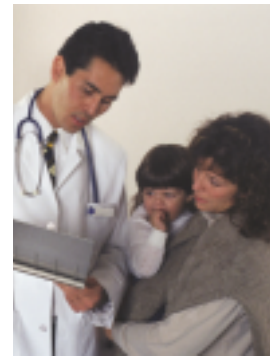
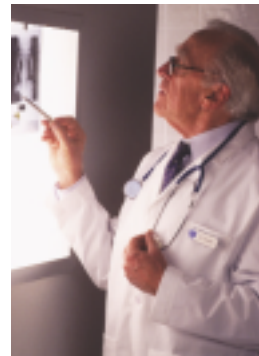


CareFirst:

Meeting Its Charitable Obligation to Citizens of the National Capital Area



DC APPLESEED
C E N T E R

W W W . D C A P P L E S E E D . O R G

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Finally, we would like to thank the many stakeholders with whom we have met to discuss the substance of this report. This list includes: senior management and board members at CareFirst and Group Hospitalization and Medical Services, Inc. (GHMSI); DC Insurance Commissioner Lawrence Mirel and the staff at the DC Department of Insurance, Securities, and Banking; members of the DC Council; and DC City Administrator Robert Bobb and his Senior Policy Advisor, Gina Logamorsino.

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MISSION OF THE DC APPLESEED CENTER

The DC Appleseed Center for Law and Justice is an independent non-profit advocacy organization whose staff works with volunteer teams of attorneys and other experts to identify serious local issues, research and analyze them, develop and publish recommendations for systemic reform, and advocate for appropriate solutions. In addition to its CareFirst project, DC Appleseed is currently working on initiatives addressing several of the most pressing issues facing the National Capital region, including: DC voting rights, restoration of the Anacostia River and its watershed, problems of special education in DC schools, the structural deficit in the DC budget, the District's HIV/AIDS epidemic, and the District's lead-in-the-water crisis.

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Section 1:

Summary of Findings and Recommendations



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SUMMARY OF FINDINGS AND RECOMMENDATIONS

I. INTRODUCTION

Group Hospitalization and Medical Services, Inc. (GHMSI) is the District of Columbia affiliate of CareFirst Blue Cross Blue Shield. GHMSI is the largest health insurance company in Washington, D.C., worth well over a billion dollars. It earned premiums in 2003 of nearly two billion dollars, has surplus of nearly 400 million dollars, and serves approximately one million subscribers in DC, Maryland, and Virginia.

GHMSI is a federally chartered nonprofit company that is regulated by the DC Insurance Commissioner and the DC Attorney General. Its congressional charter states that it is a “charitable and benevolent institution.”

After two years of examining GHMSI’s role in the National Capital area, DC Appleseed has reached the following principal conclusions about GHMSI’s legal obligation and financial capability:

- GHMSI’s federal charter means what it says: GHMSI is legally obligated to provide charitable activities within its service area.
- GHMSI’s board of directors has a fiduciary and legal obligation to ensure that GHMSI fulfills its charitable obligation. GHMSI’s compliance with its federal legal obligation is reviewable and enforceable by the DC Commissioner of Insurance and by the DC Attorney General. GHMSI’s obligation cannot be removed, diluted, or redefined by CareFirst or by Maryland or Virginia.
- GHMSI’s legal obligation is as follows: it must use its revenues and surplus to perform charitable activities to the maximum feasible extent, consistent with its need to remain viable and competitive.
- GHMSI is financially capable of engaging in charitable activities at a much higher rate than it is currently doing, and still remain viable and competitive. Specifically, it could spend between 2 and 3 percent of its earned annual premiums to charitable activities and still maintain its current pricing structure, its level of competitiveness, and a high level of surplus.
- Using this 2 to 3 percent measurement, GHMSI could spend between 41 and 61 million dollars on charitable activities in 2004. By 2008, assuming as much as 10 percent annual growth in total premium revenues, GHMSI could spend between 67 and 100 million dollars on charitable activities, and still remain viable and competitive.

GHMSI has not been meeting the described charitable obligation to citizens of the National Capital area. This billion-dollar company is spending only approximately one million dollars on charitable activities in 2004—less than one-tenth of one percent of its assets, and around only one-twentieth of one percent of its premiums. This is not in keeping with the company’s federally imposed charitable obligation.

GHMSI is in effect owned by the public. Its mission is to serve that public. It is clear that it could and should do much more to carry out that mission. We believe that it is time for it to do so. This report explains how and why GHMSI should immediately begin that undertaking. The CareFirst Watch Coalition—of which DC Appleseed is a part—endorses this report and its recommendations in full.

II. BACKGROUND

In July 2001, several Washington-area foundations asked DC Appleseed to address an expected effort by CareFirst Blue Cross Blue Shield to cease its activities as a nonprofit health insurance company and “convert” to a for-profit operation. Because CareFirst is by far the biggest health insurance company in the mid-Atlantic region, these foundations were concerned that the possible conversion might have a significant, negative impact on health care, particularly in the National Capital area.

In response to the foundations’ request, DC Appleseed helped organize and coordinate the activities of the CareFirst Watch Coalition. The Coalition is made up of over 20 organizations, and includes healthcare providers, consumer associations, and citizen groups from the area. With the support of the foundations and the pro bono legal assistance of Covington & Burling and Harkins Cunningham, DC Appleseed and the Coalition were able to mobilize resources to help determine whether the expected “conversion” attempt was in the public interest and to help influence whether the conversion should be allowed to go forward.

CareFirst applied for the expected conversion in January 2002. The company submitted applications in all three jurisdictions in which its affiliates are based—Maryland, Delaware, and the District. Each jurisdiction’s Insurance Commissioner was tasked with deciding whether the conversion should be permitted—after a showing that it would be in the public interest—and each jurisdiction’s Attorney General was entrusted with ensuring that the price paid for the company was successfully placed in a foundation that would serve the original purpose of the nonprofit. This latter responsibility meant, in effect, that the Attorney General would ensure that the value of the company’s assets would continue to serve the healthcare needs of the community.

CareFirst’s conversion application sought permission to sell the company for \$1.3 billion to WellPoint Health Networks, a California-based for-profit company. The application asserted that the price was a fair one and that the public would be well-served by the conversion and by receiving the benefit of the \$1.3 billion being placed in trust.

The reason that the price offered for CareFirst was critical was this: CareFirst has no shareholders; it is in effect “owned” by the public; therefore, if it is converted and sold, the selling price must be transferred in trust to a foundation that will continue to serve the original nonprofit purpose—in this case, serving public healthcare needs. For that reason, it was important that the price paid for the company be sufficient to ensure that the public would receive the full benefit from the operations of the resulting foundation.

In response to the conversion application, DC Appleseed did two things: first, it sought and received permission from the DC Insurance Commissioner to become a formal party in the administrative proceedings the Commissioner planned to conduct to review the conversion

application; and second, with the support of several foundations, DC Appleseed engaged experts to assist it and the Coalition in evaluating the application.

DC Appleseed engaged two kinds of experts: valuation experts (led by Dr. Richard Meyer of the Harvard Business School) to assess whether the price being offered for CareFirst was fair; and health policy experts (led by Dr. Judy Feder at Georgetown University and Dr. Sara Rosenbaum at George Washington University) to assess which outcome would better serve the public interest—maintaining CareFirst as a charitable nonprofit, or allowing it to be sold for a fair price and placing that amount in a foundation that would serve area healthcare needs.

DC Appleseed’s valuation experts showed that the value of CareFirst was approximately \$2.25 billion—*almost a billion dollars more than the selling price agreed to by CareFirst management*. In fact, our valuation experts showed that the DC-based component of CareFirst alone—GHMSI—was itself worth approximately the \$1.3 billion offered for all of CareFirst. This meant that, if the proposed conversion had been approved, the public would have lost a billion dollars that could have been devoted to area healthcare needs. (DC Appleseed’s valuation reports are available on its website—www.dcappleseed.org)

III. THE CONVERSION PROCEEDINGS

Even though CareFirst filed its conversion applications simultaneously in all three jurisdictions (Maryland, Delaware, and the District), it happened that the conversion proceedings began first in Maryland before the Maryland Insurance Commissioner, Steve Larsen. Commissioner Larsen’s proceedings began in the spring of 2002 and included many days of public hearings in late 2002 and early 2003. At the hearings, Commissioner Larsen heard testimony from witnesses and experts presented by CareFirst and by experts the Commissioner himself engaged. The Commissioner also received written comments from other interested parties, such as DC Appleseed and the Coalition. He also received DC Appleseed’s valuation studies showing CareFirst’s value to be approximately \$2.25 billion. In an earlier filing submitted to all three Commissioners, DC Appleseed and the Coalition contended that the application for conversion “does not show that the proposed conversion is in the public interest. It also does not show that the offering price and terms for the merger protect the public interest”

On March 5, 2003, Commissioner Larsen issued a 205-page decision denying the conversion application. He based his denial largely on the ground relied on by DC Appleseed, *i.e.*, that the price being offered was not a fair one. As Commissioner Larsen stated in his opinion, “this deal does not ensure that the fair value of the public assets will be distributed to [a public] Foundation as the conversion law requires. This compels a finding as a matter of law that the deal is not in the public interest.” Larsen Opinion at 198 (the entire opinion is available on the DC Appleseed website at www.dcappleseed.org/images/LarsenDecision.pdf). He also relied on the fact that CareFirst management was to receive bonuses from the proposed conversion that were excessive and not in the public interest. Opinion at 199.

Even more importantly for present purposes, Commissioner Larsen determined in his decision that CareFirst had disregarded its mission as a nonprofit company once it determined to seek conversion and sale of the company. In this connection, he pointed out that CareFirst had been focused on growth and market dominance and on exiting unprofitable market segments, rather than providing insurance at minimum cost to those that needed it. Opinion at 95-103. He further pointed out that

other nonprofit Blues plans had been able to “not only survive but also thrive as a social mission oriented nonprofit” and that CareFirst had failed to consider whether it could do the same. Opinion at 99.

CareFirst did not appeal Commissioner Larsen’s decision. Neither did it further pursue its conversion applications before the DC and Delaware Commissioners, but simply withdrew those applications.

In the wake of Commissioner Larsen’s decision, the Maryland legislature reaffirmed CareFirst’s obligation to behave as a nonprofit and required it to take steps to address public healthcare needs as part of that obligation. The legislature also appointed an oversight committee to evaluate CareFirst’s ability to carry out certain healthcare goals as part of its nonprofit mission. (The text of the Maryland legislation can be found at www.dcappleseed.org/images/2003MDLegislation.pdf.)

IV. DC APPLESEED’S NEW FOCUS FOLLOWING THE CONVERSION DENIAL

Following the conversion denial and the Maryland legislative action, DC Appleseed and the Coalition thought it important to move into a new phase—attempting to assess what GHMSI could and should be doing as a nonprofit that Congress had declared to be a “charitable and benevolent institution.” Our view was that too many people had treated the denial of the conversion as a final victory for the public interest. While we believe that the conversion as proposed should have been denied, we also believe that the denial, without more, has left the public in the worst of all possible worlds.

Here is why that is so: there are two ways for the enormous value of CareFirst and GHMSI to benefit the public; either the company can be converted to for-profit status and its full and fair value transferred to a foundation that would administer that value in the public interest, or it can behave as a nonprofit with a charitable obligation that uses its great value directly to benefit the public. *Right now neither of these is happening.* Instead, because the conversion has been denied, there is no resulting foundation; but, at the same time, CareFirst and GHMSI are not yet devoting their considerable assets to charitable activities.

For these reasons, DC Appleseed has undertaken to assess with some precision what the DC-based portion of CareFirst—GHMSI—can and should be doing to behave as a charitable organization and better serve the public interest in the National Capital area. By “the National Capital area” we mean GHMSI’s defined service area, which includes DC, Northern Virginia, and two counties in Maryland—Montgomery and Prince George’s.

We began this undertaking by asking our health policy experts at Georgetown and George Washington to shift their analysis away from determining whether the conversion would be in the public interest and to focus instead on whether the DC-based part of CareFirst (GHMSI) appeared to be fulfilling its mission as a charitable nonprofit company. That report, next described, was issued in October 2003 and showed that GHMSI is not fulfilling its mission.

In addition, we have had a series of discussions with the DC Insurance Commissioner and with representatives of GHMSI to determine their respective views with regard to the company’s obligations and its plans for meeting that obligation.

Finally—and these are the central subjects of this report—we commissioned (1) a legal analysis that would define the content of GHMSI’s charitable obligation to the National Capital area, and (2) an economic/financial analysis that would assess and measure in dollar terms GHMSI’s capacity to meet that obligation. Taken together, these undertakings demonstrate that the company is falling far short of its obligation and is missing huge opportunities to address healthcare needs in this community.

V. THE GEORGETOWN/GEORGE WASHINGTON REPORT

The Georgetown/George Washington (GT/GW) health policy experts compared the performance of GHMSI to that of nonprofit Blues in other jurisdictions in order to determine whether the company was meeting its charitable mission. They found it was clearly not doing so.

For example, they found that the company “has demonstrated no innovation in the development of products that would meet significant health insurance coverage and health status deficiencies in the area.” This was so even though other nonprofit Blues had demonstrated that such “innovation is possible.” GT/GW Report, p. 52 (the entire report is available on the DC Appleseed web site at www.dcappleseed.org/images/gwanalysis.pdf).

The report cited as obvious limitations in the GHMSI product line “its failure to offer a Medigap policy with prescription drug coverage,” and its failure to “participate in Medicaid, or, at a minimum, provide some alternative product to reach out to lower-income residents” (pp. 52-53). It also mentioned as “a glaring omission ... the lack of a disease management program or other focus on HIV/AIDS, especially given that the case rate in the District is the highest in the country” (pp. 52-53). In addition, “[j]ust as CareFirst/GHMSI has not supported lower income residents through subsidized premiums, it also has failed to do what Blues plans in other communities have done, *i.e.*, directly subsidize health care providers treating large numbers of uninsured patients” (p. 9).

Perhaps most significantly, the report found that “[a]lthough CareFirst/GHMSI has suggested that giving to the community is one of its goals, the evidence suggests that the company’s allocation toward community benefits is *strikingly low*” (p. 10) (emphasis added). For example, the report pointed out that in 2000 CareFirst/GHMSI reported contributions to DC-based organizations of only \$59,000, in 2001 of \$233,000, and, as of August 2002 only \$61,000. The report concluded that “[t]hese sums do not compare favorably to the company’s totals surplus (approximately \$800 million in 2002), its quarterly surplus (\$40.8 million, a 66 percent increase over its surplus in the second quarter of 2002), or the compensation of its Chief Executive Officer (\$2.8 million in 2002)” (p. 9).

In response to this very limited program of community benefits, the report suggested that:

Area policy makers may wish to consider the establishment of specific targets in relation to surpluses, which could take the combined form of premium subsidies for lower-income families, direct support to clinics serving the lowest income and most disadvantaged populations, and community support for health activities with broad population implications, such as cancer and chronic illness screening, additional care support for seriously ill patients, and other broadly conceived interventions (p. 10).

In the end, while the report concluded that GHMSI was falling well short of the performance the community should expect, it also concluded that the exact measure of the dollar value of that

shortfall should be “the subject of a comprehensive economic feasibility analysis of CareFirst/GHMSI in the National Capital Area by relevant experts” (p. 55).

After issuance of the GT/GW Report, *Washington Post* columnist Marc Fisher concluded that the report “paints a damning picture of the company” (December 2, 2003, p. B1). He further reported that “CareFirst does not contest the accuracy of the report.” Instead, the CareFirst spokesperson stated, “We’re constantly striving to improve our product offerings.”

VI. DISCUSSIONS WITH CAREFIRST/GHMSI REPRESENTATIVES AND WITH THE DC INSURANCE COMMISSIONER

Since the conversion was denied in March 2003, DC Appleseed has had a number of meetings and discussions both with DC Insurance Commissioner Lawrence Mirel and with representatives of GHMSI and CareFirst. The purpose of these meetings was to determine views of the Commissioner and the company of GHMSI’s obligation to serve the community better and any specific plans the company had to meet that obligation. We are grateful to the company and the Commissioner for engaging in these meetings and for the cooperative way in which they approached them.

The encouraging part of these meetings and discussions was our strong understanding that both the Commissioner and the company believe GHMSI could and should be doing significantly more to serve the healthcare needs of citizens of the National Capital area. CareFirst’s recognition of this obligation appeared to be further confirmed in January of this year (2004) when CareFirst revised its mission statement and promised among other things to:

Offer a broad array of quality, innovative insurance plans and administrative services that are affordable and accessible to our customers;

Collaborate with the community to advance health care effectiveness and quality;

Support public and private efforts to meet needs of persons lacking health insurance; and

Conduct business responsibly as a non-profit service plan, to ensure the plan’s long-term financial viability and growth

(see CareFirst’s website at <http://www.carefirst.com/company/html/AboutUsHome.html>)

We are in agreement that the company’s commitment to its charitable nonprofit mission should not be fulfilled at the expense of the company’s “financial viability.” That is also the strongly held view of Commissioner Mirel, and we completely support it. It will not help the citizens of this region if GHMSI meets its charitable obligation in a way that threatens to bankrupt the company.

We are also pleased by the indications we have received from CareFirst and GHMSI that they intend to expand their charitable benefits in 2005, that they intend to approve a plan for that expansion in mid-December of this year, and that they intend to submit reports to the various Insurance Commissioners describing those plans.

On the other hand, as the reports we next describe categorically demonstrate, GHMSI can do a great deal more than it is now doing to carry out its charitable mission—without threatening its financial viability or competitiveness. But it does not appear from our discussions with the company or the comments we recently received from it that it actually intends to shift its emphasis toward greater provision of community healthcare benefits.

It will soon be *two years* since the conversion was denied and CareFirst/GHMSI was declared to be out of compliance with its charitable mission; it is over a year since the Georgetown/George Washington report catalogued the many ways in which the company was falling well short of this mission. And yet, the company *still* has not announced—much less implemented—a plan to significantly reverse course and return to its central mission of serving the healthcare needs of the public.

In May of last year, Commissioner Mirel wrote DC Council Chair Linda Cropp and Councilmember Sharon Ambrose that he “fully and unequivocally support[s] the concept that GHMSI must operate as a charitable and benevolent organization” He said “The law requires it and I support the law.” He noted further that he and DC Appleseed “are in full agreement on that point.” He then quite rightly added: “I simply want to know what that means” May 23, 2003 Letter, pp. 3, 4.

We have, therefore, undertaken in this report to define—both in legal and financial terms—what it means for GHMSI to comply with its obligation to “operate as a charitable and benevolent organization.” We have done this by: (1) seeking and receiving a legal analysis from one of Washington, D.C.’s most respected law firms—Covington & Burling—describing the content of GHMSI’s legal obligation to perform as a “charitable and benevolent organization”; and (2) with the support of several foundations, commissioning an economic/financial study led by one of Washington, D.C.’s most respected consulting firms—Mathematica Policy Research, Inc.—analyzing and measuring GHMSI’s capacity to meet its financial obligation. The latter study constitutes the “feasibility analysis” the Georgetown/George Washington Report said was needed to determine in dollar terms what the company can and should be committing to community benefits in the National Capital area.

The Covington & Burling analysis and Mathematica study are set out in full in this report. Below we briefly summarize what they say. Together, they lay out a blueprint for what GHMSI could and should be doing to meet its charitable healthcare obligation to citizens of the National Capital area.

VII. THE LEGAL ANALYSIS

Covington & Burling has been assisting DC Appleseed and the Coalition since the beginning of this effort in the summer of 2001. A team of lawyers from the firm, ably led by Phyllis Thompson, has been involved in every facet of representing the public interest in the undertaking, including: formally representing DC Appleseed as co-counsel with Harkins Cunningham in the conversion proceedings before the DC Insurance Commissioner; preparing proposed legislation for the DC Council and meeting with and testifying before Councilmembers; meeting with and briefing the Coalition; meeting with GHMSI and CareFirst officials; and preparing numerous legal analyses pertinent to the project. To the great credit of the firm, all this work has been done wholly on a pro bono basis.

The legal analysis included with this report addresses three issues.

First, it studies and explains what GHMSI's federal charter and DC law require the company to do. The analysis concludes that Congress, in requiring GHMSI to perform as a "charitable and benevolent" entity, meant that requirement to have real, substantive content; it did not intend it as shorthand for the fact that the company was given certain tax exemptions; and it certainly did not authorize the company to behave entirely as for-profits do. Instead, Congress meant for the company to pursue a true charitable public health mission; and it meant for that mission to benefit not just the company's current subscribers, but the public at large. In summary, the analysis says, "GHMSI's obligation is to foster public health initiatives, by providing services such as health education, healthcare research, participation in public programs, and subsidized coverage to the public in the National Capital area beyond its policy holders." Covington Analysis, p. II-37.

The second issue addressed by the analysis is the content of, and guidelines for, pursuing the "charitable" mission, *i.e.*, the *scale* on which the mission must be pursued. Based on the governing case law, the analysis shows that the charitable mission must be a "primary purpose" of the company's operation, not an "incidental" one (p. II-8). This means that "GHMSI must give *priority* to spending for charitable, public health initiatives" (emphasis supplied); it cannot meet that requirement by spending only "whatever is left over" after the company has allocated full amounts "to advance all its other strategic goals" (p. II-29). Rather, "to fulfill its charitable mission, *GHMSI must use its reserves and earnings for the benefit of the community to the maximum feasible extent, consistent with its need to remain viable and competitive*" (p. II-37) (emphasis supplied). This means that GHMSI is "obligated to utilize any *excess* reserves to pursue activities and initiatives to promote and safeguard the health of the public in its service area" (p. II-27). It means that "GHMSI must have the burden of establishing that any accumulated reserves in excess of the levels required under District law and regulation are actuarially justified or otherwise are reasonable and necessary for efficient, competitive, and financially sound operation" (p. II-29). And it means that "GHMSI has an obligation to commit a substantial dollar amount of resources to spending on community health initiatives" (p. II-30).

