DC Appleseed does not believe that it is possible to impose a charitable standard in any meaningful way on standard, competitive health insurance offerings. To illustrate the impossibility, DC Appleseed notes that CareFirst now is claiming that a major portion of the $92 million community benefit package it has publicized is the company's reducing of rate increases that it otherwise would have imposed. To test such a claim with respect to GHMSI would require District regulators to know the "but for" price – the price that GHMSI otherwise would have charged. The but-for price is dependent on such things as management's perception of competitive conditions, and the degree of rigor that management adopts for its medical underwriting. It is doubtful that the Insurance Commissioner, or the Attorney General, or a court could determine a but-for price. And it is doubtful that the public could have confidence that any such claimed rate decreases were in fact "charitable," as opposed to being ordinary, competitive, market-driven decreases. DC Appleseed requested information from CareFirst and GHMSI that would allow us to examine whether the suggested decreases appear to be "charitable" rather than commercial, but the company declined to provide us any information on that issue.

For these reasons, while DC Appleseed does not disagree with the Attorney General's view that GHMSI could theoretically satisfy its charitable obligation through its standard insurance offerings at commercial rates, DC Appleseed believes that such an approach is impractical and largely unenforceable. It is unreasonable to interpret Congressional language (*i.e.*, GHMSI's charter) in a way that makes it unenforceable when other reasonable interpretations are available.

The Attorney General's analysis concluding that "GHMSI may fulfill its obligations as a 'charitable and benevolent institution' through the provision of health services to paying subscribers" [AG Memorandum at 6] stops short of discussing what the law of charitable trusts requires of an entity such as GHMSI when an original charitable purpose has become impractical. As already discussed, when GHMSI was chartered, the offering of coverage for hospitalization was itself charitable, as such coverage was not offered by for-profit insurance companies. GHMSI could and did fulfill its charitable mission through its standard health insurance offerings (which presumably were priced using a community rating rather than the

experience rating/medical underwriting that the company uses today). Today, health insurance is offered commercially in a competitive market that includes for-profit as well as nonprofit companies. All participants in that market, including GHMSI, use medical underwriting. Today, for the reasons already discussed, it has become impractical if not impossible for GHMSI to satisfy its charitable obligation through one of the activities authorized by its charter, *i.e.*, selling (medically underwritten) policies of health insurance to those who can afford to buy it.

Under the law of charitable trusts, when it becomes impractical or impossible to carry out the charitable purpose in the manner described in the instrument that created the trust, the administrators of the trust are required to carry out the "more general intention to devote the property to charitable purposes" in another manner that is consistent with and can accomplish the original charitable intent [*See* Restatement 2d of Trusts, § 399]. This rule is easily applied here, because Congress described more than one way in which GHMSI could carry out its charitable purpose. Congress authorized GHMSI not only to sell insurance, but to "cooperate, consolidate, or contract with individuals or groups or organizations interested in promoting and safeguarding the public health." In fact, the Attorney General has already made clear that the latter is a perfectly permissible way for GHMSI to meet its charitable obligation.

Thus, it might be possible for GHMSI to satisfy its charitable obligation by providing health insurance offerings that are designed specifically for the uninsured or underinsured, and that use community rating (rather than experience rating) or something close to it. (In this way, DC Appleseed agrees, GHMSI could "have a broad and positive impact on the public health if it conducts itself for the benefit of its subscribers" [AG Memorandum at 4], and it need not "divert the profits generated by its health plan services to other charitable activities" [*id.* at 6].) But if GHMSI cannot or will not accomplish its charitable purpose by providing policies of health insurance to those who cannot afford to purchase it at competitive rates, then it must satisfy its charitable obligation in some other way. It must pursue its charitable mission—and demonstrate that it is doing so—through public health initiatives directed at the broader community.

DC Appleseed agrees with the Attorney General that "the decision as to how GHMSI will use its profits and excess surplus to serve the needs of its subscribers or the public is *largely* up to its board" [AG Memorandum at 7] (emphasis supplied). It is always the case that governance of a corporation, whether for-profit or nonprofit, is left in the first instance to its board. But the decision is not *entirely* up to the GHMSI Board. The GHMSI Board may not, for example, choose for GHMSI to satisfy its charitable obligation through activities, such as reductions in premiums to existing subscribers, which are not charitable. And to date, it is still not at all clear whether GHMSI's current program is in fact charitable within the meaning of the law. We therefore turn to the question of what programs qualify as "charitable."

4. What activities by GHMSI would qualify as "charitable"?

GHMSI's mission is to operate for the benefit of its current and prospective policyholders, *i.e.*, the general public in its service area, so as to meet unmet public health needs. This is not equivalent to saying that GHMSI is to "provide a general funding source for good works in the community" or to be a "community foundation," as GHMSI asserts [GHMSI Analysis at 3, 10].

Rather, GHMSI's charitable obligation, as the "powers" clause (section 2) of its Charter indicates, has a public health focus.

DC Appleseed agrees with the Attorney General [AG Memorandum at 7-8] that GHMSI could fulfill its charitable obligation by:

- providing discounts for health insurance for subscribers with limited income;
- providing health plan benefits or other services to the poor at no charge;
- providing or supporting health-related education for subscribers or the general public in GHMSI's service area;
- engaging in cooperative efforts with private or governmental institutions to promote health in GHMSI's service area; and
- supporting the efforts of other charitable organizations to promote health in GHMSI's service area.

The Attorney General's examples accord with DC Appleseed's analysis, which points out in addition that activities by which GHMSI could fulfill its charitable obligation also include participation in public programs such as Medicaid and conducting health data analysis and health research programs for the benefit of the public. But again, as mentioned, GHMSI has not yet shown whether the program it has announced for 2005 in fact accords with these requirements.

5. What activities would be inconsistent with GHMSI's charitable obligation?

DC Appleseed agrees with the Attorney General that GHMSI would violate its charitable obligation if it:

- sought to increase GHMSI's profits or asset value without due regard for the effect on the quality, benefits, affordability, or accessibility of GHMSI's health plans
- paid GHMSI executives substantially higher compensation than is generally paid to executives at comparable non-profit institutions.

[See AG Memorandum at 7.]

In addition, GHMSI cannot regularly accumulate excess surpluses. It must manage the company to eliminate excess surpluses in ways that further its charitable obligation. Thus, for example, if GHMSI sought to make itself a more effective take-over target at the end of the five-year conversion moratorium imposed by Maryland (which expires in 2008) by building up its cash reserves beyond reasonable levels, which would violate its charitable obligation. Further, if CareFirst used GHMSI's surplus reserves to subsidize its Maryland insurance affiliates (for example, by using GHMSI's reserves to enhance the creditworthiness of the affiliates or of

CareFirst itself, thereby securing debt at lower rates or more favorable terms), that, too, would violate GHMSI's charitable obligation.

In the end, therefore, we do not think there should be doubts about which activities qualify as "charitable" and which do not. We also think that GHMSI has considerable discretion in selecting the charitable activities it wishes to engage in. But once it makes those selections, we believe they must be transparent and measurable, and they must be subject to review by the public and public officials.

6. What standard governs whether GHMSI is spending enough to meet its charitable obligation?

The Attorney General concludes that "GHMSI is to devote *its entire operation* to serving, directly or indirectly, the purposes for which it was chartered" [AG Memorandum at 2] (emphasis supplied). The Attorney General also says that "GHMSI has an obligation to use its profits and excess surplus to serve the purpose of promoting health in its service area (p.8). "In other words," the Attorney General concluded (p.6), for GHMSI, "the generation of profits or the enhancement of company value is at most a means, not an end." This is completely in accord with DC Appleseed's conclusion that GHMSI must pursue a public health mission to the maximum feasible extent consistent with financial soundness. It also supports our conclusion that GHMSI's pursuit of its charitable mission of promoting health must be a primary purpose of GHMSI's operations, not something it attends to after allocating funds for every other purpose.

7. How much can GHMSI afford to spend meeting its charitable obligation and still remain financially strong and competitive?