Finally, the analysis addresses the responsibility of GHMSI's board of directors and District regulators. It concludes that the GHMSI board of directors has a legal, fiduciary obligation to fulfill the charitable obligation imposed by GHMSI's federal charter. It also concludes that both DC's Insurance Commissioner and its Attorney General have a duty to enforce that obligation. This means that while the responsibility for meeting GHMSI's charitable mission falls in the first instance to the company and its board of trustees, DC's regulators have an affirmative oversight duty—owed to the public—to determine that the responsibility is carried out. Covington Analysis, pp II-30 through II-36.

VIII. THE ECONOMIC STUDY

The central purpose of the Mathematica Study was to measure GHMSI's financial capacity to meet its legal obligation. That is to say, given the company's obligation to commit its earnings and reserves to its charitable mission to the maximum extent feasible—consistent with its need to remain viable and competitive—the Mathematica Study set out to answer Commissioner Mirel's important question of "what that means" in dollar terms.

The Mathematica Study was led by Dr. Deborah Chollet, Senior Fellow at Mathematica Policy Research in Washington. She was assisted in the study by Dr. Jack Needleman, Associate Professor in the Department of Health Services at the UCLA School of Public Health, and Dr. Larry Brown, Professor of Health Policy and Management at the Columbia University School of Public Health. We are grateful to the foundations that funded this work. (Those foundations are listed on the acknowledgement page at the beginning of this report.)

Like the Covington & Burlington analysis, the Mathematica Study is in three parts. It first examines the great number of community health and health care needs in the National Capital area that GHMSI could address as part of its charitable mission. This discussion is illustrative, not prescriptive. DC Appleseed and the Coalition do not wish at this point to suggest the particular healthcare choices GHMSI should be making in carrying out its mission; that is a decision for GHMSI and its board to make in the first instance, ideally in consultation with the community. The important thing about the Mathematica Study is that it details the significant and varied activities that GHMSI could be, but is not now, undertaking. For example, it could provide educational programs to engage residents in healthier lifestyles and to educate the public and providers concerning public health emergencies; facilitate greater access to healthcare by supporting public clinics and subsidizing enrollments in its plans; develop and disseminate best practices for healthcare quality improvement; and improve capacity to deliver care to uninsured and underserved populations throughout the region. Mathematica Study, pp. III-14 and III-16.

The second part of the Mathematica Study examines the case of four other nonprofit health plans that are situated in their markets comparably to GHMSI and examines how those health plans meet their charitable obligations—both in terms of the types of community benefits they pay for and the amounts of their resources they commit to those benefits. Mathematica Study, pp. III-18 through II-29. Again, the proposal is not to say that GHMSI's community benefits activities should necessarily be modeled on these four other plans; rather, it is to illustrate what plans committed to their charitable mission can achieve and to underscore the point made in Commissioner Larsen's decision—that it is possible for nonprofit plans to be thoroughly committed to their charitable mission and to “not only survive, but thrive.”

The final part of the Mathematica Study—and we believe the most important—presents a financial analysis of GHMSI's capacity to substantial additional funds to its charitable mission and still remain financially sound and competitive. The Study measures this capacity in several different ways—each of which points to approximately the same amount of dollars GHMSI could commit on an annual basis to its charitable mission.

One measure was simply to assess the percentage of premium revenue that other comparably situated nonprofit plans devote to community benefits. That percentage, on average, is between 1.25 % and as much as 3% per year.

Another measure looked to the amount of GHMSI's premium revenue that is a function of its market power, *i.e.*, the percentage of its premium revenue that results from the higher prices it currently charges due to that power. That percentage was slightly higher than 2% of GHMSI's premiums per year during the period between 1998 and 2003.

A third measure took into account that GHMSI appears to have substantial capacity to increase its commitment to community benefits based on its significant surpluses. As the Mathematica Study

points out, “against normal regulatory measures and the practices of its competitors, GHMSI has substantially higher surplus that it might draw down for community benefit.” For example, in 2003, if GHMSI had maintained reserves at the levels held by its major competitors, it would have had excess surplus of \$193 million (p. III-47).

With these three measures as background, the Mathematica Study estimated GHMSI’s ability to commit between 2 and 3 percent of its premiums to community benefits for the years 2004 to 2008, consistent with its need to remain competitive and viable. Specifically, the study was designed to test GHMSI’s ability to increase its charitable expenditures not by raising the prices paid by consumers as premiums, but simply by reducing the rate at which it further increases its already high surpluses. The study also took into account that an industry downturn is expected through 2008. Based on this approach, the Study shows that GHMSI is capable of committing 2 to 3 percent of its premiums to charitable community benefit activities in the years 2004 to 2008, without evident risk to its competitive viability or its financial soundness.

In fact, the Study shows that GHMSI has the ability to spend at the 2 to 3 percent rate within its current pricing structure and still maintain its significant levels of surplus. For example, the study shows that with an additional annual expenditure for community benefit of approximately 2.5 percent of earned premium, through 2008 GHMSI would still maintain a surplus level that far exceeds that of its competitors. Mathematica Study at III-50.

In order to illustrate these calculations, the Study shows the amounts GHMSI would have available to spend on community benefits for each of the years 2004 to 2008, depending on whether the rate of expenditure was 2 percent, 2.5 percent, or 3 percent of premiums, and depending on the assumed rate of increase in total premium revenues. In 2004, the range of available funds for the charitable mission is \$40.8 million to \$61.3 million depending on the percentage selected, and assuming an 8 percent increase in total premium revenues. In 2008, assuming as much as 10 percent average annual growth in premiums, the range of available funds is \$66.7 million to \$100 million. Mathematica Study at III-52, Table 7.

In other words, in order to meet its charitable obligation under its charter, GHMSI could and should be spending approximately \$50 million currently and, in 2008, on the order of \$100 million per year on community activities, and it is capable of doing so without evident risk to its competitive viability or its financial soundness. And yet—to repeat—during 2004 it plans to spend only about \$1 million in meeting that charitable obligation. Of course, this additional spending should be managed with flexibility, taking into account circumstances that would dictate a higher or lower spending level over time. Mathematica Study at III-54. But it should be managed in a way that is at all times faithful to the company’s primary purpose—to spend the maximum amount possible on community benefits, consistent with the need to remain competitive and viable.

IX. COMMENTS FROM GHMSI

As noted, in preparing this report we met several times with GHMSI representatives to learn their views and future plans concerning increasing the company’s commitment to community activities. In the course of those meetings we asked for specific information from the company indicating how it was measuring the amount of dollars it had available for community activities, what that dollar amount will be for 2004, and what it expected that amount to be in 2005. The company did not provide us information detailing its methodology for computing available dollars or any estimate of

the amount it would spend in 2005; it did advise us, however, that the amount it expected to spend in 2004 was approximately \$1 million.

We provided the company a draft of this report setting out in detail our own methodology and solicited the company's comments. In the company's responsive comments it still has not indicated how it intends to compute the dollars it will spend on community benefits, or how much it intends to spend; but it has raised concerns with the amounts we have computed and with the methodology we used to compute them. Those concerns are addressed at various places in our legal and economic analyses. Here, we summarize a number of those responses. None of these issues causes us to change our analysis.

First, GHMSI says that we are objecting to the fact that its reserves exceed the lowest reserve levels required by insurance regulators. But that is not correct. We understand that regulatory minimums are established in order to identify circumstances in which special regulatory attention is required to ensure a plan's fiscal integrity. It follows, accordingly, that various companies' capital requirements may require surplus levels well in excess of those minimums. The surplus that the Blue Cross Blue Shield Association requires of its licensees, including GHMSI, which is almost twice as high as the regulatory minimum, reflects that view. Our point is that the company's reserves are very high by *any* standard and, that, were GHMSI to reduce its rate of surplus build-up and spend 2 to 3 percent of its premiums on charitable activities, its reserves would still be well above the minimum levels needed for financial soundness.

Second, in an apparent effort to suggest a measurement of surpluses other than those we used to derive our recommended 2-to-3-percent-of-premiums, the company says that while its reserves are indeed significant, they average out to under \$405 per member, which, the company says is less than the cost of a visit to a hospital emergency room. As the Mathematica Study points out, however, this is not a standard used by any regulator to measure adequacy of reserves. It implies that every subscriber may be expected to use a hospital emergency room within the same year, which is, of course, not the case; it also implies that GHMSI's already high surpluses should be vastly higher still, which GHMSI itself does not suggest; and it finally implies that GHMSI should retain all of its current surpluses for possible medical claims, which GHMSI also does not suggest. To the contrary, GHMSI has emphasized the many business uses of its surpluses, including information technology and new product development. Mathematica Study, III-52 n.44. In the end, the reference to the \$405 per member is not a meaningful one.

The same is true of another measure GHMSI suggests. It says that it is committed to spending more than the 1.5 percent charitable giving goal set by The Conference Board. But the Conference Board merely measures the average charitable giving of corporations—both for-profit and nonprofit—and measures that giving as a percentage of operating profits. None of this is relevant here. The Conference Board does not purport to set a standard for charitable nonprofits such as GHMSI. And, as the Mathematica Study shows, when one looks to the amounts committed to community benefits by nonprofits that are *comparable* to GHMSI, the range of their commitment is from 1.5 to 3 percent of their premiums.

Next, GHMSI implies that it may need to spend some of its very high reserves on unspecified capital investments, product development, and information technology. It puts the number at \$300 million for all of CareFirst over the next three years. Because GHMSI has provided us no information explaining this figure, it is impossible to assess it in light of the company's obligation to

spend the maximum amount possible on community benefits, consistent with its need to remain viable and competitive. We believe the company must show that the claimed \$300 million meets that standard if it is going to invoke that number as a reason for making no increases, or only insubstantial increases, in its charitable spending. In any case, \$300 million is a number for all of Care First. If half of this number were attributable to GHMSI, the Mathematica Study shows that GHMSI could spend 2 percent of premiums on charitable activities and still maintain reserves above that recommended by the Blue Cross Blue Shield Association. Mathematica Study, III-52, n. 44.

The company also states that it has a fiduciary duty to ensure that it has adequate reserves in the event of, for example, a severe flu season or a terrorist attack. We don't disagree with this point, but it does not distinguish GHMSI from its competitors, whose reserves are considerably lower. Every insurance company, particularly those in the National Capital area, presumably must set aside appropriate amounts to address the kinds of contingencies GHMSI describes. Presumably GHMSI and its competitors have already done that, and GHMSI already has significantly higher reserves than its competitors in this area. If the company now believes that it needs to raise those high reserves even higher to account for such contingencies—as a justification for not increasing its charitable expenditures—it should demonstrate with specificity why that is so.

Finally, GHMSI says that we have not fully taken into account all of the community benefits it is providing. Here, the issue relates not to GHMSI's financial capacity to fulfill its charitable obligation, but to the kinds of expenditures that should count in determining the extent to which it is fulfilling that obligation. We consider the issue of what counts as separate from the primary focus of our report. With that caveat, we note that GHMSI says, for example, that it contributes to the Rate Stabilization Fund in the District and to the Maryland Senior Prescription Drug Plan in Maryland. But these payments are specifically required by local statute, in order to account for the fact that the companies (GHMSI in DC and CareFirst in Maryland) are exempt from those jurisdictions' premium taxes. Covington Analysis, p. II-9 n. 19, p. II-30 n. 82. The dollars that GHMSI puts into those programs are dollars that it would otherwise pay in taxes. Thus, we would not consider such payments to be part of GHMSI's additional community-benefit obligation under its federal charter. And, in any case, the Mathematica Study has measured GHMSI's capability to pay for community benefits *above* those it is already expending; so these statutorily-required payments have already been accounted for in determining that GHMSI could afford to commit an *additional* 2 to 3 percent of its premiums. Mathematica Study, p. III-vi. As a last point, GHMSI also mentions that it provided \$100,000 to the Whitman-Walker Clinic toward the purchase of two mobile mini-labs for HIV/AIDS testing. If this was not included in the \$1 million estimate the company gave us for its 2004 community benefits spending, we agree it should be included. But this does not change the fact that GHMSI is still spending only approximately \$1 million on community benefits, leaving a vast gap between what the company is actually spending and what it could and should be spending.

X. CONCLUSION

GHMSI has departed significantly from its charitable mission. As measured by the work in the Covington Analysis and the Mathematica Study, GHMSI has not yet begun to return to that mission. It should now do so. And it should begin by immediately committing 2 to 3 % of its premiums to its charitable mission. That level of commitment, flexibly managed, could greatly benefit many healthcare needs in the National Capital area and present no evident risk to GHMSI's competitive viability or financial soundness. GHMSI owes it to the community to start meeting

those needs. GHMSI's board of directors has a range of reasonable discretion in determining how to meet those needs, but its legal obligation to do so is clear. We urge it to act promptly and decisively to meet that obligation.

Section 2:

GHMSI's Legal Obligation to Pursue a Charitable, Public Health Mission



DC APPLESEED
C E N T E R

GHMSI's Legal Obligation to Pursue a Charitable, Public Health Mission

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The DC Appleseed Center for Law and Justice, Inc. (“DC Appleseed”) asked Covington & Burling to analyze whether Group Hospitalization and Medical Services, Inc. (“GHMSI”) has an obligation under its federal charter or under other applicable law to behave as a charitable institution and, if so, what that obligation entails and what vehicle exists to enforce the obligation. As explained below, we conclude that GHMSI does have an obligation to pursue a charitable mission. We conclude that this mission entails support of public health initiatives as a priority and to the extent of GHMSI’s available surplus, *i.e.*, to the maximum extent that is consistent with financial soundness. We also conclude that both the District of Columbia Department of Insurance, Securities and Banking (“DISB”) and the Office of the Attorney General of the District of Columbia (“OAG”) have the authority and legal responsibility to ensure that GHMSI complies with its charitable mission.

Background

GHMSI is the congressionally-chartered, not-for-profit entity that operates as CareFirst Blue Cross Blue Shield of the National Capital Area, doing business in the District of Columbia, Montgomery and Prince George’s Counties in Maryland, and in a portion of Northern Virginia. Congress chartered GHMSI’s predecessor, Group Hospitalization, Inc. (“GHI”), by Act of August 11, 1939.¹ Congress amended the charter in 1984 to reflect the planned merger combining GHI with Medical Services, Inc., to form GHMSI;² and in 1993, to bring GHMSI under the regulatory authority of the District of Columbia.³

Congress further amended GHMSI’s charter in December 16, 1997, authorizing GHMSI to have a non-profit corporate member.⁴ The 1997 amendments to GHMSI’s charter permitted GHMSI, once it had obtained the approval of District of Columbia Department of Insurance and Securities Regulation (“DISR,” the predecessor agency to DISB), to affiliate with Blue Cross and Blue Shield of Maryland (“BCBSMD,” now known as CareFirst of Maryland, Inc.) under a holding company, which took the name CareFirst, Inc. (“CareFirst”). CareFirst is a Maryland-chartered non-stock corporation.

Section 8 of GHMSI’s federal charter declares GHMSI “to be a charitable and benevolent institution.”⁵ When GHMSI sought DISR approval to affiliate with BCBSMD, opponents of the

¹ See Pub. L. No. 395, 53 Stat. 1412.

² See Pub. L. No. 98-493, 98 Stat. 2272 (Oct. 17, 1984).

³ See Pub. L. No. 103-127, § 138, 107 Stat. 1336, 1349 (Oct. 29, 1993) (amending GHMSI Charter § 5 to provide that “The corporation shall be licensed and regulated by the District of Columbia in accordance with the laws and regulations of the District of Columbia”). This permanent charter amendment followed a temporary amendment to the same effect enacted as part of District of Columbia appropriations legislation. See Pub. L. No. 102-382, § 137, 106 Stat. 1422, 1435 (Oct. 5, 1992).

⁴ See Pub. L. No. 105-149, 111 Stat. 2684.

⁵ The full text of section 8 of the GHMSI charter is as follows:

Sec. 8. This corporation is hereby declared to be a charitable and benevolent institution, and all of its funds and property shall be exempt

(continued...)

operational merger argued that the proposed transaction effectively amounted to a “conversion” of the company to for-profit status that would place GHMSI’s charitable assets at risk.⁶ DISR Interim Commissioner Patrick Kelly approved the affiliation and holding company structure without resolving the issue of what, if any, obligations flowed from the charter declaration that GHMSI is to be a charitable and benevolent institution. Commissioner Kelly stated that “GHMSI’s ‘charitable and benevolent’ status is reinforced by this Order,” and ordered that GHMSI “continue to be bound by, and to conduct its affairs pursuant to, the requirements contained in its federal charter as a ‘charitable and benevolent institution,’ unless and until authority to deviate from such provisions is granted by the United States Congress.”⁷ However, finding that the proposed transaction would not be a conversion, Commissioner Kelly also declared that “the issue of whether or not GHMSI is a ‘charity’ does not need to be determined at this time.”⁸ Thus, the 1997 DISR Order deferred the question of the meaning and ramifications of GHMSI’s status under its charter as a “charitable and benevolent institution.”

GHMSI and its affiliates became the subject of heightened attention by insurance regulators and health care consumer advocates in late 2001, when WellPoint Health Networks, Inc. (“WellPoint”), a large California-based health insurer, announced it would seek regulatory approval to acquire CareFirst and its subsidiaries. On January 11, 2002, CareFirst and WellPoint submitted their consolidated conversion and acquisition application to the Maryland Insurance Administration (“MIA”). On the same day, WellPoint, CareFirst and GHMSI submitted a similar application to DISR (now DISB) and to the Office of Corporation Counsel of the District of Columbia (“OCC,” now known as the Office of the Attorney General of the District of Columbia).⁹ The proposed acquisition entailed, as a first step, the conversion of CareFirst and its subsidiaries to for-profit status. The parties also called for WellPoint’s payment of the proposed acquisition price,

from taxation other than taxes on real estate and unemployment compensation.

Section 8 of GHI’s 1939 charter contained nearly identical language:

Sec. 8. This corporation is hereby declared to be a charitable and benevolent institution, and all of its funds and property shall be exempt from taxation other than taxes on real estate.

53 Stat. at 1414.

⁶ See Decision and Order dated December 23, 1997 in *In Re: Group Hospitalization and Medical Services, Inc.* (DISR Docket No. A-HC-97-01) (“1997 DISR Order”) at 9.

⁷ *Id.* at 15, 17.

⁸ *Id.* at 12; see also *Fair Care Foundation v. DISR*, 716 A. 2d 987, 990 (D.C. 1998) (noting that DISR had “declined to address, as not ripe, the question of whether GHMSI is a charitable institution with charitable set-aside obligations”).

⁹ In addition, because of an affiliation agreement between CareFirst and Blue Cross and Blue Shield of Delaware, Inc. (“BCBSDE”), approval by the Delaware Commissioner of Insurance was required for some aspects of the proposed transaction. WellPoint, CareFirst and BCBSDE filed their application with the Delaware Department of Insurance on January 11, 2002.

approximately \$1.3 billion, into a charitable trust committed to “[f]unding for the [p]ublic [g]ood”¹⁰ in the service areas where CareFirst affiliates are licensed to do business. The proposal gave rise to a firestorm of questions about whether the agreed purchase price was fair, whether the CareFirst companies’ conversion to for-profit status was in the public interest, and (in the event the transaction was approved) how the funds made available for the benefit of the public should be administered and used.

Review of the proposed transaction proceeded concurrently but independently in each jurisdiction, with the applicants amending, or withdrawing and re-filing their applications with the various regulators. In the District, where the review process was governed by the Hospital and Medical Services Corporation Regulatory Act (D.C. Code § 31-3501 *et seq.*) and the Holding Company System Act (D.C. Code § 31-701 *et seq.*), the parties to the DISR review proceeding were CareFirst, GHMSI and WellPoint, which were represented by common counsel, and DC Appleseed, which applied for and was granted party status. DISR subpoenaed documents, and applicants and DC Appleseed commenced document discovery. OCC, which had responsibility to review the transaction under the Healthcare Entity Conversion Act (D.C. Code § 44-601 *et seq.*), also commenced document discovery. In addition, DISR, OCC and DC Appleseed retained experts to review the proposed transaction.¹¹

The review process was on a swift track in Maryland, where MIA had broad subpoena and discovery powers and the authority to conduct *ex parte* hearings. Then-MIA Commissioner Steven

¹⁰ CareFirst Amended Form A Statement Regarding the Acquisition of Control Of Or Merger With A Domestic Insurer filed with DISR on August 19, 2002 (“Amended Statement Supplement”) at 11.

¹¹ Along with the law firm of Harkins Cunningham, Covington & Burling acted as *pro bono* counsel to DC Appleseed during the pendency of review proceedings in the District. Covington & Burling also provided advice to DC Appleseed in its role as a member of CareFirst Watch, a coalition of metropolitan Washington health care providers, consumer advocates, and good-government groups formed to monitor, and to educate the public and to formulate and advance policy positions with respect to, the proposed conversion and acquisition and the use of charitable assets that would be paid to a foundation for the benefit of the public if the transaction were approved. CareFirst Watch held public meetings about the proposed conversion and acquisition. In addition, DC Appleseed, with the support of CareFirst Watch, successfully petitioned the Council of the District of Columbia (“the D.C. Council”) to adopt changes to the insurance company conversion and acquisition review statutes to place the burden on the applicants to establish that the proposed transaction would be in the public interest and to clarify procedural rules regarding party status in DISR review proceedings. Subsequent to withdrawal of the conversion and acquisition application that had been submitted to DISR, DC Appleseed, with the support of CareFirst Watch, drafted and circulated to the D.C. Council and to DISR draft legislation that would require GHMSI to operate as a charitable and benevolent institution.

DC Appleseed has commissioned a number of studies and analyses by experts pertinent to the proposed WellPoint acquisition and the performance of GHMSI. In addition to the expert analyses mentioned later in this memorandum, DC Appleseed commissioned the March 4, 2003 report by Professor Richard F. Meyer of the Harvard Business School, entitled *The Valuation of CareFirst*, and an October 2003 supplement, *Valuation of the D.C., Maryland, and Delaware Blue Cross Blue Shields*.

B. Larsen conducted the questioning at a series of public, evidentiary hearings held during March, April and December 2002 and January and February 2003.

The proposed conversion and acquisition came to a halt after MIA Commissioner Larsen disapproved the conversion and acquisition proposal on March 5, 2003, and District of Columbia Insurance Commissioner Lawrence Mirel subsequently suspended proceedings in the District. The starting point for Commissioner Larsen's analysis was the recognition that CareFirst of Maryland, Inc. has a public mission, articulated in its articles of incorporation and bylaws, to provide health care and services "at a minimum cost and expense" and an acknowledged duty to the public as an insurer of last resort. Report of the Maryland Insurance Administration, Steven B. Larsen, Commissioner, Regarding the Proposed Conversion of CareFirst, Inc., to For-Profit Status and Acquisition By WellPoint Health Networks, Inc., issued in MIA No. 2003-02-032 ("Larsen Decision") at 23, 24, 31, 96. Commissioner Larsen found, however, that in deciding that CareFirst and its subsidiaries should convert to for-profit status and should be acquired by WellPoint, the CareFirst Board of Directors had ignored or disregarded the insurer's corporate mission, failed to focus on the public interest, and failed to consider how the transaction would impact the accessibility and affordability of health care. Larsen Decision, *passim*.

Commissioner Larsen found further that the CareFirst Board had agreed to sell the company for less than fair value and had failed to demonstrate that the company needed to convert in order to meet its non-merger capital needs. In addition, he found that CareFirst management had been influenced primarily by the prospect of their own enrichment as a result of the planned conversion and acquisition, in violation of applicable anti-inurement law. Commissioner Larsen observed that CareFirst had been operating like a for-profit company for many years despite its legal obligation to adhere to a public-interest mission. He found that, despite their duty to advance the company's charitable goals and to "obey the articulated mission of the corporation," *id.* at 74-75, CareFirst's directors were focused on achieving growth and market dominance, on exiting unprofitable market segments, and on underwriting margins, rather than on the goal of providing insurance at minimum cost and expense. *Id.* at 95, 101.

After the collapse of the CareFirst/WellPoint conversion and acquisition proposal, the public debate shifted from whether and at what price conversion and acquisition should be permitted, to what changes should be made in the CareFirst entities' manner of operation going forward. In April 2003, the Maryland legislature responded by passing legislation that required CareFirst to reaffirm its mission as a nonprofit company; called for replacement of several Maryland-appointed CareFirst Board members with members designated by Maryland political leaders; required that compensation paid to directors, officers, and employees of CareFirst be consistent with compensation paid by similar not-for-profit companies; required the company to offer health care products in the individual and small employer group markets and to administer and subsidize Maryland's Senior Prescription Drug Program; and required the company to devote funds equal to the value of the company's premium tax exemption in a manner that serves the public interest.¹²

¹² The legislation was later modified to accommodate objections that the Maryland law encroached on the District of Columbia's regulatory jurisdiction over GHMSI, and concern by the national Blue Cross Blue (continued...)

Reacting to the Maryland legislation, District Insurance Commissioner Mirel cautioned that his office would not permit the imposition of conditions on the operations and governance of GHMSI that are “likely to render GHMSI uncompetitive and therefore not viable.”¹³ Among the conditions that Commissioner Mirel cited as likely to undermine GHMSI’s viability would be forcing GHMSI “to insure persons that competing insurers will not insure, and to charge less for its insurance than competitors charge;” Commissioner Mirel stated that “[i]n today’s highly competitive health insurance market, that would quickly put CareFirst and GHMSI out of business.”¹⁴ He warned that “to force the company to provide services and benefits beyond those already provided will threaten the company’s continued economic viability.”¹⁵

In the view of many health care consumer advocates in the District, the combined impact of (i) the collapse of the WellPoint/CareFirst transaction and (ii) DISB’s efforts to protect GHMSI from the reach of the Maryland legislation that seeks to enforce a public-interest mission for the CareFirst organization, is the worst of all possible worlds: no current prospect of the proceeds of a conversion and acquisition being paid into a foundation to serve the health needs of the public, and a regulatory environment in which GHMSI may continue operating like a for-profit company and avoid pursuing a public-interest mission. These advocates contend that, because of the declaration in its federal charter that GHMSI is a “charitable and benevolent institution,” GHMSI has an obligation, that goes beyond the open-enrollment requirements of District insurance law,¹⁶ to conduct its operations for the benefit of the public and to support public health initiatives.

On the other hand, CareFirst, at least in its August 2002 Amended Statement Supplement supporting the proposed conversion, has urged that the statement in GHMSI’s federal charter declaring it to be a charitable and benevolent institution “does not change GHMSI’s corporate purpose or obligations,” Amended Statement Supplement at 30, and imposes no special obligation on GHMSI other than a constraint against distributing its profits or net earnings to those who control the company. *Id.* at 29. CareFirst asserted that “GHMSI’s status as a nonprofit corporation

Shield Association (“BCBSA”) that the Maryland legislation unacceptably established government control over a Blue Cross Blue Shield franchisee.

¹³ Letter from DISR Commissioner Lawrence H. Mirel to Maryland Governor Robert L. Ehrlich, Jr., at 3 (April 15, 2003).

¹⁴ *Id.* at 2.

¹⁵ Letter from DISR Commissioner Lawrence H. Mirel to D.C. Council Chair Linda Cropp and Council Member Sharon Ambrose, at 3 (May 23, 2003).

¹⁶ Under District law, GHMSI is regulated as a Hospital and Medical Services Corporation. It is required to make available to D.C. residents, on a year-round basis, an open enrollment program that provides for the issuance of contracts without imposition of underwriting criteria whereby coverage is denied or subject to cancellation or non-renewal, in whole or in part, because of an individual’s age, health history, medical history, employment status, or industry or job classification. *See* D.C. Code § 31-3514. As an incentive to maintain an open enrollment program, GHMSI is entitled to pay District premium taxes at a reduced rate, but the rates it charges to open enrollment subscribers must include “a factor crediting for the benefit of this class of subscribers in an amount which assures competitive rates,” the revenue that otherwise would have been collected by the District as a premium tax. *Id.*, § 31-3514(l); *see also id.*, § 31-3508(e)(3).

does not give rise to an esoteric charitable and benevolent obligation different from its chartered purpose,” which CareFirst identified as “to provide hospitalization and medical care to its subscribers.” *Id.* CareFirst told DISR that “charitable donations and community involvement are not part of [GHMSI’s] chartered purpose.” *Id.* at 31. For his part, Commissioner Mirel has acknowledged “the obligation of GHMSI to operate as a non-profit charitable and benevolent organization,” but has asked ““what that means” and stated that he wants “to make sure that we do not require GHMSI to take on new burdens that will destroy its ability to serve its policyholders.”¹⁷

GHMSI itself is studying the issues that have been raised during and in the wake of the regulatory review proceedings and, we understand, may hold views about its mission different from those presented in the applicants’ joint submissions and different from those it presented to District regulators when proposing the affiliation with CareFirst. GHMSI also has filed a petition with the CareFirst Board to become affiliated with CareFirst solely by contract, rather than by corporate structure, a change that presumably would enable the GHMSI Board of Directors to exert more significant control over the insurer’s direction.

The foregoing developments establish that the issues that DC Appleseed has identified -- defining GHMSI’s obligations to the citizens of the National Capital Area and how those obligations may be enforced -- are important, and that DC Appleseed’s request for an analysis of the issues is timely.

Our analysis begins with the issue of whether GHMSI does in fact have an obligation established by its federal charter or other applicable law to pursue a mission as a charitable and benevolent institution. We then identify and discuss case law pertinent to what types of activities and practices by a health care insurer would be consistent with operation as a “charitable” organization, as courts have construed the term. Thus, we attempt to answer the question of “what it means” for GHMSI to be a charitable and benevolent institution.¹⁸ Finally, we analyze what responsibility and authority District regulators have to ensure that GHMSI complies with its chartered mission as a charitable institution.

SUMMARY OF CONCLUSIONS

We conclude that GHMSI does have a legal obligation to pursue a charitable mission, to provide a substantial community benefit to the public beyond its current policyholders, and to support and foster public health initiatives in its service area. This obligation is not in derogation of GHMSI’s

¹⁷ Letter from DISR Commissioner Lawrence H. Mirel to D.C. Council Chair Linda Cropp and Council Member Sharon Ambrose, at 4 (May 23, 2003).

¹⁸ An additional issue, that of whether GHMSI can take on new burdens associated with a charitable mission while remaining viable and satisfying applicable financial requirements, is beyond the scope of this memorandum. DC Appleseed has engaged Mathematica Policy Research, under the direction of economist Deborah Chollet and in cooperation with Jack Needleman at UCLA and Larry Brown at Columbia University, to prepare an analysis of that issue.

continuing role in offering health insurance at commercial rates in competitive markets; but, as we explain below:

- GHMSI's charter language establishes, and the legislative history of its charter amendments confirms, that GHMSI is to be a charitable institution. No sound legal basis exists for ignoring, or for refusing to give practical significance to, the charter declaration. Pursuing a charitable mission is consistent with GHMSI's charter mandate to operate for the benefit of policyholders and with its charter authority to engage in activities to promote and safeguard the public health.
- As a health insurer pursuing a charitable mission, GHMSI should pursue activities such as
 - offering health education programs and conducting health data analysis and health research programs for the benefit of the public in its service area;
 - offering subsidized or low-cost coverage to a large number of persons;
 - addressing and accommodating the needs of high-risk individuals and small groups;
 - participating in public programs such as Medicaid and Medicare; and
 - selecting a board of directors broadly representative of the community.
- GHMSI has an obligation to pursue such charitable activities as a primary purpose of its operations, not as mere incidental activities. This obligation requires GHMSI to support such activities to the maximum feasible extent consistent with its financial soundness. A policy or practice of deciding what residual amount GHMSI can spend for charitable purposes only after allocating the company's net earnings to other corporate goals is not consistent with GHMSI's charitable mission.
- District regulators have an obligation not only to safeguard GHMSI's financial health and to protect GHMSI's assets in the event of a conversion, but also to ensure that GHMSI's Board and management cause the company to comply with its obligations as a charitable institution.

ANALYSIS

I. GHMSI Has An Obligation to Pursue A Charitable, Public Health Mission.

We conclude that GHMSI has an obligation to pursue a charitable, public health mission. That obligation is grounded both in its federal charter and in District of Columbia law.

A. GHMSI Is Bound By Its Chartered Purpose As A “Charitable and Benevolent Institution.”

Conventional principles of statutory construction provide the starting point for an analysis of what GHMSI's federal charter – the congressional Act of August 11, 1939 – requires. A federal statute is to be interpreted so as to give effect to all of its terms. *See Hibbs v. Winn*, 124 S. Ct. 2276,

2286 (2004) (citing 2A N. Singer, *Statutes and Statutory Construction* § 46.06, at 181-186 (6th ed. 2000) for the principle that a “statute should be construed so that effect is given to all its provisions, so that no part will be inoperative or superfluous, void or insignificant”); *TRW, Inc. v. Anderson*, 534 U.S. 19, 31 (2001) (if possible, every word in a statute must be given effect). In 1939, as now, “the words of [a] statute should be construed according to their ordinary sense and with the meaning commonly attributed to them.” *D.C. v. Cato Institute*, 829 A. 2d 237, 240 (D.C. 2003) (citing *E.R.B. v. J.H.F.*, 496 A.2d 607, 609 (D.C. 1985) (quoting *Davis v. United States*, 397 A.2d 951, 956 (D.C. 1979)); *United States v. Goldenberg*, 168 U.S. 95, 102-03 (1897) (“the intent of the lawmaker is to be found in the language that he has used”).

It has been suggested, however, that the declaration in section 8 of GHMSI’s charter that it is to be “a charitable and benevolent institution” was solely for the purpose of conferring tax-exempt status on the corporation, and is obsolete and of no legal effect given that GHMSI (like other Blue Cross/Blue Shield insurers) has long paid federal taxes.¹⁹ This is the thrust of the argument that CareFirst made in its August 2002 Amended Statement and that GHMSI made in a 1997 memorandum submitted to DISR in connection with its proposed affiliation with CareFirst.²⁰ Our analysis persuades us that this argument is untenable. The relevant statutory language, interpretive case law, and legislative history will not sustain a conclusion that GHMSI’s charter declaration as a “charitable and benevolent institution” is meaningless or obsolete.

As CareFirst noted in its Amended Statement, “[t]he charitable and benevolent declaration is common language in tax-exemption provisions.”²¹ Of particular note, many state legislatures incorporated such declarations into Blue-Cross-plan enabling statutes, in an effort to qualify the plans for tax exemption, in many cases adopting language that had been drafted by the American

¹⁹ Since January 1, 1987, GHMSI has paid federal income tax. In addition, GHMSI pays real estate, unemployment, franchise, social security, Medicare, excise, public safety and arena taxes and premium taxes. See Group Hospitalization and Medical Services, Inc. Opposition to the Fair Care Foundation’s Petition to Intervene, October 4, 1997 at 15 (submitted in *In the Matter of Group Hospitalization and Medical Services, Inc.*, DISR Docket No. A-HC-97-01) (“1997 GHMSI Memorandum”).

As long as GHMSI maintains an open enrollment program, it is subject to a District premium tax of only 1 percent instead of the 1.7 percent premium tax established under D.C. Code § 47-2608. See D.C. Code § 31-3514(j). Moreover, GHMSI may elect either to pay the 1% premium tax rate or to contribute an equivalent amount to a Rate Stabilization Fund, which “shall be used solely to subsidize open enrollment contracts to assure competitive rates.” *Id.*, § 31-3514(j)(1); see also D.C. Code § 31-3508(e)(3) (“the revenue which would have been otherwise collected by the District of Columbia government through the imposition of the 1% premium tax pursuant to § 31-3514(j), but which a corporation has contributed to a Rate Stabilization Fund in accordance with § 31-3514(j)(1), shall be credited by the corporation to the benefit of this class of subscribers in an amount which assures competitive rates”).

²⁰ GHMSI argued that “while Section 8 of GHMSI’s Charter does describe GHMSI as a ‘charitable and benevolent institution,’ it is clear from a review of similar state law provisions governing Blue Cross and Blue Shield Plans that this language was used in an attempt to exempt Plans from income taxes.” *Id.* at 14.

²¹ Amended Statement Supplement at 30 (citing the example of D.C. Code § 31-5320, declaring fraternal benefit societies, which D.C. Code 31-5301 recognizes are operated for the benefit of their members, to be charitable and benevolent institutions).

Hospital Association (“AHA”).²² The AHA language apparently was designed to establish a basis for Blue Cross plan tax exemptions in states whose constitutions limited tax-exempt status to charitable institutions.²³

The language of section 8 of GHMSI’s charter undeniably is similar to language that state legislatures have included in the enabling legislation of Blue Cross organizations, fraternal benefit societies and other organizations for the (possibly sole) purpose of affording them exemption from taxes. However, the implication that *Congress* needed to express a “premise” in order to confer tax exemption (and that the declaration of GHMSI’s charitable and benevolent status was intended as nothing more than a predicate for tax exemption) is highly dubious. Congress has plenary power over taxation. It was already well-established at the time Congress chartered GHMSI’s predecessor, GHI, that Congress may afford tax exemption as it sees fit; it need not declare an organization “charitable” to achieve that result.²⁴ Furthermore, in laws passed both before and after the Act of August 11, 1939, Congress has on many occasions specified that entities or their properties are to be tax exempt without declaring them to be charitable institutions.²⁵ We conclude, therefore, that

²² See *Illinois Hospital & Health Service, Inc. v. Aurand*, 373 N.E. 2d 1021, 1024 (Ill. App. Ct. 1978); *Associated Hospital Service, Inc. v. Milwaukee*, 109 N.W.2d 271, 274-275 nn. 2 and 3 (Wisc. 1961). The model AHA statutory language stated that “Every corporation subject to the provisions of this act is hereby declared to be a charitable and benevolent institution, and its funds, operations, and properties shall be exempt from taxation.” *Id.* at 275.

²³ See e.g., *Illinois Hospital & Health Service*, 373 N.E. 2d at 1022 (discussing article IX, section 6 of the Illinois Constitution of 1970, which stated in pertinent part that “The General Assembly by law may exempt from taxation only the property of the State, units of local government and school districts and property used exclusively for agricultural and horticultural societies, and for school, religious, cemetery and charitable purposes”); *Dickison v. Woodmen of the World Life Ins. Soc’y*, 280 S.W. 2d 315 (Ct. Civ. App. Tex. 1955) (considering a Texas statute declaring fraternal benefit societies to be “charitable and benevolent” institutions and purporting to exempt them from property taxes, and invalidating the statute in light of Art. 8, sec. 2 of the Texas Constitution, which permitted the legislature to afford property tax exemptions only to property used exclusively by “institutions of purely public charity”).

²⁴ See, e.g., *Steward Machine Co. v. Davis*, 301 U.S. 548, 584 (1937) (Congress has broad latitude in taxing and may tax a particular kind of business and exempt some other kinds of businesses closely akin thereto). By contrast, some state constitutions restrict tax exemptions to “charitable” organizations, thus constraining state legislatures in their dispensing of tax breaks. See note 23, *supra*.

²⁵ See, e.g., 36 U.S.C. § 22507 (codification of 1925 federal charter provision declaring that the personal property and income of American War Mothers are exempt from taxation “so long as held or used only to carry out the purposes of the corporation”); 36 U.S.C. § 70706 (codification of 1900 federal charter provision exempting a property owned by the Frederick Douglass Memorial and Historical Association from taxation “as long as the property is used for the purposes of the corporation”); and 45 U.S.C. § 581(c)(5) (1988) (exempting from taxation local rail companies that took over Conrail commuter operations), quoted in *SEPTA v. Pennsylvania Pub. Util. Comm’n.*, 826 F. Supp. 1506, 1511 (E.D. Pa. 1993). In each of these provisions, Congress conferred tax exemption without declaring the affected entity to have “charitable and benevolent” status (or any other status) as a “premise” for the exemption.

Congress's declaration that GHMSI is to be a charitable and benevolent institution cannot be dismissed as merely a (now-obsolete) predicate for tax exemption.²⁶

It has been argued, however, that, even if Congress did not need a premise to confer tax exemption, in section 8 of GHMSI's charter, Congress nonetheless used formulaic language that had been used by other legislatures for the purpose of conferring tax exemption and that is devoid of any other meaning. That argument might have some force if Congress had utilized the formulaic language and left it to stand with no further attention and no further indication that it intended GHMSI to be a charitable institution. But that is not the case. The post-1939 legislative history of GHMSI's charter shows that neither the charter itself nor section 8 in particular can be disregarded as a forgotten and obsolete remnant of a bygone era.²⁷

Congress has amended or proposed to amend GHMSI's charter numerous times since 1939.²⁸ In amending the charter in 1984, Congress focused specifically on section 8, changing its language so as to narrow GHMSI's tax exemption to an exemption from all but real estate and unemployment compensation taxes. (Previously, real estate taxes had been the only exception.) Thus, in the mid-

²⁶ We note, moreover, that an analysis focusing on the sentence structure of section 8 of the charter probably should take into account the margin notes to section 8 of the original GHI charter (the Act of August 11, 1939) as printed in the Statutes-at-Large. The margin notes to section 8 read: "Purposes declared; property tax-exempt; exception." 53 Stat. 1414 (1939). The format of this notation -- in particular the use of semi-colons, which are used to denote independent ideas -- suggests that the first clause of section 8 (the declaration of the corporation's status as a charitable and benevolent institution) is independent of the tax exemption described in the second clause. Commas may be used to separate either dependent or independent clauses, *see Dan's Super Market, Inc. v. Wal-Mart Stores, Inc.*, 38 F. 3d 1003, 1006 (8th Cir. 1994), and *Washington Ins. Guaranty Ass'n v. Guaranty Nat'l Ins. Co.*, 685 F. Supp. 1160, 1164 (W.D. Wash. 1988); but semi-colons "are a veritable declaration of independent clauses." *Bill Call Ford, Inc. v. Ford Motor Co.*, 830 F. Supp. 1053, 1057 n. 2 (N.D. Ohio 1993).

²⁷ It is also worth observing that, by 1939, Congress had established its own formulaic language for conferring tax exemption, and might have used that language if tax exemption had been all it intended to accomplish by its declaration of GHI's charitable and benevolent status. Section 101(8) of the Internal Revenue Code of 1939, in language similar to that of current section 501(c)(3) of the Internal Revenue Code, provided for exemption from federal income taxes of organizations "operated exclusively" for charitable purposes. *See* 53 Stat. 1, 33 (1939). Congress has sometimes used that formulaic language in chartering entities. *See, e.g.,* 36 U.S.C. § 80102 (codification of 1901 charter language providing that the General Federation of Women's Clubs "shall be organized and operated exclusively for charitable and educational purposes within the meaning of . . . the Internal Revenue Code . . . and shall comply with the requirements for classification as a tax exempt organization"). But that is not the language Congress used in GHMSI's federal charter; instead, Congress declared GHI "to be a charitable and benevolent institution," and separately conferred tax exemption by providing that GHI "shall be exempt from taxation other than taxes on real estate."