The Attorney General specifically did *not* address "whether GHMSI has in fact been operating consistently with its charter" (p.2), but DC Appleseed has addressed that issue. Mathematica's analysis of GHMSI's surplus levels, conducted for DC Appleseed, demonstrated that GHMSI had accumulated surplus (also called unobligated funds) well above its competitors. It concluded that GHMSI could afford to expend at least two percent of earned premium for community benefit each year at current levels of premium *simply by forgoing further surplus buildup*.

Measured on a risk basis (which adjusts measurement of surplus for the company's asset and business risk), GHMSI held total adjusted capital equal to 951 percent of authorized control level (ACL) risk based capital (the level at which regulators consider the company insolvent) in 2004. This was nearly 50 percent more than that held by CareFirst of Maryland relative to ACL and 2.5 times the minimum standard established by the Blue Cross Blue Shield Association (BCBSA). In turn, the BCBSA standard (375 percent of ACL) is nearly twice the minimum standard (200 percent) established by the NAIC for all health insurers.

Table 1

Surplus, Surplus Buildup, and Total Adjusted Risk-Based Capital: CareFirst Affiliates, 2004

	Surplus ($millions)	Surplus buildup ($millions)	Surplus buildup as a percent of premium	Total adjusted capital as a percent of authorized control level (TAC/ACL)
GHMSI	$501.0	$109.0	5.4%	951.3%
CareFirst of MD	$352.4	$14.0	1.1%	638.4%
CareFirst Blue Choice	$171.5	$42.8	4.1%	673.2%
BCBS of Delaware	$128.3	$9.8	3.2%	1262.8%

Source: Mathematica Policy Research, Inc. analysis of company annual statements.

Mathematica's estimate that GHMSI could expend 2 to 3 percent of earned premium for community benefit also coincides with several other measures of GHMSI capacity. Specifically:

- As the area's dominant insurer, GHMSI exerts substantial market power. We estimated that market power accounted for $13.8 billion of GHMSI's economic prices (conventionally measured as earned premiums minus medical losses incurred) between 1998 and 2003, relative to its largest competitor in the national capital area (Kaiser-MidAtlantic). Since 1998, his amount has averaged 2.1 percent of earned premium per year.
- Other nonprofit insurers that hold a similar or lower market share compared to GHMSI but are known to be active in providing community benefit typically dedicate resources in the range of 1 to 2 percent of earned premium per year. Kaiser-MidAtlantic is one such insurer.
- GHMSI enjoys exemption from District taxes equal to 2 percent of earned premium per year. The District requires that it contribute 1 percent of premium to "rate stabilization," to subsidize its mandatory open-enrollment individual product. However, GHMSI actually spends only a fraction of these funds, an issue discussed further in #11 below.

A recent Maryland Health Care Commission (MHCC) report noted "most insurers in the US hold surpluses in the range of [just] 350 to 400 percent, even at the low point in the underwriting cycle" (http://www.mhcc.state.md.us/spotlight/health_ins_prem_spotlight_0305.pdf) . Against its current ratio of *951 percent,* Mathematica estimates that GHMSI could expend 2 to 3 percent of earned premium for community benefit each year, and still hold approximately 570 to 740 percent of ACL risk-based capital at the likely low-point of the underwriting cycle (in 2008).

8. Does GHMSI have an affirmative duty to show that it is meeting its charitable obligation?

In light of GHMSI's assertion that it has no charitable obligation and in light of indications that GHMSI in the past was accumulating surplus in order to render itself an attractive acquisition target, the answer is clear. District lawmakers and regulators should require GHMSI to show affirmatively that it is meeting its charitable obligation. In our view, it has not yet done so.

9. Has GHMSI shown how much it believes it can and should spend on community benefits?

GHMSI has not shown how much it believes it can and should spend on community benefits. Instead, GHMSI merely asserts that its ability to commit funds to charitable purposes is severely constrained by its need for funds—$200 million to $300 million, it asserts—to improve and update information technology, and by its needs to position itself to respond to claims that may arise in the event of terrorist acts or other catastrophic events. It suggests that CareFirst's announced program of community benefit activities was guided by the goal of committing all that it can to support public health activities consistent with such constraints.

These assertions by GHMSI are not new. For example, the company has been saying for a number of years that it must direct its surplus toward information technology (IT) improvements. The Accenture report entitled *An Assessment of Health Coverage Industry Trends and CareFirst's Strategic Response* dated November 16, 2001, which CareFirst circulated in connection with its 2002 conversion/acquisition filings, estimated that large health plan average investment needs on e-commerce technologies, improvements to IT infrastructure and operational systems, and related customer service improvements would, at the high end, be in the neighborhood of $130 million over the ensuing three to five years. In his testimony before the Maryland Insurance Administration on March 11, 2002, GHMSI President and CEO William Jews testified that "CareFirst must increase its access to capital to provide the anticipated $300 million over five years necessary to invest in technology, service, and other enhancements necessary to comply with regulatory mandates and compete effectively with national insurers." In his testimony before DISB on March 24, 2005, Mr. Jews stated that "External consultants have advised us that, based on the competitive marketplace, we should spend between $200 million and $300 million over the next few years to upgrade our IT infrastructure to ensure that we can enroll members accurately, process claims in a more timely manner and provide the services demanded by both members and providers." As these statements show, GHMSI's estimates of its IT investment needs appear to be a rolling target. In the context of the present debate, there is a risk that the company's stated IT investment goals become like the horizon—always in sight and never reached. At the very least, these statements raise the question of whether GHMSI is relying on its claimed IT investment goals as an all-purpose and conveniently hard-to-contest reason for accumulating extraordinary surpluses. To the extent that GHMSI has not spent what it said years ago it needed to spend, its IT claims are no longer credible. To the extent that it has spent what it said it needed to spend, then it must be asked whether its IT investment is somehow not cyclical (unlike the IT investments of other major corporations, including insurance companies). If GHMSI is going to continue to insist that IT needs trump

charitable undertakings, we believe it must *show*: what it has spent for IT since it began asserting in public forums in Maryland and the District that it has unmet and important IT needs; how much it has committed or plans to invest in the immediate future; how it has determined what it claims is the necessary level of investment; and why it is that IT displaces charitable expenditure rather than some other types of corporate expenditure. We also believe that GHMSI should be required to *show* the maximum amount it can afford to spend consistent with remaining competitive and financially stable.

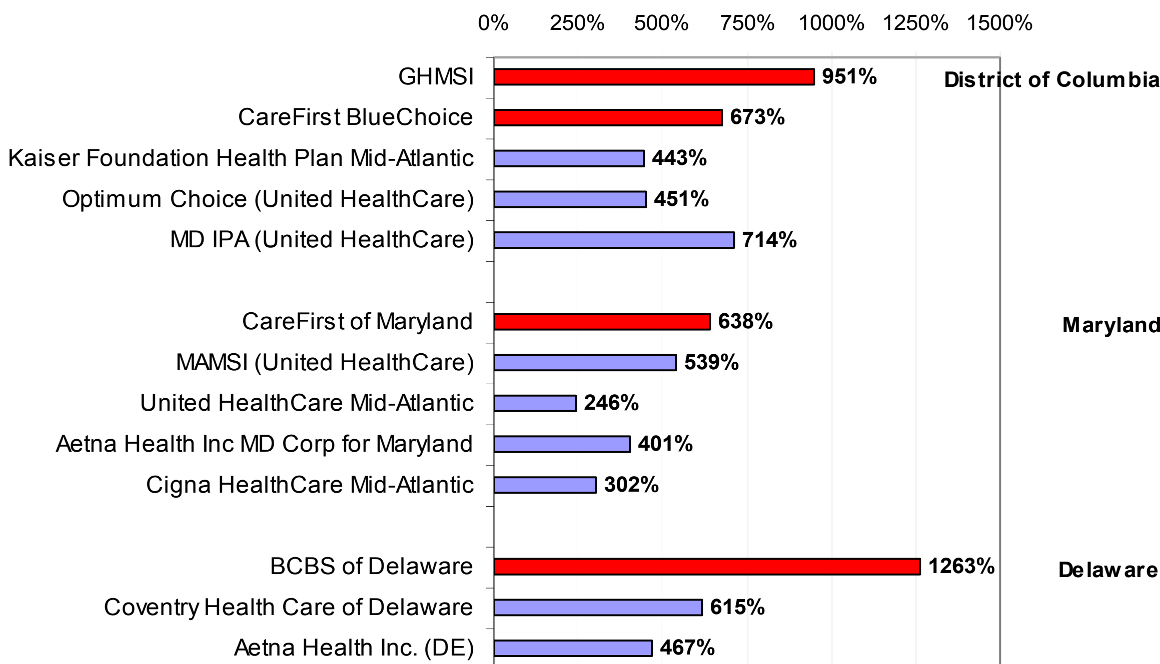
Furthermore, we believe CareFirst should be required to explain the $92 million for community benefit it has announced for 2005. Of this amount, at least $24 million of the proposed amount is fully financed from the company's exemption from taxation in Maryland and the District, and therefore represents no net community benefit. In addition, CareFirst offers $60 million as a reduction in premiums against anticipated levels, while there is evidence that other insurers also are moderating premium increases in 2005. Indeed, in light of GHMSI's very high current surplus, there is no evidence that it would need to increase premiums in any event: GHMSI has filed 2005 rates with DISB that do not reflect an unusually high ratio of medical expenditure to premiums. While targeted reductions in premiums to low-income workers or individuals might indeed meet a test of charitable spending, CareFirst has announced no such program. Of the balance of the $92 million—just $8 million—CareFirst has not indicated what proportion is charitable spending and how much is attributable to GHMSI. Until CareFirst demonstrates clearly how its proposed spending meets the test of charitable spending, District officials and the public will be unable to determine whether GHMSI is meeting its charitable obligation to citizens of the National Capital area.