²⁸ In addition to enacted charter amendments, bills to amend GHMSI's charter were introduced but not enacted in 1949 (S. 1592, 81st Cong., 1st Sess.), 1958 (*see* 104 Cong. Rec. 14934 (July 24, 1958)), and 1960 (*see* S. 3663, H.R. 12520 and H.R. 12535, 86th Cong., 2d Sess.).

1980's, section 8 was not merely an "obscure and forgotten portion" of the charter.²⁹ Further, Congress did not treat the language of section 8 as a formula, but as plain, living language. Section 8 was front and center, but Congress did not disturb the declaration that GHMSI is a "charitable and benevolent institution."

Congress's failure to remove the charitable and benevolent language when it amended GHMSI's charter cannot be attributed to a lack of awareness of how the company had grown and evolved or to a misperception about GHMSI's need for economic development incentives.³⁰ During the debate on the 1984 charter amendments, Congress was made aware that GHMSI was "pretty much a commercial type of enterprise as contrasted to the way this move started in 1939." 130 Cong. Rec. 25522 (1984) (floor statement of Rep. Kindness). Similarly, when Congress amended GHMSI's charter in 1993, it recognized that the company had "grown well beyond original congressional expectation." 139 Cong. Rec. 16964 (1993) (statement of Rep. Stark); 139 Cong. Rec. 17036 (1993) (statement of Sen. Nunn).

Nor can Congress's retention of the section 8 declaration of GHMSI's "charitable and benevolent institution" be attributed to congressional inattention. Far from overlooking GHMSI's declared status as a "charitable and benevolent institution," the congressional debate that preceded the 1997 GHMSI charter amendments emphasized the importance of preserving GHMSI's status. Delegate Norton explained that she could support the legislation permitting GHMSI's affiliation with CareFirst because GHMSI could "make no change in its nature, purpose, or structure without the Congress taking further action on its charter, and, again, I emphasize that."³¹ Representative Cardin endorsed Delegate Norton's remarks, commenting that the legislation "makes it clear that the benevolent and charitable status of the D.C. Blue Cross plan remains in place" and would "ensure that the D.C. Blue Cross plan will remain a benevolent and charitable organization."³²

These 1997 statements are significant, because, although "the view of a later Congress does not establish definitively the meaning of an earlier enactment, . . . it does have persuasive value." *Gonzlon-Peretz v. United States*, 498 U.S. 395, 406 (1991) (quoting *Bell v. New Jersey*, 461 U.S. 773, 784 (1983)). This is especially the case when Congress, "at its most authoritative," is "not merely expressing an opinion . . . but is acting on what it understands its own prior acts to mean." *Bell v. New Jersey*, 461 U.S. at 784 n. 12 (quoting *Mt. Sinai Hosp. v. Weinberger*, 517 F. 2d 329, 343 (5th Cir. 1975)). The 1997 Congress did not understand the terms "benevolent" and "charitable" in GHMSI's charter to be merely formulaic (as the reversal of their order in Rep. Cardin's remarks shows); to the contrary, the

²⁹ Cf. *U.S. v. Reid*, 206 F. Supp. 2d 132, 139 (D. Mass. 2002) (Congress's amendment to an Act was evidence that the Act, including a provision of the Act that Congress had left intact for 71 years, was not an "obscure, forgotten portion" of the U.S. Code, "but instead remains vital to the process of interpreting the rest of the code").

³⁰ Cf. 1997 GHMSI Memorandum at 14 (asserting that Blues Plans "were initially described as 'charitable and benevolent institutions' in order to give them an advantage as they struggled to create a system for insuring health. This advantage was, therefore, more in the nature of an economic development incentive program and was never intended to transform Plans into charities").

³¹ 143 Cong. Rec. 26488 (1997) (statement of Del. Norton).

³² *Id.* at 26489 (statement of Rep. Cardin).

1997 Congress accorded significance to the terms without any reference to GHMSI's tax status, and relied on the terms' ordinary meaning in enacting the 1997 charter amendments that permitted GHMSI to become part of the CareFirst organization. The views of the 1997 Congress that the charter declaration of GHMSI's charitable and benevolent status had continuing, independent meaning is persuasive evidence that the declaration does have practical import.³³

CareFirst and GHMSI have argued, however, that, notwithstanding the language of GHMSI's charter, the 1986 amendments to the Internal Revenue Code signaled an end to any congressional expectation that Blues organizations have a social mission. As they have noted, prior to 1986, the federal government routinely qualified Blue Cross organizations as tax exempt pursuant to section 501(c)(4) of the Internal Revenue Code, as organizations formed to promote "social welfare."³⁴ Eventually, however, the growth of the commercial health insurance industry placed Blue Cross/Blue Shield organizations in competition with commercial carriers. In 1986, Congress responded by amending the Internal Revenue Code to provide that an organization described in section 501(c)(3) or 501(c)(4) of the Code "shall be exempt from tax . . . only if no substantial part of its activities consists of providing commercial-type insurance."³⁵ Congress reasoned that because Blue Cross/Blue Shield organizations were engaged in fundamentally commercial rather than charitable activities, the tax exemption was providing them with an unfair competitive advantage over their for-profit commercial insurance competitors.³⁶

GHMSI argued in 1997 that its tax-exempt status, like that of other Blue Cross organizations, ceased in 1987 (with the effective date of Pub. L. 99-514) and implied that its declared status as a "charitable and benevolent institution" also ceased to have significance after that time. GHMSI may be correct about the 1986 legislation's impact on its federal income tax status,³⁷ but its assumption

³³ See also *Western Fuels-Utah, Inc. v. Lujan*, 895 F.2d 780, 786 n. 10 (D.C. Cir. 1990) (while "the federal coal leasing system created by the 1920 Congress is relevant insofar as it sheds light on what later Congresses were trying to do when they amended" the Mineral Lands Leasing Act, "it is the intent of those later Congresses that must control"); but see *O'Gilvie v. United States*, 519 U.S. 79, 90 (1996) (the view of a later Congress cannot control interpretation of an earlier enacted statute).

³⁴ See Tax Reform Act of 1986, Part III. Miscellaneous Tax Subjects Hearing Before the Senate Comm. on Finance, 99th Cong., 2d Session, 35 (1986).

³⁵ 26 U.S.C. § 501(m)(1).

³⁶ Staff of the Joint Comm. of Taxation, 100th Cong., General Explanation of the Tax Reform Act of 1986, 584 (Joint Comm. Print 1987).

³⁷ GHMSI asserted that its general tax-exempt status ended on the effective date of sections 501(m) and 833 of the Internal Revenue Code, 26 U.S.C. §§ 501(m) and 833, enacted through sections 1012(a) and (b), respectively, of the Tax Reform Act of 1986, Pub. L. No. 99-514, 100 Stat. 2085. See Group Hospitalization and Medical Services, Inc.'s Response to the Office of the Corporation Counsel's Proposed Findings of Fact and Recommended Conditions on the Business Combination of Group Hospitalization and Medical Services, Inc. and Blue Cross Blue Shield of Maryland, Inc. at 20. Section 501(m) provides that an organization "described" in section 501(c)(3) or 501(c)(4) of the Internal Revenue Code can be exempt from federal income tax "only if no substantial part of its activities consists of providing commercial-type insurance." 26 U.S.C. § 501(m). Section 501(m) at least arguably does not apply to GHMSI, because GHMSI has never been qualified as a section 501(c)(3) or 501(c)(4) organization. See 1997 GHMSI (continued...)

about the 1986 tax legislation signaling an end to any charitable obligation it might have is unwarranted.

To begin with, it is not true that as a general matter Blues plans abandoned any social mission by the time of or in the wake of the 1986 tax reforms. Long after 1986, it continued to be the case that some Blues Plans had a social service mission while others began with or “evolved into . . . the ‘mutual company’ model . . . principally existing to serve their subscribers.”³⁸ Even more important, it is not correct that Congress abandoned any expectation that Blues organizations would pursue a charitable mission. Although Congress did amend the tax code to establish that organizations described in 501(c)(3) and (4) would qualify for tax exemption only if no substantial part of their activities consisted of providing commercial-type insurance, the tax reform legislation also provided that “commercial-type insurance” does not include “insurance provided at substantially below cost to a class of charitable recipients.” 26 U.S.C. § 501(m)(3)(A). Moreover, the House Ways and Means Committee explained that the tax legislation it proposed would authorize the Treasury Department to issue regulations providing for special treatment for “the unique activities (such as open enrollment) of Blue Cross and Blue Shield and their affiliates for high risk individuals and small groups.” H.R. Rep. No. 99-426 at 665 (1985). Thus, Congress was aware of the concept of subsidized insurance for the poor, and it specifically contemplated a continuing community benefit role for at least some health insurance companies. From the fact that Congress did not remove from the GHMSI charter the declaration that it is to be a charitable and benevolent institution, it is much more reasonable to infer that Congress intended GHMSI to be among any companies that pursued a charitable, public benefit mission than to posit (merely on the basis of the tax reforms that Congress implemented) that Congress intended to render the “charitable and benevolent” clause of GHMSI’s charter superfluous.

Memorandum at 10 (asserting that “GHMSI has never been classified as a 501(c)(4) organization” and “GHMSI has never been classified as a 501(c)(3) organization”). It also appears that GHMSI was never an organization “described” in section 501(c)(3) or 501(c)(4), each of which refers to organizations “operated exclusively” for the purposes identified therein. See H.R. Rep. No. 99-426 at 665 (1985) (reference to section 501(m) applying only to section 501(c)(3) or (4) “charitable or social welfare organizations”). By contrast, section 833 (enacted through section 1012(b) of Pub. L. No. 99-514) provides for taxation of “any existing Blue Cross or Blue Shield organization” in the same manner as a stock insurance company, subject to a special deduction. 26 U.S.C. §§ 833(a)(1)-(2), (c)(1)(A). Congress may amend one law through a different law, see *Univ. Of Texas Medical Branch at Galveston v. United States*, 557 F. 2d 438, 453 (5th Cir. 1977), citing 2 A Sutherland, Statutory Construction §§ 51.02, 51.05 (4th ed. 1973); and Congress may have modified the tax exemption clause of section 8 of GHMSI’s charter through section 1012(b) of Pub. L. No. 99-514 (which, by providing for taxation of Blue Cross organizations, may trump the tax exemption clause of GHMSI’s charter at least insofar as it applies to federal income taxes). However, nothing in section 1012 or elsewhere in the 1986 tax legislation purports to amend the charter declaration that GHMSI is to be a charitable and benevolent organization.

³⁸ Testimony of Mark A. Orloff, Vice President and Deputy General Counsel of the Blue Cross and Blue Shield Association, submitted to the New York State Assembly, Committee on Insurance and Health, New York City, April 11, 1997, at 4; see also Larsen Decision at 97-98 (describing activities by BlueCross of Northeastern Pennsylvania, Highmark BlueCross Blue Shield, and Independence Blue Cross to fulfill a “social mission”).

As discussed above, Congress amended GHMSI's charter in 1984, two years before it effectively revoked the tax exemption of Blues organizations and other entities that sold commercial-type insurance as a substantial part of their activities; and Congress amended the charter again in 1993 and 1997, years after it enacted the Tax Reform Act of 1986. On each occasion, Congress amended the charter while being aware that GHMSI was a "commercial type of enterprise," 130 Cong. Rec. 25522. Congress's having first amended section 8 of GHMSI's charter without repealing it, all the while recognizing that GHMSI was competing with commercial insurers; then having left the "charitable and benevolent" language of section 8 of GHMSI's charter undisturbed in the wake of the 1986 tax reforms (including the statutory and legislative history references showing that Congress was aware of the practice of providing insurance "substantially below cost to a class of charitable recipients" and of Blues organizations' activities with respect to high-risk individuals and small groups); and then having emphasized the continuation of GHMSI's "benevolent and charitable" status, make it inappropriate to conclude that Congress, sub silentio, intended the changes it made in the Internal Revenue Code to undo or render meaningless GHMSI's declared status as a "charitable and benevolent institution." We think this history and principles of statutory construction compel the conclusion that Congress intended GHMSI to have a charitable mission.

Congress passed the 1997 amendments to GHMSI's charter in lieu of a bill, H.R. 497, that would have repealed GHMSI's federal charter and subjected GHMSI to the District's Nonprofit Corporation Act. The rationale for H.R. 497, as explained on the second page of the House Republican Conference *Legislative Digest* FloorPrep of February 26, 1997, was that "[t]he federal charter governing GHMSI imposes rigid requirements that are not required of competing insurance companies, putting GHMSI at a competitive disadvantage." *Id.* H.R. 497 created a further occasion for Congress to eliminate the declaration of GHMSI's charitable and benevolent institution status if doing so were thought to be appropriate in the circumstances. Congress nonetheless permitted the federal charter, including section 8, to remain in place, despite warnings about the competitive disadvantage that the federal charter allegedly created for GHMSI.

The foregoing history squarely rebuts the argument that section 8 of the GHMSI charter is obsolete or superfluous. Other rationales for giving no effect to the charter declaration that GHMSI is to be a "charitable and benevolent institution" are equally unavailing.

In a 1997 memorandum, GHMSI argued that if Congress had "intended to make GHMSI a charitable organization for all purposes, it would have exempted it from all taxes, including those on real estate and unemployment compensation."³⁹ This reasoning is flawed. There are numerous examples of Congress (and other legislatures) having limited the exemption from certain types of taxes, such as property taxes, to a subset of charitable, religious or educational organizations, while nonetheless recognizing the exempt status of a broader group of organizations for purposes of income and other taxes.⁴⁰ The fact that Congress did not extend GHI's (and then GHMSI's) tax

³⁹ See 1997 GHMSI Memorandum at 10.

⁴⁰ For example, in 1942 when Congress enacted the District of Columbia tax legislation that is now codified at D.C. Code § 47-1002, it afforded an exemption from District real property taxes not to all types of organizations that qualify for federal income tax exemption under section 501(c)(3), but only to specified organizations, including "institutions which are used for purposes of public charity principally in the District of Columbia." D.C. Code § 47-1002(8).

exemption to real estate and unemployment taxes may reflect Congress's recognition that GHMSI would not be operated exclusively for charitable purposes (as was required of charities that qualified for federal income tax exemption under section 101(8) of the Internal Revenue Code of 1939 and of charities that qualify for exemption under section 501(c)(3)). An organization can provide a charitable, community benefit, "responding to some inducement that is not market-based," even though it is not operated *exclusively* for charitable purposes. See *IHC Health Plans, Inc. v. Commissioner*, 325 F. 3d 1188, 1201 n. 29 and 1198 n. 19 (10th Cir. 2003).

GHMSI's 1997 memorandum also cited a number of cases in which courts refused to let state legislatures' declarations of "charitable and benevolent" status in a health insurer's charter or enabling statute control the determination about whether the insurer actually was a charitable organization (that qualified for tax exemptions available to entities organized and operated exclusively for charitable purposes).⁴¹ See, e.g., *Hassett v. Associated Hospital Service Corporation of Massachusetts*, 125 F.2d 611 (1st Cir.), *cert. den.*, 316 U.S. 672 (1942) (holding that charitable intent and practice prevail over state charter language in determining whether an entity is a charitable organization entitled to federal tax exemption).⁴² The issue those cases addressed – whether an entity's charter entitled it to exemption from taxes regardless of whether the entity had actually been acting as a charitable organization – is different from the issue under discussion with respect to GHMSI. The cases that GHMSI cited stand only for the obvious propositions that entitlement to tax exemption depends not only on a (state) charter but upon the corporation's behavior; that a charter cannot predetermine whether the entity's behavior has complied with the charter; and that the assessment of actual behavior is for the courts. The issue here, however, is not whether GHMSI's behavior "earned" it tax-exempt status for any period. The issue is whether GHMSI's charter obligates GHMSI to pursue a charitable and benevolent mission. *Hassett* and other cases on which GHMSI relied in 1997 do not (and did not purport to) answer that question.

Abbott v. Blue Cross and Blue Shield of Texas, Inc., 113 S.W. 3d 753 (Tex. App. 2003), is a recent decision in which a court held that despite a Blue Cross organization's statutory enabling language stating that the "corporation will be one of charity and benevolence," the organization was not a common-law charitable corporation whose assets (upon conversion) must be preserved for charitable purposes. See *id.* at 762. The court's ruling does not undermine the conclusion we have described about GHMSI, because the ruling was based on the court's observation that the declaration pertaining to "charity and benevolence" was contained in the organization's "powers clause." The court held that the controlling language was contained instead in the corporation's "purpose clause," which stated that the corporation was "formed for the purpose of establishing, maintaining and operating a nonprofit hospital service plan whereby hospital care may be provided

⁴¹ See 1997 GHMSI Memorandum at 9-15.

⁴² But see *In the Matter of the Application of Blue Cross and Blue Shield of New Jersey, Inc. For Conversion to a Domestic Mutual Insurer Pursuant to NJSA 17:48E-45 to 48*, Superior Court of New Jersey, Appellate Division, DKT No. A-004505-96T1 (Oct. 24, 1997) (applying N.J.S.A. 17:48E-41, which provides that a "health service corporation subject to the provisions of this act is hereby declared to be a charitable and benevolent institution," citing the "well settled principle that the legislature has the right to declare the status of institutions," and holding that it was not necessary to delve deeper than the act's literal terms to conclude that BCBSNJ is a charitable and benevolent institution).

to the members . . .” *Id.* The court reasoned that it is inappropriate to attribute greater importance to the corporation’s powers clause than to its purpose clause. *Id.* (“The purpose is dominant. It, not the power clause, is the real measure of corporate authority”).

By contrast, the margin notes to GHMSI’s charter legislation, the Act of August 11, 1939, identify section 2 of the charter as containing the “Powers” clause of the charter. Section 2 of GHMSI’s charter empowers the company, *inter alia*, to enter into contracts to provide for hospitalization and medical care. It is section 8 of the charter, which contains the declaration that the corporation is to be a charitable and benevolent institution, that contains what the margin notes identify as “Purposes declared.” Such margin notes “may be referred to as indicating the intention of Congress.” *Motorola v. United States*, 729 F. 2d 765, 771 (Fed. Cir. 1984). Under the *Abbott* court’s reasoning, the declaration in the section 8 purpose clause that GHMSI is to be a charitable and benevolent institution should dominate over other provisions of the charter.

To summarize, neither the structure of section 8 of GHMSI’s charter, nor the history surrounding the tax treatment of Blue Cross organizations, nor the limitations of GHMSI’s tax exemption, nor case law denying tax exemption to or otherwise declining to recognize the charitable status of health insurers whose enabling documents declare them to be “charitable,” establishes an adequate legal basis for ignoring or for refusing to accord practical significance to GHMSI’s declared status as a “charitable and benevolent institution.” To the contrary, we conclude, the declaration of Congress that GHMSI is to be a “charitable and benevolent” institution must be taken as a declaration that Congress intended GHMSI to pursue a charitable mission.

B. GHMSI’S Pursuit of a Charitable Mission Is Consistent with Its Charter Obligation to Operate for the Benefit of Its “Aforesaid Certificate Holders.”

The fact that section 3 of the GHMSI charter states that the “corporation shall not be conducted for profit, but shall be conducted for the benefit of the aforesaid certificate holders” does not change our conclusion that section 8 of the charter obligates GHMSI to pursue a mission as a charitable organization (which, as discussed below, entails providing substantial benefits to the public beyond its subscribers). The two charter mandates are not inconsistent.

The term “certificate holders,” used in section 3 of the GHMSI charter, is similar to the term “policyholders.” “Policyholder” is a term that has been interpreted to refer to both current and prospective or potential policyholders. See *Barnett Banks of Marion County, N.A. v. Gallagher*, 839 F. Supp. 835 (M.D. Fl. 1993), *aff’d*, 43 F. 3d 631 (11th Cir. 1995), *rev’d on other grounds*, 517 U.S. 25 (1996). In *Barnett*, the court discussed the provision of the federal McCarran-Ferguson Act,⁴³ that generally protects (from federal preemption) state laws “regulating the business of insurance.”⁴⁴ The court noted that the McCarran-Ferguson Act protects state laws that regulate “the relationship

⁴³ The McCarran-Ferguson Act is codified at 15 U.S.C. §§ 1011 *et seq.*

⁴⁴ Section 1012(b) of the McCarran-Ferguson Act states that “No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance . . . unless such Act specifically relates to the business of insurance.” 15 U.S.C. § 1012(b).

between the insurance company and the policy-holder.”⁴⁵ The issue before the court was whether a Florida law that attempted to regulate the relationship between “insurer and *potential* policyholder, that is, the insurance-purchasing public at large, rather than one between insurer and *present* policyholder” fell within the ambit of the McCarran-Ferguson Act’s protection.⁴⁶ The court resolved the issue in the affirmative, stating that it would “construe[] the term ‘policyholder’ in its broadest sense, as to encompass both existing and potential purchasers of insurance.”⁴⁷ The court found that the Florida law, which purported to prohibit banks from selling insurance, was a law directed at the relationship between insurers and policyholders because it was “aimed at protecting the insurance purchasing public at large,” i.e., “the potential policyholding public.”⁴⁸

The reasoning in *Barnett* suggests construing the term “certificate holder” in section 3 of the GHMSI charter to refer to “the potential certificate holding public” or the “insurance purchasing public at large.”⁴⁹ Several factors convince us that this possible interpretation is in fact the correct interpretation.

First, the “aforesaid certificates holders” to whom section 3 of GHMSI’s charter refers are the individuals or groups of individuals mentioned in section 2 of the charter, with whom GHMSI is authorized and empowered to enter into contracts to provide for hospitalization and medical care, and to whom GHMSI is authorized to issue “appropriate certificates evidencing such contracts.” In other words, the “aforesaid certificate holders” to whom section 3 refers and for whose benefit GHMSI is to be conducted are individuals or groups who may come to hold GHMSI certificates, not necessarily existing certificate holders.

Second, the reference to benefiting “the aforesaid certificates holders” in section 3 of the charter and the “charitable and benevolent” declaration of section 8 of the charter are not the only

⁴⁵ 839 F. Supp. at 840, citing *SEC v. National Sec., Inc.*, 393 U.S. 453, 460 (1969).

⁴⁶ *Id.* at 840.

⁴⁷ *Id.* at 841.

⁴⁸ *Id.* The decision in *Barnett* was reversed on the grounds that the state law that was in dispute, which the lower courts found regulated the business of insurance, was preempted by a federal law that specifically permitted the insurance activities that the state law purported to prohibit.

⁴⁹ The reasoning of the D.C. Superior Court in its Memorandum Opinion and Order in *Fair Care Foundation v. GHMSI*, C.A. No. 98-506 (Feb 17, 1998) also suggests such an interpretation. The court observed that “[n]otwithstanding the terminology of the charter here, the reality is that policyholders as a category are in flux with new ones entering and old ones leaving.” *Id.*, slip op. at 11. This meant that the plaintiffs, actual or potential policyholders who described themselves as the intended beneficiaries of the GHMSI charter, could not be “*distinguish[ed] . . . from the public in general.*” *Id.* (emphasis supplied). See also *Sound Health Ass’n v. Commissioner*, 71 T.C. 158, 185, 188, 189-90 (1978) (holding that the plaintiff HMO was operated for charitable purposes and reasoning that “[t]he class of possible members of the Association is, for all practical purposes, the class of members of the community itself. The major barrier to membership is lack of money, but a subsidized dues program demonstrates that even this barrier is not intended to be absolute”; that “there is no meaningful limitation on Association membership”; and that “[w]hen possible membership is so broad, benefit to the membership *is* benefit to the community”).

provisions of the GHMSI charter that indicate that GHMSI may have the mission to serve the needs of potential policyholders or of the insurance purchasing public at large. Section 2(c) of the charter -- which appears to have received little attention to date -- states that GHMSI is authorized and empowered “to cooperate, consolidate, or contract with individuals or groups or organizations interested in promoting and safeguarding the public health.”⁵⁰ Although it authorizes rather than mandates activities directed to promoting and safeguarding the public health, it is important to recognize that section 2(c) stands on the same footing as section 2(a), which authorizes and empowers (but does not require) GHMSI to “enter into contracts with individuals or group of individuals to provide for hospitalization and medical care of such individuals, upon payment of specified rates or premiums, and to issue such individuals appropriate certificates evidencing such contracts.” Sections 2(a) and 2(c) both have been in the GHI and then the GHMSI charter from the outset, and there is no apparent reason for regarding section 2(a) as more expressive of GHMSI’s mission than section 2(c), with its focus on “promoting and safeguarding the public health.”

The third point (which is somewhat related to the second) concerns an argument that CareFirst advanced in its Amended Statement. CareFirst asserted that “GHMSI’s charter sets forth its purpose – to provide hospitalization and medical care to its subscribers.” Amended Statement Supplement at 29. CareFirst also asserted that:

D.C. law also makes it clear that a charitable health care entity’s chartered purpose is its charitable purpose. As part of the Healthcare Entity Conversion Act of 1997, the following legislative finding was made: “charitable health care entities hold all their assets in trust, and those assets are irrevocably dedicated, as a condition of their tax-exempt status, to the specific charitable purposes set forth in the articles of incorporation of those entities.” D.C. Code 44-601.

Amended Statement Supplement at 30. From this CareFirst argued that GHMSI’s charitable purpose does not extend beyond providing hospitalization and medical care to its subscribers, the activity described in section 2(a) of its charter. Yet, if the content of GHMSI’s charitable purpose is to be found in section 2 of its charter, that charitable purpose includes cooperating, consolidating, or contracting with others to promote and safeguard the public health, which logically encompasses supporting and fostering health initiatives for the benefit of the general public.

⁵⁰ The GHMSI charter does not explain what Congress meant by “promoting and safeguarding the public health,” but we note that similar language has been contained in the charters of other Blue Cross organizations. When Blue Cross and Blue Shield of Missouri took steps to reorganize itself as a for-profit company, it amended its articles of incorporation to delete a similar “public health provision.” The deleted provision recited that it was a purpose of the company “to advance the availability of quality health care by promoting and safeguarding the public health by collection of information, statistics and data on health care matters and by participation in such benevolent, educational and related activities as are intended to benefit the public health.” *Blue Cross and Blue Shield of Missouri v. Angoff*, 1998 Mo. App. LEXIS 1490, * 15, *50 (Mo. Ct. App. 1998).

In a 2003 submission to DISR in response to a question from Commissioner Mirel about the impact of Maryland legislation affecting CareFirst, GHMSI stated that “operating for the benefit of its policyholders . . . does, indeed, contribute towards the improvement of the overall health status of Maryland residents.”⁵¹ This statement suggests a possible argument that GHMSI may meet its charitable purpose of promoting and safeguarding the public health if it does no more than operate for the benefit of its current policy holders. We believe that any such argument should be rejected. Under familiar principles of statutory construction, it is inappropriate to construe the charter reference to activities to safeguard and promote the public health in section 2(c) of GHMSI’s charter to mean no more than providing health insurance coverage, as described in section 2(a) of the charter.⁵² Such a construction would impermissibly render section 2(c) superfluous. In the end, once section 2(c) is given its plain and natural meaning, it undercuts any argument that GHMSI’s federal charter requires it to be operated *solely* for the benefit of its current policyholders.⁵³

Even if arguably GHMSI may limit its services to individuals who are its actual current policyholders, the chartered purpose of promoting and safeguarding the public health could entail making it possible for persons who cannot afford unsubsidized health insurance to *become* GHMSI policyholders by making insurance available at a below-market cost. We note that in *Kartell v. Blue Shield of Massachusetts*, 592 F. 2d 1191 (1st Cir. 1979), the court stated that Blue Cross and Blue Shield of Massachusetts was “organized to provide ‘for the preservation of the public health by furnishing medical services *at low cost* to members of the public who become subscribers,’” citing 1941 Mass. Acts c. 306, preamble. Mass. G.L. c. 176B (Blue Shield); c. 176A (Blue Cross) (emphasis added). *Kartell and Angoff* (*see supra*, note 50) suggest that for GHMSI to cooperate with others interested in promoting and safeguarding the public health might entail at a minimum (i) furnishing insurance at low cost and (ii) offering health education and related activities for the public in GHMSI’s service area (the location of its current and prospective policyholders); as we explain in the second part of this memorandum, these are the same types of activities that would be entailed in its operating as a charitable institution. We furthermore note that, during the debate on proposed amendments to the GHI charter during 1958, Senator Morse referred to GHMSI as a nonprofit “public-service corporation” and expressed a desire to set forth in the charter procedures to assure that “rate changes are made only to the extent necessary to maintain a sound financial position for the operation.” 104 Cong. Rec. 14934 (1958).

⁵¹ See Letter from Edward J. Baran, Chair, GHMSI Board of Trustees to Commissioner Lawrence H. Mirel, at 4 (Sept. 10, 2003).

⁵² See, e.g., *Russell v. Law Enforcement Assistance Admin.*, 637 F.2d 354, 356 (5th Cir. 1981) (“where different language is used in the same connection in different parts of a statute it is presumed that the Legislature intended a different meaning and effect”) (citation omitted); 2A N. Singer, *Statutes and Statutory Construction* § 46.06, at 193-94 (6th ed. 2000) (“courts do not construe different terms within a statute to embody the same meaning”).

⁵³ Note that section 3 of the charter states that GHMSI “shall be conducted for the benefit of the aforesaid certificate holders.” By contrast, mutual insurance companies “are organized, maintained, and operated *solely* for the benefit of their policyholders.” *Allegaert, Derivative Actions by Policyholders in Behalf of Mutual Insurance Companies*, 63 U. Chi. L. Rev. 1063, 1067 (1996) (*italics added*), quoted in *State Farm Mutual Automobile Ins. Co. v. Superior Court*, 8 Cal. Rptr. 3d 56, 62 (Cal. Ct. App. 2003).

To the extent that there is any tension between section 8 and section 2(c) of the charter (which appear to direct GHMSI's focus toward benefiting individuals who are not necessarily its members) and section 3 (which directs GHMSI to conduct its operations for the benefit of "aforesaid certificate holders"), the tension *should* be resolved in a way that does not ignore any of the statutory language. See *Pharmaceutical Research and Mfrs. of America v. Thompson*, 362 F. 3d 817, 824 (D.C. Cir. 2004) (where there is tension between language of different sections of a statute, the preferred interpretation is one that is "consistent with the literal meaning of the statutory language," that "permits all of the language [that Congress drafted] to be given its plain meaning" and "produces[s] a coherent statutory scheme"). The way to do this is to conclude that section 2(c) and section 8 make it appropriate to interpret section 3 as requiring GHMSI to conduct its business both for the benefit of its current policyholders and for the benefit of its prospective policyholders, *i.e.*, so as to benefit the general public in GHMSI's service area. Stated differently, it seems appropriate to interpret the statement in section 3 of GHMSI's charter, that "the corporation shall not be conducted for profit, but shall be conducted for the benefit of the aforesaid certificate holders," as simply another way of saying that GHMSI shall be conducted for a public purpose rather than for private inurement.⁵⁴

C. District Law Also Requires GHMSI to Benefit the Public Beyond Its Current Policyholders.

CareFirst and GHMSI appear to have acknowledged that GHMSI is subject to the provisions of the Healthcare Entity Conversion Act of 1997, codified at D.C. Code § 44-601 *et seq.* They cite the provisions of the Healthcare Entity Conversion Act as establishing the nature of GHMSI's "charitable" purposes.⁵⁵ Their 2002 conversion/acquisition proposal entailed a plan to pay the value of GHMSI's assets into a charitable trust as required under D.C. Code §§ 44-603(c)(12) and 44-604(a).⁵⁶

⁵⁴ Cf. Treasury Regulations, 26 C.F.R. § 1.501(c)(3)-1(d)(1)(ii) (providing that an organization will not be considered charitable "unless it serves a *public rather than a private interest*" (emphasis added))."

The punctuation in the margin notes to section 3 of the original GHI charter also supports the interpretation that GHMSI's operation for the benefit of its certificateholders signifies nonprofit operation: "Nonprofit business, conducted for benefit of certificate holders." 53 Stat. 1413 (1939). Compare the use of the comma in the section 3 margin notes to the semi-colon used in the section 8 margin notes: "Purposes declared; property tax-exempt" (denoting independent concepts). 53 Stat. 1414 (1939). See the discussion in note 26, *supra*.

⁵⁵ See Amended Statement Supplement at 30 (relying on the statement, in D.C. Code 44-601(1), that the assets of charitable health care entities are dedicated "to the specific charitable purposes set forth in the articles of incorporation of the entities").

⁵⁶ In enacting sections 44-603(12) and 44-604(a), the D.C. Council in essence applied and codified the doctrine known as "cy pres," the principle under which trust property is applied to a closely related charitable purpose when it becomes impossible to carry out the original purpose for which the property was placed in (continued...)

GHMSI's endorsement of the declaration contained in section 44-601 amounts to an acknowledgment that GHMSI holds its assets in trust for the benefit of the public, as section 44-601(1), (2) and (4) establish: "[c]haritable healthcare entities hold all their assets in trust," and "[t]he public is the beneficiary of that trust" and "the beneficiary of the charitable assets." Indeed, CareFirst stated that it was "undisputed that the public 'owns' the entire consideration paid by WellPoint to acquire CareFirst."⁵⁷ We think it is untenable to acknowledge that the public would be entitled to the value of GHMSI's assets upon a conversion while also maintaining that, so long as GHMSI continues not-for-profit operations, it has no obligation to benefit the public and may operate solely for the benefit of its current policyholders.

Furthermore, as a hospital and medical services corporation, GHMSI not only must provide open enrollment, but also must provide "other public services in the District of Columbia consisting of 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."⁵⁸ Thus, even if arguably GHMSI's charter does not mandate that GHMSI must use its assets for the benefit of the public beyond its current policyholders, District law so mandates (at least with respect to health education programs). We conclude, therefore, that there is no real issue as to whether GHMSI has a current, charitable obligation to use its assets to benefit the public; the issue is what GHMSI must do to fulfill that obligation.

II. Pursuing A Charitable Mission Requires GHMSI to Provide Substantial Health-Related Benefits or Services to the Public Beyond Its Current Subscribers, and To Do So As A Priority and to the Maximum Feasible Extent, Consistent with Financial Soundness.

If the declaration of GHMSI's "charitable and benevolent" status is not to be treated as meaningless or obsolete -- and we believe that would be a legally unjustifiable outcome --the next inquiry must be: what is required for GHMSI as a health insurer to conduct itself as a charitable and benevolent institution? To answer that question, we have looked to the particular practices or manner of operation that distinguish health care or health insurance-type entities recognized as "charitable" organizations.

trust. *See* Restatement (Second) of the Law: Trusts 2d § 399 (1959). The cy pres doctrine is applicable only to charitable trusts and charitable corporations. *Id.*

⁵⁷ Memorandum of Law in Support of The Compensation Arrangements Approved by the Board of Directors of CareFirst, Inc., November 13, 2002, at 15, quoted in Larsen Decision at 5.

⁵⁸ D.C. Code § 31-3514(i) (*italics added*). The 1997 DISR Order that permitted GHMSI to affiliate with BCBSMD and to come under a holding company structure also required GHMSI to be licensed as a Hospital and Medical Services Corporation. 1997 DISR Order at 20-21.

A. Relevant Authority

Because the effort is to give content to the meaning of a federal charter provision, we have looked initially to federal case law establishing what it means to be a “charitable” organization.⁵⁹ Because the pertinent federal law is found predominantly in the tax context, we have looked primarily to federal tax cases for guidance (even though, as explained above, it is incorrect to regard GHMSI’s declared status as a charitable and benevolent institution as merely a predicate for tax-exempt status). We believe this is appropriate because federal tax authorities have sought to interpret the term “charitable” in its “generally accepted legal sense,” not as a specialized tax term.⁶⁰ We note that the tax cases deal ultimately with the issue of whether an entity is operated *exclusively* for charitable purposes (interpreted in recent decisions to mean “primarily” for charitable purposes), the standard for tax exemption under section 501(c)(3).⁶¹ We have not relied on the courts’ analyses of whether entities met that ultimate test for federal tax exemption, but on the courts’ preliminary discussions about what activities or purposes are “charitable” within the ordinary meaning of that term and what manner of operation is consistent with having a charitable purpose.⁶²

Just as the courts have done in federal tax cases, we have also looked to state courts’ reasoning and criteria in judging an entity to be a “charitable” organization. Because section 5 of GHMSI’s charter makes the company subject to licensure and regulation by the District of Columbia, a logical starting point for defining its charitable obligation is District of Columbia law. However, the term “charitable” is used but not defined in the District of Columbia Nonprofit Corporation Act (D.C. Code Ann. §§ 29-301 *et. seq.*), the Hospital and Medical Services Corporations Regulatory Act (D.C. Code Ann. § 31-3501 *et. seq.*), and in various District tax law provisions. *See* D.C. Code Ann. §§ 47-1002 (real estate tax), 47-1508 (personal property tax), and 47-1802.01 (income tax). The District’s Healthcare Entity Conversion Act refers to “healthcare entities” that provide “as part of their charitable mission a large list of services to low-income families and the poor, elderly, and disabled,” D.C. Code Ann. § 44-601(3), but also does not define the term “charitable.”⁶³ Case law suggests that

⁵⁹ The term “benevolent” as used in section 8 of the GHMSI charter is not used in the Internal Revenue Code or in federal tax case law. Therefore, the following discussion focuses on the meaning of the term “charitable.” Notably, a number of courts have ruled the terms “charitable” and “benevolent” to be synonymous. *See Hight v. United States*, 256 F. 2d 795, 798 (2d Cir. 1958) (“Decisions by the courts holding ‘benevolent’ synonymous with ‘charitable’ are legion”).

⁶⁰ *See, e.g.*, 26 C.F.R. § 1.501(c)(3)-1(d)(2).

⁶¹ *See, e.g.*, *Geisinger Health Plan v. Commissioner*, 985 F. 2d 1210, 1215 (3d Cir. 1993).

⁶² *See IHC Health Plans*, 325 F. 3d, at 1194 (describing the court’s inquiry as involving, first, a determination about whether the plaintiff organizations were operated in furtherance of some purpose considered charitable in the generally accepted sense of that term).

⁶³ Although some commentators have referred obliquely to GHMSI’s obligation to the public as a not-for-profit corporation, GHMSI is not organized under the District Nonprofit Corporation Act; moreover, that Act provides that “organizations subject to any of the provisions of the insurance laws of the District may not be organized under this subchapter.” D.C. Code Ann. § 29-301.04. In addition, the Nonprofit Corporation Act is of little help in understanding the substance of GHMSI’s obligations. Corporations organized under it may have “commercial, industrial, business or trade” missions in addition to or in lieu of charitable, benevolent, educational or other missions. *Id.* The principal operating restrictions that the (continued...)

courts in the District would likely follow federal jurisprudence in deciding whether an entity is a “charitable organization.”⁶⁴

B. What It Means to Be A “Charitable” Organization

When Congress chartered GHI as a “charitable and benevolent institution” in 1939, it was already recognized under Supreme Court case law that a charitable organization may not be operated for the benefit of its subscribers alone. See *Jones v. Habersham*, 107 U.S. 174, 189 (1882).⁶⁵ Under more recent federal jurisprudence as well, to qualify as a charitable organization, an organization must provide a substantial “community benefit,” *i.e.*, a benefit to the community beyond its subscribers. See, *e.g.*, *Geisinger Health Plan*, 985 F.2d at 1219.

In its 1978 decision in *Sound Health Ass’n v. Commissioner*, 71 T.C. 158, 181 (1978), the U.S. Tax Court applied this so-called “community benefit” test in analyzing whether a health maintenance organization (“HMO”) qualified as a charitable organization. The court noted that the Internal Revenue Code uses the term “charitable” in its “generally accepted legal sense” and that “[i]n determining what is charitable in the generally accepted legal sense, the courts have looked to the law of charitable trusts.” *Id.* at 177. Under the law of charitable trusts, the court noted, a trust is not charitable “if the persons who are to benefit are not of a sufficiently large or indefinite class so that the community is interested in the enforcement of the trust. This is true even though the purpose of the trust is to promote health.” *Id.* at 181, quoting 4 A. Scott, *Trusts*, § 372.2 at 2897 (3d ed. 1967).⁶⁶ Accordingly, the court reasoned, for an organization to be charitable, the community must benefit from its activities to a substantial degree. *Id.* at 181.⁶⁷ The court found that the HMO’s

Nonprofit Corporation Act imposes are that a not-for-profit corporation may not authorize or issue shares of stock and that “[n]o dividend shall be paid and no part of the income of [the] corporation shall be distributed to its members, directors, or officers” (although the corporation may “pay compensation . . . in a reasonable amount to its members, directors, or officers for services rendered [and] may confer benefits upon its members in conformity with its purposes”). *Id.*, § 29-301.27.

⁶⁴ See, *e.g.*, *Government Services, Inc. v. District of Columbia*, 189 F.2d 662, 663 n.4 (D.C. Cir. 1951) (citing U.S. treasury regulations in determining whether petitioner was a charitable organization exempt from franchise, motor vehicle and personal property taxation by the District).

⁶⁵ See also *State ex. rel. Goodell v. Security Benefit Ass’n*, 87 P. 2d 560, 565 (Kan. 1939) (fraternal benefit societies, conducted for the sole benefit of their members, “are not to be classed as ‘charitable and benevolent’ in character”).

⁶⁶ See also Restatement of the Law: (Second) *Trusts* 2d § 368 cmt. at 248 (“A purpose is charitable if its accomplishment is of such social interest to the community as to justify permitting the property to be devoted to the purpose in perpetuity”).

⁶⁷ The court also found that the tests that have been applied to determine the charitable status of a hospital are relevant to a determination of the status of an HMO. *Id.* at 178-79. In *Geisinger*, the U.S. Court of Appeals for the Third Circuit found “no reason to conclude” that it was error to apply hospital precedent in analyzing a health plan’s status as an organization operating for charitable purposes. See 985 F.2d at 1216.