10. Has GHMSI justified the size of its surplus?

In 2004, GHMSI's total adjusted capital (TAC) rose to 951 percent of authorized control level (ACL) risk-based capital—substantially more than that of CareFirst of Maryland or CareFirst Blue Choice, or its competitors in DC (Figure 1). GHMSI has not justified the size of this surplus.

Figure 1

Total Adjusted Capital as Percent of Authorized Control Level Risk-Based Capital: CareFirst Affiliates and Major Competitors in DC, Maryland, and Delaware, 2004



Source: Mathematica Policy Research, Inc. analysis of company annual statements.

We find the analysis offered by Milliman and Robertson (M&R) advising that GHMSI hold surplus of 800-1100 percent of ACL flawed in its methods and excessively conservative in its findings. Specifically:

- The analysis considers all underwriting loss cycles between 1980 and 2003. These include the "especially severe" underwriting losses in 1986-1988, even though the authors themselves "do not believe that the circumstances leading to losses of this magnitude are likely to occur today" (p. 32).
- The analysis combines GHMSI's loss experience with the underwriting cycles experienced by 20 unidentified BCBS plans. However, GHMSI's circumstance as the dominant insurer in a single metropolitan area is arguably unique. The significantly greater loss cycles experienced by these comparison plans—at the lower bound, 42 percent more severe than GHMSI's historical pattern—support this point (p. 49). (Because the analysis included GHMSI's 1986-1988 losses, the report offers no valid comparison of losses at the upper bound.)

In addition, the M&R analysis implies that all other major insurers—including CareFirst Blue Choice and Care First of Maryland, as well as *every major competitor* in CareFirst's DC, Maryland, and Delaware market areas (with the exception of BCBSD)—are holding too little surplus, even at the top of the underwriting cycle. This is very unlikely to be true. Indeed, to

accept the analysis offered in the M&R report would be to call into serious question the substantially lower surplus levels held by every other major carrier in the DC, Maryland, and Delaware markets.

The MHCC report mentioned above observed that “a regulatory bias toward large surpluses may increase the consumer cost of insurance without securing greater market stability.” Mathematica’s analysis concludes that GHMSI’s unusually high surplus is consistent with its market power and that it is substantially greater than is needed to ensure its financial stability. GHMSI has not made a convincing case to the contrary.