(continued...)

operations met this community-benefit test because, even though the HMO's primary purpose was to provide fee-for-service health care to members, it offered a program of subsidized membership for persons who could not afford the full monthly payments; its membership fees were set on a community-rating basis, meaning that the fees "do not shift regardless of the amount of use, or the lack of use, to which each member puts the Association" so that "the risk of illness is spread throughout the entire membership"; it operated a "substantial outpatient clinic" that provided emergency care to all regardless of membership status and ability to pay; it rendered free care to persons referred from a family clinic; it offered health education courses open to the public (in particular, a "public health forum program" that would be "responsive to requests by the community for programs on particular subject matters"); it had outlined a research program to study better ways of delivering health care services; it had a plan "to devote a fixed percent of the Association's gross income to emergency-charity patients"; and it projected increasing utilization of its services by Medicaid recipients and charity care patients.⁶⁸

The community benefit test was refined and narrowed in *Geisinger*, in which the U.S. Court of Appeals for the Third Circuit found that the Tax Court in *Sound Health* had "ventured too far when it reasoned that the presence of a subsidized dues program meant that the HMO in question served a large enough class that it benefited the community." 985 F.2d at 1219. The Third Circuit held that the Geisinger Health Plan ("GHP"), failed the community benefit test because it "benefits no one but its subscribers." *Id.* at 1219. The Court cited in particular the plan's failure to offer free services to non-subscribers and educational programs to the public and its failure to conduct research. *Id.* Citing GHP's "miniscule" subsidized dues program, the court stated that "[a]rranging for the provision of medical services only to those who 'belong' is not necessarily charitable, particularly where, as here, the HMO has arranged to subsidize only a small number of such persons [35 people, compared to over 70,000 paying subscribers]." *Id.* at 1220. The court recognized that the "promotion of health" is a charitable purpose *where it is for the benefit of the community*. *Id.* at 1216-17; *see also IHC Health Plans*, 325 F. 3d at 1195 ("the promotion of health for the benefit of the community is a charitable purpose," quoting *Geisinger*).

In its 2003 decision in *IHC Health Plans*, 325 F. 3d 1188, the U.S. Court of Appeals for the Tenth Circuit applied the community benefit test and upheld the denial of affiliated HMOs' request for tax exemption as charitable organizations. The court analyzed whether the HMOs had a charitable purpose and whether they were operated primarily for that purpose, *id.* at 1194; its analysis of the former issue is relevant here. The court applied a community benefit test in determining whether

After the *Sound Health* decision, the IRS set out a list of key factors it would use to determine whether a health care organization met the community benefit test. They include: "actual provision of health care services and maintenance of facilities and staff; provision of services to nonmembers on a fee-for-service basis; care and reduced rates for the indigent; care for those covered by [M]edicare, [M]edicaid or other similar assistance programs; emergency room facilities available to the community without regard to their ability to pay . . . ; a meaningful subsidized membership program; a board of directors broadly representative of the community; health education programs open to the community; health research programs; health care providers who are paid on a fixed fee basis; and the application of any surplus to improving facilities" (Gen. Couns. Mem. 39,828 (Sept. 30 1987)).

⁶⁸ *Id.* at 170-74, 184-85, 189-90.

the HMOs had a charitable purpose. The court listed several factors that are relevant under a community benefit analysis: “(1) size of the class eligible to benefit; (2) free or below-cost products or services; (3) treatment of persons participating in governmental programs such as Medicare or Medicaid; (4) use of surplus funds for research or educational programs; and (5) composition of the board of trustees.” *Id.* at 1197 n. 16. It noted that “an organization cannot satisfy the community-benefit requirement based solely on the fact that it offers health-care services to all in the community in exchange for a fee.” *Id.* at 1197 (footnote omitted). The community benefit test, it reasoned, requires some additional “plus,” “positive externalities” or “public goods,” such as “providing free or below-cost services,” “maintaining an emergency room open to all regardless of ability to pay,” servicing Medicare and Medicaid populations, and “devoting surpluses to research, education and medical training.” *Id.* at 1197-98. A community benefit “must either further the function of government-funded institutions or provide a service that would not likely be provided within the community but for the subsidy.” *Id.* at 1198. In addition, the community benefit test requires a charitable purpose; “incidental community benefit is insufficient.” *Id.* See also *Supervisor of Assessments of Montgomery County v. Group Health Ass’n*, 517 A. 2d 1076 (Md. 1986) (HMO was not a charitable organization because charitable activities were “only incidental” to its main purpose of providing medical care to members for a fee).

By contrast, the court found that the plaintiff HMOs had not shown a charitable purpose because they “provided virtually no free or below-cost health-care services,” had discontinued Medicare plans that lost money, and showed no evidence of having a charitable purpose. *Id.* at 1200 n. 25. The plans also did not “conduct[] research or offer[] free educational programs to the public,” facts that “bolster[] our conclusion that petitioners did not operate for the purpose of promoting health for the benefit of the community.” *Id.* at 1200- 1201.

Another pertinent federal tax case is *Hassett v. Associated Hospital Service Corporation of Massachusetts*, 125 F. 2d 611. In *Hassett*, the U.S. Court of Appeals for the First Circuit considered whether an entity that was described in Massachusetts law as a “charitable and benevolent organization” was in practice being conducted as a charitable organization. The court reasoned that the fact that the entity “retains its entire surplus for the benefit of future members,” using it to reduce rates or increase services for members, and the fact that any surplus the entity might have upon liquidation must be devoted to some charitable purpose, were not sufficient to establish that the entity operated as a charitable organization. *Id.* at 615. The fact that the entity “exact[s] a fee as a prerequisite to the receipt of benefits in every case” showed that the entity was conducted solely on a business basis and not on a charitable basis. *Id.* at 614-15.

The criteria for “charitable” operation that state courts have articulated generally are consonant with the tests applied in the federal tax cases discussed above. A common theme in cases addressing whether an entity is charitable is whether the entity affords benefits narrowly (*i.e.*, to subscribers) or instead provides benefits to the entire community that it serves. In *Blue Cross and Blue Shield of Kansas City, Inc. [BCBSKC] v. Nixon*, 26 S.W. 3d 218 (Mo. Ct. App. 2000), for example, in which the court found that the corporate purpose of BCBSKC was to serve the public as a charitable entity, the court emphasized that BCBSKC’s “corporate purpose statements repeatedly refer to service to those residing *in its territory*, rather than merely those who have paid a premium. BCBSKC and its predecessors articulated and carried out a purpose to serve a more far-reaching constituency than just its subscribers.” 26 S.W. 2d at 232 (*italics in the original*). The court also noted that BCBSKC had “more or less consistently declared” that among its purposes and activities were activities such as “the compilation of data of value to the community” and “the conservation and protection of the

health of the public.” *Id.* The court emphasized in addition that three members of the company’s Board of Trustees were to represent the general public. *Id.* at 230. *See also Federation Pharmacy Servs. v. Commissioner*, 625 F. 2d 804, 807 (8th Cir. 1980) (“An organization which does not extend some of its benefits to individuals financially unable to make the required payments reflects a commercial activity rather than a charitable one”); *Abbott v. Blue Cross and Blue Shield of Texas, Inc.*, 113 S.W. 2d at 768 (“to be a charity the organization must provide services beyond a defined group of persons for whose exclusive benefit it was organized”); *Illinois Hospital & Health Services, Inc.*, 373 N.E. 2d at 1025 (holding that a health plan lacked the requisite charitable intent to qualify as a charitable organization because “[n]o provision is found under this plan whereby any charity is dispensed to those members who do not pay, or to any destitute member of society in general”).⁶⁹

From these cases, it is possible to derive a community benefit test that relies on a variety of concrete indicia to serve as a standard for assessing whether GHMSI is meeting its obligations as a charitable institution. Key elements in the test would include whether the company offers free health education programs and conducts health data analysis and health research programs for the benefit of the public in its service area; whether it offers coverage at below-market rates to a large number of persons, or charges premiums based on a community rating;⁷⁰ whether it participates in public programs such as Medicare and Medicaid; whether it uses its surplus for the benefit of the public beyond its members; and whether charitable activities are a more than incidental purpose of its operations. Another relevant factor is whether GHMSI has utilized its charter authority to determine the manner of election of its trustees⁷¹ to select a board of directors broadly representative of the community.

In our view, none of the foregoing tests suggests that, to comply with its charter mission as a charitable institution, GHMSI must transform its basic business of selling insurance in exchange for experience-rated premiums; or dispose of or convert its for-profit subsidiary.⁷² GHMSI is an unusual entity -- a nonprofit corporation that has a congressionally enacted charter deeming it a charitable institution, but one that must also compete in insurance markets. The cases illuminate but ultimately do not control the issue here, which concerns the meaning of the charter obligation to be

⁶⁹ *Cf. Harvard Community Health Plan, Inc. v. Board of Assessors of Cambridge*, 427 N.E. 2d 1159, 1164 (Mass. 1981) (holding that the health plan was entitled to property tax exemption as a charitable organization because it “provide[s] substantial medical services, at a lower than average costs, to a large number of persons,” and because “[t]he class of persons potentially benefited by [the provider] is not so small that the promotion of its health is of no benefit to the community at large”).

⁷⁰ In general, the use of a “community rating” means that the financial risk of health insurance is spread across the entire population of a community; the community’s experience is pooled, and premium rates are developed from that pooled experience. The result is that health insurance is made available at a price that is the same for all applicants, regardless of age, sex, health status, anticipated need for health care services, etc.

⁷¹ Congress initially required that the Commissioners of the District of Columbia appoint one of GHI’s successor trustees. Act of August 11, 1939, § 3, 53 Stat. 1412, 1413. Congress later amended the charter to provide that “The number of trustees, their terms of office, and the manner in which they may be elected shall be fixed by the bylaws.” GHMSI Charter, § 3, as amended on October 17, 1984 by Pub. L. No. 98-493.

⁷² GHMSI has an ownership interest (reportedly, 40 percent) in a for-profit subsidiary known as CareFirst Blue Choice, Inc. a health maintenance organization. Amended Statement at 1.

“charitable and benevolent” for *this* corporation. Congress was aware that GHMSI sold commercial-type insurance, *see* 130 Cong. Rec. 25522 (1984), and presumably was aware that GHMSI must successfully compete in order to do so. Congress also was aware that GHMSI had one or more for-profit subsidiaries, *see* 138 Cong. Rec. 20141 (1992), but did not express dissatisfaction with that state of affairs and did not amend GHMSI’s charter or otherwise legislate to prohibit such arrangements. As has been recognized, a nonprofit insurer can use profits from its for-profit subsidiaries to fund its social mission.⁷³ Moreover, GHMSI reportedly receives no charitable donations that it can use to conduct charitable activities, so it must fund those activities out of earnings from operations and/or investments.

Nor is GHMSI required to spend all of its surplus, beyond the reserves required by law, for public purposes.⁷⁴ Courts have recognized that the complex financial realities of operating a modern health care organization “often require[] deliberately designed surplus revenues to ensure adequate levels of service and resources.” *Rideout Hosp. Foundation v. County of Yuba*, 8 Cal. App. 4th 214, 225 (Cal. Ct. App. 1992).⁷⁵ GHMSI is, however, obligated to utilize any excess reserves to pursue activities and initiatives to promote and safeguard the health of the public in its service area,⁷⁶ because the case law requires this of charitable institutions. *See, e.g., Radosevic v. Virginia Intermont College*, 633 F. Supp. 1084, 1087 (W.D. Va. 1986) (noting that under the Virginia common law of charitable immunity, a factor relevant to whether an entity is a charitable organization is whether any surplus revenue the entity realizes is devoted to charitable work); *George v. Jefferson Hospital Ass’n, Inc.*, 987 S.W. 2d 710, 713-14 (Ark. 1999) (surplus did not destroy a hospital’s charitable status where the funds’ anticipated use was in furtherance of the hospital’s overall charitable purposes); *Wilson Area School District v. Easton Hospital*, 747 A. 2d 877, 881 (Pa. 2000) (to qualify as a public charity, a hospital was required to utilize surplus revenue “to increase the efficiency of the hospital or with the expectation of a reasonable return in support or furtherance of its charitable purpose”); *Miami*

⁷³ *See* Larsen Decision at 97-98 (noting that this is a practice followed by Highmark BlueCross Blue Shield, a plan that then-MIA Commissioner Larsen found is “taking steps to fulfill a ‘social mission’”); *see also IHC Health Plans*, 325 F. 3d at 1199 n. 22 (recognizing “that an activity that is not ‘inherently charitable’ may nonetheless further a charitable purpose”).

⁷⁴ “Surplus provides a safety cushion to absorb adverse results and protects the policyholder and the company by helping maintain the company’s solvency during periods of unfavorable operating results.” *State Farm*, 8 Cal. Rptr. 3d at 63, quoting Troxel et al., *Property-Liability Insurance Accounting and Finance* (4th ed. 1995) at 129. “An insurer must have an adequate surplus at all times, especially in light of potential catastrophes that may result in substantial damage to numerous policyholders.” 8 Cal. Rptr. 3d at 63.

⁷⁵ *See also Sound Health*, 71 T.C. at 188 (“We do not believe that the Association has to bankrupt itself to prove that it is ‘charitable’ . . . A defunct charity can hardly help anyone”).

⁷⁶ The case law does not suggest a mandatory or maximum time period for spending down any excess reserves, but analogous tax law suggests that GHMSI could do so over time pursuant to a rational spending plan. *Cf. Erie Endowment v. United States*, 316 F. 2d 151, 155 (3d Cir. 1963) (reasoning that “[t]he standard to be applied is whether the taxpayer can justify the total accumulation of income at the end of the taxable year, in terms of both time and amount, on the basis of a rational program of charitable intent. The plan must be viewed in its entirety,” and finding that where endowment had no specific projects for which its accumulations were to be kept and no program of expenditures of its accumulated income, its accumulation of \$10 million before accumulation ceased appeared “patently unreasonable”).

Retreat Foundation v. Ervin, 62 So. 2d 748, 751-52 (Fl. 1953), (“There is nothing inconsistent with the character of a corporation not for profit, that profits result from its operations, if such profits are devoted to the charitable purpose for which it was organized”); *IHC Health Plans*, 325 F. 3d at 1197-98 (noting it is characteristic of a health organization with a charitable purpose to devote surpluses to research, education and medical training).

This, of course, raises the question of what are necessary reserves. As a starting point GHMSI must maintain the level of reserves required by District law to ensure safety and soundness. Reportedly, GHMSI’s reserve levels substantially exceed statutory reserve levels and are driven in part by the minimum liquidity level that GHMSI is obliged or induced to maintain as a BCBSA licensee. BCBSA explains that Blues organizations need reserves substantially in excess of statutory reserve levels to maintain financial strength and to compete effectively, and that the level of reserves needed by each individual organization “must take into account the unique business requirements of each Plan” and will vary on the basis of “competitive environment, market demographics, provider structure, economies of scale and size of operations, and future business plans and strategies,”⁷⁷ presumably including information technology and emergency preparedness strategies.

Our legal analysis gives us no basis to dispute that “[t]he financial soundness of an insurance company ‘depends on numerous factors that are difficult to quantify’” and that it may be “impossible to specify the ‘right’ amount of [surplus] for most insurers through a formula.”⁷⁸ However, in light of the foregoing case authority establishing that a charitable organization must devote its surplus to charitable purposes and in light of GHMSI’s charter obligation to pursue charitable purposes, we believe that GHMSI must have the burden of establishing that any accumulated reserves in excess of the levels required under District law and regulation are actuarially justified or otherwise are reasonable and necessary for efficient, competitive, and financially sound operation. Unless GHMSI bears and meets this burden, its charitable obligation to spend surplus for the benefit of the community beyond its subscribers would be negated.

Also, and in any event, we believe GHMSI has an obligation to ensure that its pursuit of charitable, public health initiatives is not merely “incidental” to its commercial insurance activities.⁷⁹ This means that GHMSI must give priority to charitable spending for public health initiatives, so that its level of expenditures for public health initiatives is not merely whatever is left over after the company has allocated earnings to advance all of its other strategic goals. If GHMSI may spend only “whatever is left” to support public health initiatives, the possibility exists that it will fail to provide a substantial community-benefit. This is not consistent with its declared status as a charitable organization. *Cf.* 61 Pa. Code § 32.1(iv)(A) (2004) (where an organization hires a promoter to run a professional golf tournament, and the money raised by the event is used to pay the promoter for his services or to pay the event participants, with *any remaining funds distributed to*

⁷⁷ Letter from Scott Serota, President and CEO of BCBSA, to Pennsylvania Insurance Commissioner M. Diane Koken, at 3 (Sept. 23, 2004).

⁷⁸ *State Farm*, 8 Cal. Rptr. 3d at 63, quoting Cummins et al., *An Economic Overview of Risk-Based Capital Requirements for the Property-Liability Insurance Industry*, 11 J. Ins. Reg. 427, 435 (1993).

⁷⁹ See *Supervisor of Assessments of Montgomery County v. Group Health Ass’n*, 517 A. 2d 1076; *IHC Health Plans*, 325 F. 3d at 1198.

exempt organizations, the event is not a charitable fundraising event) (italics added); *see also St. David's Health Care System v. United States*, 349 F. 3d 232 (5th Cir. 2003) (reasoning that for the founding documents of a partnership between a nonprofit hospital and a for-profit healthcare corporation to state a charitable purpose, they must commit the partnership “to give charitable purposes priority”);⁸⁰ *compare Quad Cities Open v. City of Silvis*, 804 N.E. 2d 499, 505, 510 (Ill. 2004) (holding, upon evidence that the articles of incorporation of a company that operated golf tournament stated that the company had the specific purpose “that all profits in excess of a one-year contingency fund” would be used in promoting the public good and that the company continued to donate to charities from its operating reserve fund even in a year when the tournament operated at a loss, that the tournament was operated for a charitable purpose and was a means to a charitable end).

These authorities suggest that GHMSI cannot reasonably be said to be pursuing its chartered charitable mission purpose if the company's charitable mission cedes position and inevitably yields to other corporate goals (however laudable or reasonable). If GHMSI's charitable purposes are a priority, as they must be, they must be ahead of at least some other strategic goals; they may not be subordinated to last position. Thus, the GHMSI Board has an obligation not to permit GHMSI's chartered mission, and the activities that the company has identified as consistent with and in furtherance of that mission, to take a backseat to earnings allocations and budgets that can stand as “an obstacle to the accomplishment and execution of the full purposes and objectives of Congress.”⁸¹ To ensure that this is not the result, we believe that, at a minimum, GHMSI has an obligation to commit a substantial dollar amount of resources to spending on community health initiatives. (Because it is to be a charitable institution, its charitable activities may not be “virtually inconsequential.” *IHC Health Plans*, 325 F. 3d at 1200 n. 27.) We also believe GHMSI's charitable mission obligates it to make this substantial commitment before completing the allocation of its earnings to other purposes (particularly those purposes, such as emergency preparedness, as to which the appropriate level of spending falls within a range or cannot be determined with precision). This could entail, for example, a decision by the Board to spend a stated percentage of premiums or of net earnings for public health initiatives. This may also entail an obligation for GHMSI to manage its earnings so that it realizes revenues that can be used to pursue activities that are consistent with its charitable mission, just as corporations manage their earnings to achieve other revenue goals.

⁸⁰ *See also* Rev. Rul. 98-15, 1998-1 C.B. 718 (1998). Revenue Ruling 98-15 addresses the circumstance of a partnership between a hypothetical non-profit hospital and a for-profit hospital corporation in which control over the partnership's capital and operating budgets and over distribution of earnings is shared equally with the for-profit; and in which the nonprofit “will not be able to initiate programs . . . to serve new health needs within the community without the agreement of at least one governing board member appointed by the” for-profit, which “will not necessarily give priority to the health needs of the community,” meaning that the partnership “will be able to deny care to segments of the community.” The Revenue Ruling concludes that upon contributing all of its operating assets to the partnership and ceding control in that way, the hypothetical nonprofit hospital would be unable to establish that it is operated primarily for charitable purposes.

⁸¹ *Hines v. Davidowitz*, 312 U.S. 52, 67 (1941).

Finally, to fulfill its charitable mission, GHMSI may have an obligation to do more than CareFirst of Maryland is required to do to fulfill its nonprofit mission of providing insurance at minimum cost and expense, *see* Larsen Decision at 23, and its obligations under Maryland law. Because CareFirst's nonprofit mission arguably is not co-extensive with GHMSI's charitable mission, we believe the GHMSI Board has a duty not to cede control to the nonprofit corporate goals of CareFirst (which could entail, for example, providing public health benefits only to the extent of any tax exemptions, thereby possibly falling short of the substantial community benefit standard).⁸² This obligation of GHMSI's Board flows from the principle that a Board of Directors' "duty of loyalty lies in pursuing or ensuring pursuit of the charitable purpose or public benefit which is the mission of the corporation" for which they have oversight responsibility.⁸³

III. District Regulators Have An Obligation Not Only to Safeguard GHMSI's Financial Health and to Protect Its Assets in the Event of A Conversion, But Also to Ensure That the Company Complies On an Ongoing Basis With The Mandates of Its Charter.

There appears to be no basis for doubt that Congress intends that the GHMSI charter be enforced. When Congress amended the GHI charter in 1984 to permit GHI to merge with the D.C. Medical Service to form GHMSI, it included in section 5 of the charter language requiring GHMSI to file its charter, bylaws, contract forms and annual financial reports with the District of Columbia Superintendent of Insurance. The amended section 5 also instructed that "If said superintendent shall have reason to believe that this corporation is *not complying with the provisions of this charter*, or is being operated for profit, or fraudulently conducted, he shall cause to be instituted the necessary proceedings to enjoin such improper conduct, or to dissolve the corporation." GHMSI Charter, § 5, as amended on October 17, 1984 by Pub. L. No. 98-493 (*italics added*). That language remained in place until 1993, when Congress replaced all of section 5 with a provision stating that "The corporation shall be licensed and regulated by the District of Columbia in accordance with the laws and regulations of the District of Columbia." GHMSI Charter, § 5, as amended on October 29, 1993 by Pub. L. No. 103-127, 107 Stat. 1336. Regulating GHMSI in accordance with the laws of the District means assuring that federal laws affecting GHMSI -- including first and foremost its federal charter -- are faithfully executed, as D.C. Code Ann. § 31-202(a) requires.