11. Has GHMSI explained its failure to meet its open enrollment obligation?

Just as GHMSI has failed to explain and justify its failure to meet its charitable obligation, it has also failed to explain and justify its activities in the one program where it acknowledges an obligation—the open enrollment program. GHMSI is plainly required to devote just half of the value of its premium tax exemption in the District to subsidize open-enrollment premiums, but it has not done so. (This is a lesser requirement than in Maryland: CareFirst contributes to the Maryland Senior Prescription Drug Program an amount equal to the full value of the company’s exemption from premium taxation in Maryland.)

GHMSI expends very little of the 1 percent of non-FEHBP premiums that it is obligated to contribute to its “rate stabilization fund” each year to subsidize open-enrollment premiums. In 2004, just 220 individuals were enrolled in GHMSI’s open-enrollment product, and GHMSI spent just 19 percent of its 2004 contribution to rate stabilization to subsidize the product.

However, even this low level of expenditure was much more than GHMSI spent in 2002 or 2003 (since its obligation to pay into a rate stabilization fund was clarified), and much more than it projects to spend in 2005. In 2005, GHMSI has projected that it will enroll 343 individuals in the open enrollment product, although the basis for this projection is unclear. Even so, of the nearly $3 million that GHMSI will pay into the rate stabilization fund in 2005, it expects to pay just $270,000 in open enrollment premium subsidies—about $790 per member. At the same time, it expects to add more than $2.7 million to its holdings in the rate stabilization fund, bringing the accumulated balance to $9.3 million.

The remarkably low enrollment in GHMSI’s open-enrollment product reflects the difficulty that consumers have in locating this product. In fact, GHMSI runs two other products for individuals who are unable to buy underwritten coverage: a group conversion product (very similar in design to GHMSI’s open enrollment product) and a HIPAA product (offered only with a low deductible). While GHMSI wrote only 200 open enrollment contracts in 2004, it wrote 370 conversion-product contracts at approximately twice the open enrollment premium, and 95 HIPAA-product contracts at nearly 3 times the open enrollment premium.

The fact that GHMSI has enrollment in its much more expensive conversion and HIPAA products is evidence that the open enrollment product is not sufficiently marketed. Indeed, multiple calls placed to GHMSI as a consumer to inquire about the open enrollment product in DC produced the same information each time: that no such product exists, and that GHMSI offers no alternative to individuals who are rejected for coverage in its Blue Preferred product.

Although they represent no effort net of the companies' tax exemptions, CareFirst counts both GHMSI's contribution to the rate stabilization fund and CareFirst's expenditures for the Maryland Senior Prescription Drug Program as more than 26 percent of its total proposed community benefit plan in DC, Northern Virginia, Maryland, and Delaware combined. In our view, neither of these programs can be counted toward the company's charitable obligation. But the company should faithfully carry out both programs, and regulators should ensure that this occurs.

12. What action should DISB take now?

District law imposes on DISB an obligation to ensure that GHMSI complies with the charitable obligation that federal legislation (i.e., the GHMSI charter) imposes on the company [*See* D.C. Code § 31-202(a)]. Accordingly, we believe that:

- DISB should require GHMSI to provide particulars on its spending and budgeted spending on information technology and to explain why any amounts accumulated for information technology improvement purposes, but not spent or committed for this ostensible purpose, are not available to support charitable public health initiatives. (GHMSI should consider submitting for DISB review copies of any consultants' reports assessing the company's information technology needs—both existing reports and reports prepared after April 8, 2005—and estimating how much the company will need to spend to put in place the needed improvements.)
- DISB should require GHMSI to show why it needs a level of surplus to meet future contingencies such as terrorism, which dramatically exceeds the surplus levels of its competitors. As suggested by DISB Commissioner Mirel at the March 24 hearing, GHMSI should show why it needs to be an A+ company (rather than an A- company) in this and other regards, if A+ status means forgoing present opportunities to further the company's charitable mission.
- DISB should systematically investigate what constitutes adequate surplus levels in the D.C. market—taking into account general industry standards, the surplus levels held by comparable Blues organizations, and the surplus levels of the companies that compete in this region. DC Appleseed urges DISB to publish a notice of inquiry and to elicit a broad range of expert advice on this issue. In light of both the unique risks and oligopolistic character of the D.C. market, there may be reason to establish a standard for minimum surplus other than that developed by the NAIC, as well as a standard by which to gauge excessive surplus.

- DISB should examine the relationship between a finding that surplus levels are not excessive and the ability to increase charitable spending. As described below, in Pennsylvania, a finding that surplus levels were not excessive did not preclude the Commonwealth from formalizing very substantial charitable spending commitments by the four Pennsylvania Blues plans.
- DISB should initiate a program of regular oversight of GHMSI's community benefit activities, which should entail requiring GHMSI to show affirmatively what it can afford to spend on charitable public health activities each year. (GHMSI should consider submitting for DISB review copies of the report(s) and working documents of the CareFirst or GHMSI mission committee, to the extent that these documents address this issue.) DISB should identify an expected range of spending by the company on charitable public health initiatives (including, as the company deems appropriate, subsidized health insurance coverage), and should permit a lesser level of expenditures only as specifically justified by the company. DC Appleseed believes that the expected range over the next several years should be in the range of $50 million to $100 million per year.
- DISB should actively and continuously monitor GHMSI's offer of open enrollment coverage, and GHMSI's open enrollment product should be offered immediately to all conversion and HIPAA subscribers. Based on its projections for 2005, it is apparent that GHMSI could accept many more individuals in its open-enrollment product—at least 5 times the number it accepted in 2004, at the same relatively high level of subsidy it provided (about $2700 per contract).
- DISB should establish a level of reasonable reserves against anticipated losses in GHMSI's open-enrollment product. GHMSI's expected reserve in 2005—$9.3 million—is 35 times its projected level of losses against premium, apparently much more than adequate. Thus, DISB should require that GHMSI expend its full annual contribution to rate stabilization (approximately $3 million in 2005) to subsidize the open-enrollment product, and that it continue to do so until reserves for this product are at the DISB-established level.
- DISB should require GHMSI to show how GHMSI's charitable commitment affecting District of Columbia residents compares with its commitment affecting Maryland and Virginia, and with the relative amounts of revenues attributable to GHMSI's operations in each jurisdiction.
- Finally, DISB should amend its regulations at 26 DCMR 4500 *et seq.* so as specifically to require the Code of Conduct for directors and officers of a hospital and medical services corporation to include provisions requiring the directors and officers to "manage the affairs of the corporation, including all policies and proposals, in a manner that is in the public interest and so as to cause the corporation to assist and support public health initiatives in its service area to the maximum extent feasible, consistent with financial soundness."

13. What action should the Attorney General take now?

GHMSI inaccurately characterizes the Attorney General's Memorandum as reaching the "same conclusion" that GHMSI asserts, which it that the company "has no legal obligation to engage in charitable activities beyond what it is already doing" [GHMSI Memorandum at 1]. The Attorney General should consider issuing a supplemental memorandum clarifying and amplifying its actual conclusion, which is that the GHMSI Board should keep in mind that the "goal of maximizing benefits for GHMSI's subscribers should be pursued in a manner that is consistent with the larger 'charitable' purpose of promoting better health in GHMSI's service area" [AG Memorandum at 8].

Further, the Attorney General should review GHMSI's announced program of community benefit activities to determine whether that program in fact meets the company's charitable obligation. We believe such a review will be necessary in order for the Attorney General to exercise his "common law authority to enforce GHMSI's obligation to operate consistently with its 'charitable and benevolent' purpose" [AG Memorandum, p.8].

In addition, activities in a number of states offer precedents for action by the Attorney General that would be beneficial in clarifying GHMSI's community benefit obligation in the District and monitoring its performance with respect to that obligation. For example:

- In Massachusetts, the attorney general has established formal community benefit guidelines and requires each nonprofit plan to submit a standard annual community benefit plan report. These reports are posted on the Massachusetts Attorney General's web site. Other states, too, have worked with large nonprofit insurers, in particular, to direct high surpluses toward broader health care initiatives.
- In early February 2005, the Commonwealth of Pennsylvania formalized the prospective "community activities" of the four Pennsylvania Blues plans (even though the Commissioner of Insurance ruled that that the plans were not operating "with inefficient or excess surplus"). The plans agreed to commit $150 million annually to a six-year community health reinvestment program, including $85 million to support basic health coverage for low-income and uninsured residents, and $65 million for other community activities related to health care.