A. DISB's Authority and Obligations

The discussion above sets out the legal basis for concluding that GHMSI's federal charter obligates it to pursue a charitable mission. It also provides definition and content to that obligation.

⁸² We note that Md. Code Ann. § 14-106 exempts CareFirst, as a nonprofit health service plan, from the premium tax established under Md. Code Ann. § 6-101(b), "so that funds which would otherwise be collected by the State and spent for a public purpose shall be used in a like manner and amount by the nonprofit health service plan" to subsidize the Maryland Senior Prescription Drug Program and to increase the accessibility and affordability of health care products and services. Section 14-106(e) states that "[t]he subsidy required under the Senior Prescription Drug Program may not exceed the value of the nonprofit health service plan's premium tax exemption under § 6-101(b)."

⁸³ *Summers v. Cherokee Children & Family Servs.* 112 S.W. 3d 486, 504 (Tenn. Ct. App. 2002).

As already noted, while not disagreeing that GHMSI's charter imposes such an obligation, DISB Commissioner Mirel has expressed concern about protecting the public by ensuring that GHMSI -- the largest health insurer in the National Capital Area -- remains a viable insurer.

There can be no doubt that the District's insurance regulators have a responsibility to protect current GHMSI policyholders and the public by ensuring that GHMSI can remain financially healthy and can continue to provide health insurance coverage for District residents. To that end, District law specifically authorizes the Mayor (who has delegated his responsibility to DISB) to establish surplus and risk-based capital requirements for GHMSI as a Hospital and Medical Service Corporation. *See* D.C. Code Ann. § 31-3506(d). It also specifically authorizes District insurance regulators, upon finding that an insurer's continued operation in the District is hazardous to policyholders, creditors or the general public, to issue an appropriate corrective order, which may include, for example, an order to the insurer to increase its surplus. *See* D.C. Code § 31-2102 (a). The DISB Commissioner may also petition the Superior Court of the District of Columbia for an order authorizing him to rehabilitate an insurer whose financial condition is hazardous to its policyholders, creditors or the public. *See* D.C. Code § 31-1310.

At the same time, however, District law makes it the duty of the Commissioner to ensure that GHMSI complies with the requirements of the federal legislation that is its charter. D.C. Code Ann. § 31-202(a) states in pertinent part that "(a) It shall be the duty of the Commissioner [of insurance] to see that all laws of the United States relating to insurance or insurance companies, benefit orders, associations, and others doing insurance business in the District are faithfully executed" This provision creates a duty for the District's Insurance Commissioner to take steps to assure that GHMSI conducts its operations in a manner consistent with the declaration in its federal charter that it is to be a charitable and benevolent institution.⁸⁴

1. DISB May Regulate to Ensure That GHMSI Complies with Its Federal Charter Notwithstanding Any Conflicting Regulation By Other Jurisdictions.

DISB has full authority to regulate to ensure that GHMSI complies with its obligations under its federal charter and under District law, notwithstanding any conflicting regulation by other jurisdictions. The provisions of GHMSI's federal charter and District law and regulation (to the extent not inconsistent with the charter) preempt any other laws or regulations that purport to impose conflicting obligations on GHMSI. This is the result of the McCarran-Ferguson Act.

Through the McCarran-Ferguson Act, Congress granted the states broad authority to regulate the business of insurance, notwithstanding the fact that the business of insurance falls within Congress's power to regulate interstate commerce. The Act declares that "The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business." 15 U.S.C. § 1012(a). It is well-established

⁸⁴ On September 17, 2004, pursuant to D.C. Code § 31-3520, DISB adopted rules, entitled "Oversight Role and Fiduciary Obligations of Members of the Board of Directors of a Hospital and Medical Service Corporation," that *inter alia* require GHMSI's directors to "carry out the corporation's purposes as set forth in its charter," annually to review the corporation's charter, and to "review the use of the corporation's funds." 26 D.C.M.R. § 4504.1; 51 D.C. Reg. 9011 (Sept. 17, 2004).

that, within the limits of due process, state insurance regulation may condition an insurer's authority to do business in a state on the insurer's compliance with the various procedural and substantive requirements of the state's laws.⁸⁵

Nonetheless, it would not be correct to conclude that Maryland, Virginia, Delaware and other states may regulate GHMSI as they see fit to the extent of their interest in GHMSI's activities. That is because the McCarran-Ferguson Act contains not only a general insulation of state insurance regulation from Commerce Clause attack, but also the following limitation: "No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, *unless such Act specifically relates to the business of insurance.*" 15 U.S.C. § 1012(b) (emphasis added).

The 1993 amendments to GHMSI's charter, adopted through the Act of October 29, 1993, established that GHMSI "shall be licensed and regulated by the District of Columbia in accordance with the laws and regulations of the District of Columbia." It seems clear that the Act of October 29, 1993, like the entire charter, is an "Act specifically relating to the business of insurance." See *SEC v. National Sec., Inc.*, 393 U.S. 453, 460 (1969) (the "business of insurance" refers in part to the "licensing of companies"); *Masoner v. First Community Ins. Co.*, 81 F. Supp. 2d 1052, 1057 n. 3 (D. *Id.* 2000) (statute by which Congress authorized FEMA to regulate the business of flood insurance was an Act specifically relating to the business of insurance, and FEMA regulation preempts otherwise applicable state laws). Thus, the effect of the 1993 charter amendments was not only to authorize the District to regulate GHMSI, but to give primacy to the District's regulation of GHMSI over any conflicting state laws.

2. DISB Has An Obligation to Ensure That GHMSI's Board Identifies and Causes GHMSI Management to Implement Activities to Meet GHMSI's Charitable Mission.

In response to the 2003 Maryland legislation imposing new requirements on the CareFirst organization, Commissioner Lawrence Mirel issued an order, dated October 24, 2003, limiting the reach of Maryland law as it affects GHMSI. Among other things, the order specified that

GHMSI shall not participate in, or provide any healthcare product, benefit, or financial subsidy to, any public or private health care program or initiative that is mandated by any law or regulation by the State of Maryland that would benefit any person, organization, or government entity that is not a GHMSI policyholder without obtaining the prior written approval of the Commissioner of Insurance of the District of Columbia Department of Insurance and Securities Regulation.

⁸⁵ Due process requires that the state have a substantial interest in and ties to the conduct that is regulated. See *Gerling Global Reins. Co. v. Low*, 296 F. 3d 832, 839 (9th Cir. 2002), and cases cited therein. Thus, for example, a state generally may impose requirements on an out-of-state insurer as to the types of insurance policies sold in the state, and similarly may exercise authority over any acquisition, sale, reorganization or change in governance affecting the control or financial condition of a domestic insurance company. See, e.g., *Hoylake Investments Ltd v. Washburn*, 723 F. Supp. 42, 47 (N.D. Il. 1989).

To the extent that this provision of the October 24, 2003 order requires GHMSI to obtain the District Insurance Commissioner's approval before offering a benefit to non-policyholders *so as to comply with Maryland law*, the provision is appropriate and is consistent with section 5 of GHMSI's charter, which specifies that GHMSI is to be "licensed and regulated by the District of Columbia in accordance with the laws and regulations of the District of Columbia." For the reasons discussed above, we believe that Commissioner Mirel acted appropriately in asserting the District's primary regulatory authority over GHMSI⁸⁶ and that GHMSI, likewise, has responded appropriately in taking the position that it will challenge any application of Maryland law that purports to require GHMSI to operate in a manner that is inconsistent with and preempted by GHMSI's federal charter.⁸⁷

To the extent that the intent of Commissioner Mirel's October 24, 2003 directive quoted above (*i.e.*, that GHMSI may not provide any benefit or subsidy mandated by Maryland law to anyone who is not a GHMSI policyholder without DISB approval) is to ensure that GHMSI's activities do not pose a threat to the company's financial soundness, the directive may be justified as an exercise of the District's regulatory safety-and-soundness authority.⁸⁸ However, if the October 24, 2003 order is

⁸⁶ Commissioner Mirel has done so in a number of communications. In a March 5, 2003 letter to MIA Commissioner Larsen following Commissioner Larsen's order disapproving the WellPoint application, Commissioner Mirel asserted that his office is the "primary regulator of GHMSI" and objected to Commissioner Larsen's statement that while he might take into account the views of the DC Commissioner regarding the fate of GHMSI, "he is not required to do so." Commissioner Larsen relied on a November 12, 2002 opinion of the Maryland Attorney General that "it is within the Maryland Commissioner's discretion to decide whether and how much to defer to the judgment of the District of Columbia regulator" in matters affecting GHMSI's operations that may have an impact on Marylanders. Opinion No. 02-019, 2002 Md. AG LEXIS 18 at *2 (November 12, 2002). *See* Larsen Decision at 8.

Commissioner Mirel also responded to a bill before the Maryland legislature that would change the corporate governance structure of CareFirst, saying that any Maryland legislation that proposed to dictate any change in the way in which GHMSI is required to conduct its business, would be considered "a usurpation by Maryland of the District of Columbia's primary regulatory authority over GHMSI." *See* letter from Commissioner Lawrence H. Mirel to the Honorable Steve B. Larsen, at 2 (March 18, 2003). Commissioner Mirel termed "probably unconstitutional" proposed Maryland legislation that, in his words, was "designed to place the District's Blue Cross plan under the control of Maryland politicians." *See* letter from Commissioner Lawrence H. Mirel to The Honorable Thomas Middleton, Chairman of the Senate Finance Committee, Maryland State Senate, at 1, 2 (March 31, 2003).

⁸⁷ *See* letter from Edward J. Baran, Chair, GHMSI Board of Trustees to Commissioner Lawrence H. Mirel, at 4 (Sept. 10, 2003).

⁸⁸ We note, however, that in light of GHMSI's recent reported surplus levels, there appears to be no basis for doubt that GHMSI could provide ample additional community benefits before reaching the maximum feasible level consistent with its financial health and ongoing viability. *See* the report by Mathematica Policy Research, commissioned by DC Appleseed and entitled *Opportunities and Capacity for Community Service Mission: CareFirst/GHMSI's Potential Role in the National Capital Area*. It also appears that GHMSI's yearly community-benefit spending does not even reach the amount of its District premium tax exemption (*i.e.*, the 0.7% of premium GHMSI does not have to pay by virtue of being a hospital and medical services corporation). *See* footnote 19, *supra*.

(continued...)

intended generally to discourage or deter GHMSI from offering any subsidized or low-cost products, benefits or programs directed at individuals or groups who are not current GHMSI policyholders, the legal basis for the Order is, in our opinion, untenable, in light of GHMSI's federal charter declaration as a charitable and benevolent institution and its charter authority to "to cooperate, consolidate, or contract with individuals or groups or organizations interested in promoting and safeguarding the public health."

Rather than restrict and require prior approval for GHMSI's public benefit activities, the appropriate role for DISB would appear to be to hold the GHMSI Board accountable for ensuring that the company adheres to a charitable and benevolent mission, pursuing public health initiatives to the maximum extent that is consistent with the company's obvious need to remain financially sound. This approach recognizes that there are many ways in which GHMSI might comply with its charter obligation as a charitable institution. Even so, DISB should assure itself that GHMSI is reasonably complying with its mandated charitable mission.

DISB's regulatory oversight role could entail a scheme such as DC Appleseed proposed to the D.C. Council last year. The draft legislation that DC Appleseed circulated would have amended the Hospital and Medical Services Corporation Regulatory Act of 1996 (D.C. Code 31-3501 *et seq.*) to require GHMSI's Board of Directors

- to manage the affairs of the corporation in the public interest and in a manner that is consistent with GHMSI's status as a charitable and benevolent institution to the maximum feasible extent, taking into account current and anticipated market conditions;
- to submit to DISB a report by an independent, qualified expert assessing whether, in what manner, and to what extent GHMSI can operate in the public interest and as a charitable

In addition, an October 2003 report by health policy experts at the George Washington and Georgetown Universities concluded that by comparison to community needs and the practices of nonprofit Blue Cross Blue Shield companies in other jurisdictions, GHMSI's practices fall well below what consumers and providers should be able to expect from a non-profit health insurer with a charitable and benevolent mission. *See Analysis of CareFirst's Performance as a Charitable Not-for-Profit Health Insurance Company in the National Capital Area*, written by the George Washington University School of Public Health and Health Services and the Georgetown University Institute for Health Care Research and Policy, prepared under contract with DC Appleseed. CareFirst's statements are consistent with these findings. For example, in its Amended Statement submitted to DISR in 2002, CareFirst acknowledged that under District law, GHMSI is required to "provide health-related educational support to residents of its service area." Amended Statement Supplement at 28. CareFirst asserted, however, that GHMSI was meeting that obligation by offering health education programs and on-line health information resources solely to its contract holders. *Id.* at 26-28. In addition, CareFirst confirmed that as of July 2002, only 281 D.C. residents and a total of 1,948 residents in GHMSI's service area were covered by GHMSI's open-enrollment product. Amended Statement Supplement at 27. Indeed, commenting on the George Washington University/Georgetown University report finding that CareFirst is failing to meet Washington's health needs and is doing less in the National Capital Area than other Blues plans across the country do in their communities, CareFirst reportedly "[did] not contest the accuracy of the report" and did not find fault with it. *See* Marc Fisher, *Insurance Firm Doesn't Ensure Peace of Mind*, Washington Post, Dec. 2, 2003, page B01.

and benevolent institution and remain viable in the long term, taking into account current and anticipated market conditions, and thereafter to submit to DISB a plan for modifying GHMSI's operations so that it operates in the public interest and as a charitable and benevolent institution to the maximum feasible extent, taking into account current and anticipated market conditions, which plan would be subject to public comment prior to DISB approval;

- to report annually on how GHMSI has complied with the public plan during its most recently completed fiscal year and how it proposes to comply with the public plan in the coming fiscal year;
- to adopt a code of conduct and compliance program⁸⁹ obligating GHMSI's directors, before establishing policies or approving management proposals, to consider whether the policies and proposals are consistent with operation of GHMSI in the public interest and as a charitable and benevolent institution to the maximum feasible extent, taking into account current and anticipated market conditions;
- annually to review the compensation proposed to be paid directly or indirectly by GHMSI to its officers and other managers to ensure that such compensation is reasonable by comparison to compensation of management of similar not-for-profit health insurance issuers; and
- to direct, in the event that the Board determines that GHMSI has an overall surplus of reserves (considering the reserves that are reasonably necessary for GHMSI to remain viable as an issuer of health insurance in the long term, taking into account current and anticipated market conditions), that the surplus be utilized to promote and safeguard the public health in GHMSI service area.

Such requirements, whether imposed through legislation, regulation or DISB order, would give due consideration to the justifiable safety and soundness concerns that Commissioner Mirel has articulated and also give latitude to GHMSI in meeting its obligations under its federal charter.

B. The Role of the Office of Attorney General of the District of Columbia

The Office of the Attorney General of the District of Columbia also has a role to play in enforcing GHMSI's charitable mission. The D.C. Council, in enacting the Healthcare Entity Conversion Act, found and declared among other things that the Corporation Counsel (now Attorney General) is entrusted by common law not only to protect the interests of the public in the event of a transfer of the assets of a charitable healthcare entity, but also "to bring actions on behalf

⁸⁹ Note that D.C. Code § 31-3520 requires DISB to promulgate regulations requiring hospital and medical service corporations to "adopt a code of conduct and compliance program for all board members, officers and employees of the corporation."

of the public in the event of a breach of the charitable trust of a healthcare entity.” D.C. Code § 44-601(5).⁹⁰

Although the provisions of the Healthcare Entity Conversion Act pertain only to actions of the Attorney General upon the sale or transfer of assets of a charitable healthcare entity, it seems clear that the Attorney General’s common law authority to sue to prevent or correct breaches of a charitable trust would extend to actions to prevent an entity that holds assets in trust from withholding the expenditure of funds to meet the entity’s charitable obligations. In *YMCA v. Covington*, for example, the D.C. Court of Appeals upheld an injunction prohibiting the trustees of the Anthony Bowen YMCA from withholding funds necessary to renovate and to prevent the further physical deterioration of the facility’s physical premises. 484 A. 2d at 593. Likewise, if GHMSI fails to use excess reserves to pursue community health activities, the Attorney General could properly sue to require it to expend funds for that purpose.⁹¹

CONCLUSION

To summarize, we answer DC Appleseed’s questions as follows. GHMSI has an obligation under its federal charter and under District law to pursue a charitable mission. More particularly, GHMSI’s obligation is to foster public health initiatives, by providing services such as health education, health care research, participation in public programs, and subsidized coverage to the public in the National Capital Area beyond its policyholders. To fulfill its charitable mission, GHMSI must use its reserves and earnings for the benefit of the community to the maximum feasible extent, consistent with its need to remain viable and competitive. GHMSI has an obligation to commit to a level of charitable spending that will provide a substantial community benefit. District regulators -- both the Insurance Commissioner and the Attorney General -- have an obligation to ensure that GHMSI’s Board focuses on and causes the company to adhere to the company’s charitable mission.

⁹⁰ This duty of the Attorney General is in lieu of any right of the general public to enforce the terms of a charitable trust. The general rule, as recognized by the District of Columbia Court of Appeals, is that members of the general public -- the beneficiaries of GHMSI’s assets -- do not have standing to enforce a charitable trust. See *Young Men’s Christian Association v. Covington*, 484 A. 2d 589, 591 (D.C. 1984); see also Restatement (Second) of the Law: Trusts 2d, § 391, cmt. at 279 (“Since the community is interested in the enforcement of charitable trusts, a suit to enforce a charitable trust can be maintained by the Attorney General of the State in which the charitable trust is to be administered”).

⁹¹ An issue that might arise is whether an action by the Attorney General would be barred under the so-called “filed rate doctrine.” That doctrine, which recognizes the integral relationship between an insurer’s regulatorily-approved rates and its reserve levels, bars a collateral attack on rates approved by insurance regulators. See, e.g., *Ciamaichelo v. Independence Blue Cross*, 814 A. 2d 800 (Pa. Commw. Ct. 2002) (dismissing, on the basis of the doctrine, a suit alleging *inter alia* that the Blue Cross plan had accumulated excessive surplus for non-charitable purposes). We have found no case in which a court in the District has applied this doctrine. Were the Attorney General to act pursuant to the D.C. Council’s declaration of that office’s common law responsibility “to bring actions on behalf of the public in the event of a breach of the charitable trust of a healthcare entity,” there would be strong arguments that the filed-rate doctrine should not bar such a suit. The gravamen of such a challenge would be not to GHMSI’s rates, but to its accumulated reserves being in excess of a level compatible with its mission as a charitable institution.

Section 3:

Opportunities and
Capacity for
Community Benefit:

*GHMSI's Potential
Role in the National
Capital Area*



DC APPLESEED
C E N T E R

**Opportunities and
Capacity for Community
Benefit: GHMSI's
Potential Role in the
National Capital Area**

Final Report

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EXECUTIVE SUMMARY

This study was developed in the wake of an attempt by CareFirst, Inc. to be sold to a for-profit health plan, WellPoint, in 2001. The sale did not occur, but discussion continues about the appropriate role of CareFirst's nonprofit affiliates in providing community benefit consistent with their status in the community and respective charters. This study focuses on just one of CareFirst's nonprofit member companies—General Health and Medical Services, Inc. (GHMSI). GHMSI is the largest insurer in the District of Columbia, and a major insurer in suburban Maryland and Northern Virginia as well. It is also the largest of the CareFirst affiliated companies.

This study approaches the question of GHMSI's potential role in providing community benefit from three perspectives. We first consider the viewpoints of community health leaders who responded in writing and in interviews to questioning about how a large health insurer might contribute to improving community health and health care in the national capital area.

We then consider the roles of four nonprofit health plans located in various areas of the country (including one in the national capital area). Each of these plans holds roughly the same share of the market, or less, than GHMSI holds in the District of Columbia, and each generally is viewed as providing significant benefit to their community. We conducted document review and a series of interviews with the senior officials in each plan responsible for planning and implementing community benefits activities to learn how they identified and prioritized community needs, set and met community benefit funding goals, and viewed the effect of competition on their community benefit mission.

Finally, we present an economic and financial analysis of GHMSI's capacity to provide community benefit beyond its current efforts. We consider GHMSI's relative market position, measure its use of market power in setting economic prices (that is, premiums net of medical benefits paid), and market power in the national capital area, and confirm the practice of shadow pricing by the smallest insurers in the market. Based on this evidence, we consider GHMSI's level and accumulation of surplus (premiums net of both medical benefits and administrative cost) since 1998 and develop a simple simulation model to project GHMSI's premiums and surplus to 2008, assuming the same relative level of administrative costs and a downward underwriting cycle of the same magnitude as the upward cycle since 1998. We find that GHMSI's surplus levels are approximately twice those of significant competitors, higher than other CareFirst companies that write business in the national capital area, and two to four times as high, respectively, as the BCBS and NAIC standards that would trigger possible concern about the company's financial strength.

We conclude that GHMSI is indeed capable of significantly greater community benefit than it now provides. At least through 2008, a community benefit goal of 2 to 3 percent of direct premiums appears to be a feasible goal for GHMSI, consistent with both its market power and extraordinary accumulated surplus. This level of commitment annually would provide an estimated \$41 to \$61 million for community benefit in 2004, and potentially \$67 to \$100 million by 2008.

Addressing Community Need

The prevalent concerns of community health leaders in the national capital area mirror those of health leaders across the country. Population health status and behaviors related to obesity, mental

health, substance abuse, teenage pregnancy, and HIV/AIDS are of great concern. Targeted health education, action to stem the erosion of private health insurance, and greater access to culturally competent providers and services could address many of the most debilitating and costly health problems that affect area residents.