14. What action should the DC Council take now?

GHMSI, the Attorney General and DC Appleseed all agree that GHMSI's charter authorizes it to undertake activities to promote and safeguard the public health. Moreover, section 5 of the charter explicitly subjects GHMSI to regulation under the laws of the District of Columbia. Therefore, D.C. Council legislation that would require GHMSI to pursue charitable public health initiatives consistent with its federal charter is appropriate.

Such Council legislation now seems particularly appropriate in light of GHMSI's declaration that it has no charitable obligation. In our view, the Council of the District of Columbia should

remove all doubt on this issue and pass legislation that explicitly recognizes the company's obligation to the public to promote public health. Provisions of the Maryland Insurance Code can be a model for such District legislation. Specifically, section 14-102 states that, as a condition of doing business in Maryland, CareFirst and all of its affiliates, must among other things "assist and support public and private health care initiatives for individuals without health insurance" and "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."

District legislation should also require that GHMSI be guided by the company's charitable obligation in making all decisions about the company's direction. The Medical Insurance Empowerment Act of 2005, introduced on March 15, 2005, by Council Member Graham, would accomplish this by amending the Hospital and Medical Service Corporation Act to provide that the Board of a hospital and medical service corporation

> shall manage the affairs of the corporation, including all policies and proposals, in a manner that is in the public interest and so as to cause the corporation to assist and support public health initiatives in its service area to the maximum extent feasible, consistent with financial soundness.

In addition, the D.C. Council should consider amending D.C. Code § 31-3509 [entitled "reserves"] by adding a new paragraph specifying that:

> The directors or trustees of the corporation shall ensure that the reserves maintained by the corporation are not excessive, but are consistent with operation of the corporation in the public interest and with the goal of the corporation assisting and supporting public health initiatives in its service area to the maximum feasible extent, consistent with financial soundness;

and amending D.C. Code § 31-3514 by modifying paragraph (i) thereof to read as follows:

> A corporation issued a certificate of authority under this chapter shall provide other public services in its service area, which public services may consist of but need not be limited to health-related educational support for residents of the corporation's service area who, based upon such educational support, may experience a lesser need for hospital and medical services, or benefits and indemnification for such services. The directors or trustees of the corporation shall submit to the Mayor, as part of the report required under 31-3504(d)(1), a report on health-related educational support for residents of the corporation's service area that the corporation has provided.

While GHMSI is obligated to pay 1 percent of non-FEHBP premiums toward rate stabilization of its open enrollment product, it enjoys exemption from an additional 1 percent of non-FEHBP

premiums—projected to be worth nearly $3 million in 2005—for which District residents currently receive no commensurate benefit. GHMSI might use at least these funds to develop premium assistance for its open enrollment product in cooperation with DC government, targeting premium subsidies to enrollees with income below 400 percent of the federal poverty level and ineligible for coverage in DC Alliance. At least 25 percent of the District's uninsured residents—and one-third of uninsured nonfederal workers—are in this circumstance. Legislation should be enacted requiring GHMSI to provide subsidized coverage directed at such uninsured residents.

With a larger amount of funding, the DC Council might develop a true open-enrollment pool, comparable to the Maryland Health Insurance Plan (MHIP), which offers good coverage to 5,000 enrollees for an average premium of about $350 per month. This program is expected to require funding of about $20 million in 2005.

III. Conclusion

Based on the foregoing information, and the earlier information in DC Appleseed's December report, it is clear that GHMSI has a charitable obligation to citizens of the National Capital area. It is also clear that the company can and should be doing more to meet that obligation. Now that the company has denied having any obligation at all, we believe it is timely and appropriate for DC's regulators—the Insurance Commissioner, the Attorney General, and the D.C. Council—to enforce that obligation.