Local health leaders believe that the area's health insurers could be key players in several roles that few have developed broadly or at all. Insurers can engage residents in healthier lifestyles and facilitate greater access to health care services by supporting public clinics and subsidizing enrollment in own plans. They can develop and disseminate best practices for ongoing quality improvement, and diagnostic and care protocols for management of public health emergencies. The area's largest insurers have developed educational materials for their members that would be equally valuable to the broader community if distributed through the area's safety net clinics or in the "community wellness centers" that some local health leaders envision.

The need for greater capacity to deliver care to uninsured and underserved populations throughout the region is apparent. Local health leaders cite the need for more clinics, greater incentives for providers to serve low-income and uninsured adults and children, more language interpreters, and more training in cultural competency. The inability of patients—insured or uninsured—to "use the system" effectively (sometimes due to the plans' own administrative practices) diminishes health outcomes and adds to cost in the region. Failure to coordinate primary care and failures of access to prescription drugs are obvious sources of low-quality care and unnecessary cost. Some health leaders suggest that insurers are uniquely positioned to improve the efficiency and quality of care and therefore reduce cost, but few have made a real effort to do so.

Affordable health insurance is a critical issue, especially in the area's suburbs where general affluence masks a significant and apparently rising number of uninsured residents. The low-cost private insurance programs that one nonprofit insurer offers in the national capital region and in other communities are limited and have not developed widely. However, a substantial and growing need for "dues subsidy" programs that adjust health insurance premiums to family income is apparent.

Local health leaders view the area's prominent health insurers as potential partners and leaders in other areas, as well. For example, insurers could take a lead role in educating their members, health care providers, and the general public in how to respond to public health emergencies. Providers might be instructed how to coordinate with public health departments in such an emergency. Financial incentives to adhere to clinical guidelines for testing and treatment could reduce health care costs in general and help to avoid system "overload" during a public health emergency.

Examples of Community Benefit

Some nonprofit health plans have extensive histories of community benefit. These plans offer a window on how GHMSI might proceed to develop and implement its community benefit mission. We investigated four such plans. Each defines its community benefit role in consultation with the community in some way—although the processes typically are informal. Coincidentally, all but one originated as a clinic- or hospital-based integrated health care plan. These plans continue to rely on their provider networks to implement some part of their community benefit mission, but all pursue significant community benefit activities in addition to those that they undertake to meet their nonprofit hospital community benefit obligations. All four plans see access to care as an essential

part of their community benefit mission, and all attempt to improve access in important ways—by serving public programs, funding and supporting health clinics, and/or substantially subsidizing plan enrollment for low-income children and adults.

Resources and Competition

The annual level of resources these plans devote to community benefit typically ranges from 1 to 2 percent of earned premium. Each balances the priorities of managing a sound financial operation and pursuing its community benefit mission somewhat differently, but all have a commitment to protecting and developing funding for community benefit. None regard competition as a compelling constraint on community benefit, although of course all recognize the fundamental importance of maintaining the health plan's financial integrity. In general, each regards competition as “baked into the business” and community benefit as an essential part of the health plan's mission.

GHMSI's Market Position

GHMSI is the largest insurer in the national capital area. It held an estimated 29 percent of the risk market in 2003, including its FEHBP business, other group coverage, and individual coverage (but excluding its business as an administrator for self-insured employer plans). Kaiser is GHMSI's nearest competitor, although it is about half GHMSI's size.

Over the last five years, GHMSI's total premium revenue has grown at an average rate of 15 percent per year, and much faster in suburban Maryland and Northern Virginia— respectively averaging 40 percent and 21 percent per year. For non-FEHBP coverage especially, average premiums have grown very fast: from 2002 to 2003, average (per enrollee) premiums increased more than 25 percent. At the same time, enrollment dropped 3 percent in the District, 6 percent in suburban Maryland, and nearly 14 percent in Northern Virginia. It is likely that at least some of those leaving GHMSI enrollment in response to steep premium increases became uninsured.

Market Power

GHMSI's very large market share offers simple evidence of a noncompetitive health insurance market. In recent years GHMSI has accumulated surplus (net of medical and administrative costs) at an average rate of 27 percent per year. GHMSI's accumulated surplus equaled 21 percent of premiums in 2003, nearly four times Kaiser's level of surplus relative to premiums. In 2003, GHMSI's surplus build-up accounted for about 6 percent of premiums, while Kaiser “gave back” to enrollees about 1 percent of premiums in the form of surplus reduction.

Much of GHMSI's surplus and surplus build-up may relate to BCBS plans' general practice of holding very high surplus relative to risk-based capital (a measure of an insurer's financial condition). However, between 1998 and 2003, GHMSI's average surplus relative to risk-based capital was more than four times the level that would trigger regulatory concern, and more than twice that of either its largest competitors or BCBS minimum standards. In general, this means that GHMSI's competitors were able to offer lower consumer prices for coverage, provide more health care per premium dollar, or both. However, it means also that GHMSI's pricing has sheltered smaller competitors that shadow-price GHMSI's products, and probably has raised area prices for health insurance overall.

Statistical analysis of insurer behavior in the District, Maryland, and Virginia, offers strong evidence that GHMSI exercises significant market power in the national capital area. Specifically, we

estimate that GHMSI built nearly \$14 billion into its economic prices between 1998 and 2003 related to its market power, averaging 2.1 percent of earned premium.

Financial Capacity for Greater Community Benefit

A simulation of the impact of greater expenditure for community benefit on GHMSI's financial position indicates that it is financially capable of providing substantial community benefit. At the likely low point of the underwriting cycle (in 2008), we estimate that GHMSI could allocate annually an additional 2 to 3 percent of premium to community benefit while maintaining its current level of surplus relative to premium (and therefore not raising the observed price (that consumers pay for coverage) net of increases in medical benefits paid). At that level of expenditure for community benefit, GHMSI's projected surplus also seems likely to remain at approximately twice the NAIC standard and also greater than the BCBS standard for minimum risk-based capital.

A commitment of 2 to 3 percent of GHMSI's direct premiums would equate to community benefit of \$41 to \$56 million in 2004, and as much as \$100 million in 2008. However, if total premiums were to rise very fast—by 15 percent per year through 2008—it might put upward pressure on observed prices, as GHMSI may attempt to spread accumulated surplus over its fast-rising premium base. Thus, our simulations lend support to a more obvious point: any rule for allocating a percentage of premiums must be managed with flexibility. Nevertheless, it seems clear that GHMSI could allocate substantially more than it does now to community benefit, and a range of 2 to 3 percent of direct premiums appears to be a feasible goal for this expenditure.

I. COMMUNITY HEALTH NEEDS

The problems of health status and health care in the Washington, DC metropolitan area are significant and complex. As in other metropolitan areas of the United States, the socioeconomic and ethnic diversity of the national capital area's population complicates the challenge of addressing problems of health care access and quality that all parts of the region have in common. But the Washington, DC area also faces unique challenges, including the relatively high likelihood of a region-wide public health emergency and the need to coordinate responses across multiple city, county, and state jurisdictions.

This report describes the major problems of health status among area residents and then reviews a series of issues that were raised by area health leaders as priorities for concern and targets of current local, often isolated, initiatives. These include the development of healthy behaviors to prevent illness, mental and behavioral health problems, children's access to care, more general access to care, language and cultural competency, health care quality, and emergency preparedness. The purpose of our investigation of local health problems and initiatives was to identify and understand in some detail the initiatives that area insurers—and GHMSI in particular—might pursue in the context of a focused community health program.

The information in this report comes from several published sources as well as an extensive process of obtaining commentary from local area health leaders—including health agency directors, leaders of community service organizations, and others engaged in advocating for improved health access and services in the national capital region. Their commentary was provided in response to an e-mail survey, semi-structured interviews conducted by telephone and in person, and a group discussion. The data collection process is described in Appendix A.

A. HEALTH CONDITIONS AND BEHAVIORS

1. Clinical Indicators of Health Status

On many measures of health status, residents of the Washington, DC metropolitan area rank at or above the national average. One recent report prepared by the Metropolitan Washington Public Health Assessment Center concluded that the region scored better than the national average for 19 of 27 health indicators.¹ Improvements in some indicators of health status—death from coronary heart disease and screening for breast cancer—have surpassed 2010 national targets, and the change in adult obesity is approaching the 2010 target (Metropolitan Washington Public Health Assessment Center 2001). Nevertheless, all three—coronary heart disease, breast cancer, and obesity—continue to be important health problems in the national capital area, as they are nationally, as well as major

¹ A recent study conducted by the Metropolitan Washington Public Health Assessment Center provides information on health conditions for people living in the larger metropolitan area, including the District of Columbia, northern Virginia, and suburban Maryland. Data for the study were obtained from the Centers for Disease Control and Prevention (CDC)—including the National Center for Health Statistics (NCHS), the Behavioral Risk Factor Surveillance System (BRFSS), and CDC's disease surveillance systems—as well as from the health departments of the District of Columbia, Maryland, and Virginia and from the Metropolitan Washington Council of Governments.

sources of health care costs. In the District of Columbia, the rate of death due to heart disease (296 per 100,000 population in 1999) is higher than deaths due to any other cause and exceeds the national average (270 per 100,000 population) (CDC 1999).

Rates of HIV/AIDS and other sexually transmitted diseases (STDs), binge drinking, and firearm-related deaths also are relatively high among residents of the Washington, DC metropolitan area. And the area-wide rates of infant mortality and low birth weight exceed the national average. These problems largely reflect health conditions in the District of Columbia. In 2001, the District reported 152.1 AIDS cases per 100,000 population—10 times the national average (14.9 per 100,000 population) (CDC 2001). The rate of infant deaths in the District was nearly twice the national average—12.0 per 1,000 live births compared with 6.9 nationally (CDC 2002).

The prevalence of specific health conditions varies among the jurisdictions that comprise the Washington, DC metropolitan area. Residents of higher-income jurisdictions generally have better average health status. Consistent with this pattern, residents of the District of Columbia on average have much worse health status than residents of suburban Maryland and Virginia.

However, there are some notable exceptions to this. For example: Prince George's County residents have higher rates of coronary heart disease, obesity, diabetes, and motor vehicle crashes than residents of the District. In Alexandria, the number of people reporting poor mental health on 8 or more days of the past 30 days is higher than in either the District or the region as a whole. In Arlington County, the suicide rate is higher than in the District, the region, or the nation as a whole (Metropolitan Washington Public Health Assessment Center 2001).

2. Prioritizing Health Conditions

While various indicators of area residents' health status suggest cause for concern, we attempted to identify which may be of greatest concern in terms of the social cost or burden of illness. A disability-adjusted life-year, or DALY, is one measure developed for this purpose. Computed as the sum of (1) years of life lost due to premature mortality in the population and (2) years of disability, DALYs measure fatal and nonfatal health outcomes for diseases, injuries, and risk factors in terms of lost productive years of life. International studies of public health needs often use DALYs to help target research and interventions on areas of improvement likely to have the greatest benefit for the community (Michaud 2001).

Table 1
Estimated Disability-Adjusted Life Years (DALYs) for Major Conditions - Washington, DC Metropolitan Area

MEN					WOMEN				
Rank	Condition	Total DALYs ^a (in thousands)	DALYs per 100,000 population	% of Total DALYs	Rank	Condition	Total DALYs ^a (in thousands)	DALYs per 100,000 population	% of Total DALYs
	All conditions	318.7	63.4	100%		All conditions	276.4	55.0	100%
1	HIV/AIDS	104.7	20.8	33-46%	1	Ischemic heart disease	18.4-19.0	3.7-3.8	7%
2	Homicide/violence	47.7	9.5	15%	2	Unipolar major depression	18.4	3.7	7%
3	Ischemic heart disease	29.6-30.5	5.9-6.1	9-10%	3	Cerebrovascular disease	12.2	2.4	4%
4	Alcohol abuse/dependence	14.9	3.0	5%	4	Lung, trachea, and bronchus cancers	10.5-12.4	2.1-2.5	4%
5	Lung, trachea, and bronchus cancers	11.4-12.2	2.3-2.4	4%	5	Breast cancer	8.8	1.8	3%
6	Road traffic conditions	11.1	2.2	3%	6	Alcohol abuse/dependence	8.4	1.7	3%
7	Cerebrovascular disease	10.9	2.2	3%	7	Osteoarthritis	8.3	1.7	3%
8	Drug use	9.9	2.0	3%	8	Dementia	8.1	1.6	3%
9	Unipolar major depression	7.8	1.6	2%	9	Diabetes Mellitus	8.0	1.6	3%
10	Congenital abnormalities	7.6	1.5	2%	10	Congenital Abnormalities	7.1	1.4	3%
11	Diabetes mellitus	7.0	1.4	2%	11	Road traffic conditions	5.5	1.1	2%
12	Osteoarthritis	6.3	1.3	2%	12	Chronic obstructive pulmonary disease	5.3	1.1	2%
13	Dementia	6.1	1.2	2%	13	Asthma	4.7	0.9	2%
14	Chronic obstructive pulmonary disease	5.8	1.1	2%	14	Colon or rectum cancer	3.6	0.7	1%

Source: Mathematica Policy Research, Inc. Washington, DC.

^aCalculated from the U.S. figures (Michaud, CM, CJL Murray and BR Bloom, "Burden of Disease: Implications for Future Research," JAMA (285:5), February 7, 2001), adapted to the Washington DC MSA based on information reported for Washington, DC (Behavioral Risk Factor Surveillance System, National Vital Statistics System, CDC HIV/AIDS Surveillance Report, SAMHSA National Household Survey on Drug Abuse) or all MSAs (National Health Interview Survey).

We calculated DALYs separately for men and women for 14 health conditions that rank as major sources of lost disability-adjusted life-years.² Notably, the ranking of health problems in the Washington, DC metropolitan area differs for men and women, potentially contributing to a diversity of perspectives about priority health needs in the metropolitan area (Table 1).³

Among men in the national capital area, HIV/AIDS and homicide/violence are the greatest sources of disability-adjusted life-years lost (whereas they rank fourth and seventh, respectively, in the United States as a whole). Drug use and congenital abnormalities also are greater sources of disability and lost life-years among men in the national capital area than nationally.⁴

Among women, the conditions that contribute most to disability or lost life-years are much different than for men. Heart disease, depression, cerebrovascular disease (stroke), and lung and related cancers are leading sources of disability-adjusted lost life-years among women in the region. However, like men, women in the national capital area suffer more often from the burden of alcohol dependence and congenital abnormalities than the average nationwide.⁵

As a guide for health policy in the Washington, DC metropolitan area, these estimates warrant at least two important caveats. First, the incidence and burden of children's illnesses in the region may be underrepresented. Because DALY calculations discount future years of productivity relative to current productivity, they systematically give less weight to disease burden among children.⁶

Second, while obesity is a major public health concern in the United States, published DALY calculations (from 1996) omit obesity as leading source of lost disability-adjusted life-years. This omission may reflect how obesity was measured and classified—as one of a number of risk factors that contribute to health problems, but not itself a principal diagnosis. Nevertheless it is likely that

² Data sources are described in Appendix B. Using published sources, we considered only health conditions that correspond to high DALY estimates nationally. However, we were unable to identify any conditions that were significantly more prevalent in the District of Columbia (or in Metropolitan Statistical Areas generally) than in the United States as a whole.

³ Comparing various health status indicators for the District, Delaware, Maryland, and Northern Virginia, Lewin (2004) identified a similar (though less detailed) list of conditions. Their report identified (1) reducing chronic disease through improved health behaviors; (2) improving access to primary and preventive services, (4) improving the quality of services related to chronic disease/prevention, and (4) eliminating racial disparities as themes for potential action to improve health status and health systems.

⁴ In contrast, other risk factors such as road traffic incidents and chronic obstructive pulmonary disease are more prominent as national issues. Some potentially important sources of disability and lost life-s, such as self-inflicted injuries (which ranked n for men in the United States) are omitted from this list, as we had no data for the District of Columbia or metropolitan areas separate from other geographic areas for calculating a local ranking.

⁵ In contrast, osteoarthritis and chronic obstructive pulmonary disease are more prominent sources of disability-adjusted lost life-years among women nationally.

⁶ Even so, in 1999, 5 of the top 10 causes of disease burden worldwide primarily affected children. These included lower respiratory tract infections, diarrheal diseases and nutritional deficiencies (Michaud 2001).

many risk factors—physical activity, diet, and cholesterol and blood pressure levels, as well as obesity—contribute to the burden of disease and should be considered (Michaud 2001).

When asked about their perceptions of significant health problems in the region, local residents and stakeholders identified priorities that vary according to the part of the region and type of organization they represent. For example, in a recent survey conducted by the Kaiser Family Foundation, a sample of adults in the District identified HIV/AIDS and other STDs as the most pressing health issue.⁷ Our questioning of local health leaders also identified HIV/AIDS as a major problem, but they also identified mental health and substance abuse, chronic disease (including asthma, diabetes, cardiovascular disease), and lifestyle/obesity as important health problems.

Health leaders in the Maryland and Virginia suburbs identified a different range of issues. In Maryland, health leaders pointed to infant mortality and rising rates of HIV infection—specifically among women in Prince George’s County—as important problems. Other health leaders identified cancer, violence and abuse, trauma and related disorders, problems that the growing population of elderly face, and unintended pregnancies and poor birth outcomes as critical health issues regionally. In Alexandria, early findings from an area health assessment suggest that priorities for that community are obesity, tobacco use, and mental health/substance abuse; HIV/AIDS is of less concern.

B. COMMUNITY ISSUES AND INITIATIVES

Personal health and health behaviors, improvements in access to care, cultural competence, and quality improvement are problems in the Washington, DC metropolitan area, as they are nationally. Local health leaders identified several problems where greater attention and resources would make important differences—including effective education to promote healthy behaviors; greater access to mental health, adult and child health services; language and cultural competency; quality of care; and emergency preparedness. While funding is available for a number of local activities that have made progress in addressing these problems, most initiatives have operated on a scale that is too small to achieve significant impacts. When asked what needs to be done to make important improvements with respect to any of the problems that local health leaders identified as priorities, respondents listed ideas that ranged from building on current programs to “thinking big” and creating systemic change.

The following sections summarize responses to a formal survey of health leaders in the Washington, DC Metropolitan area as well as discussions that occurred in a series of in-person and telephone interviews. Specifically, we asked what might be done to address the major concerns that area health leaders identified and, in particular, what health insurers in the region might do.

1. Healthy Behavior

Local health leaders contend that many of the region’s most debilitating and costly health conditions—HIV/AIDS, substance abuse, chronic diseases, and obesity—could be addressed by

⁷ Responding to an open-ended question about serious health concerns in the District of Columbia, 24 percent identified HIV/AIDS as a major concern (Lillie-Blanton 2003).

improving nutrition, encouraging exercise, and reducing unsafe sex, use of illegal drugs, and smoking. Area residents appear to be receptive to such activities. Responding to a survey conducted by the DC Primary Care Association (DCPCA), residents' most frequent request was for more fitness and wellness programs (DCPCA 2003).

Local health leaders suggested various interventions as likely to be helpful in improving healthy behaviors, including the following examples:

- A regional campaign of preventive efforts focused on diet, exercise, and smoking might be mounted. Washington, DC's current campaign urging residents to "Eat Smart, Move More" was offered as one model.⁸ Health leaders also pointed to Philadelphia's seemingly effective campaign to control obesity as a possible model for expanding efforts to promote healthy behavior.
- Health education programs for children and adults might be developed regionally. Local health leaders generally agreed that current health education strategies are inadequate and often ineffective. Because many children adopt behaviors from their peers, formal peer education programs might reach children more successfully than instruction by adults, along with better enforcement of health education requirements and activities in schools.⁹ Montgomery County is exploring such school-based strategies to address childhood obesity.
- "Lifestyle change centers" for adults could provide access to dietitians, counselors, nurses, and other health professionals via existing community organizations. In addition, programs such as the area food bank's Super Pantry Program might be expanded to increase the number of practical classes that teach parents how to prepare nutritious meals. Medicaid and other insurers do not routinely cover such nutritional classes or obesity interventions. Private insurers might also share more broadly with the community the materials they develop to educate their own members on management of specific conditions (such as hypertension).
- Financial incentives might encourage health providers to engage in health promotion activities and for plan members to participate in such activities. For example, providers might be reimbursed for health education and promotion activities and insured employees

⁸ The Washington, DC *Eat Smart/Move More* Food Stamp Nutrition Education Program (FSNEP) offers community-based nutrition education programs for families with young children, youth, the elderly, and individuals with special needs who receive or are eligible to receive Food Stamps. *Eat Smart/Move More* is funded by the U.S. Department of Agriculture's Food and Nutrition Service (FNS), with matching state and local support from the District of Columbia Department of Health, Nutrition Programs Administration and the Department of Human Services, Income Maintenance Administration [http://dchealth.dc.gov/services/wic/index_fsnep.shtml] accessed August 26, 2004.

⁹ One respondent suggested the National Commission for Health Education Credentialing, which certifies health educators, as a potential partner in the enforcement of schools' health education and activities requirements.

and public program beneficiaries rewarded for obtaining regular preventive screenings and improving their health status.

- Public policy changes could create effective incentives to improve health. For example, measures to prevent or address childhood obesity could be adopted and coordinated throughout area schools, tobacco taxes might be increased, and region-wide policies to discourage smoking might be developed.

2. Mental and Behavioral Health

Mental health problems are reported to be a leading diagnosis in hospital admissions in the District of Columbia and a crucial issue throughout the region. In the suburban counties mental health issues are even more prevalent than in the District of Columbia.

Local health leaders identified several factors that contribute to the problem:

- The number of behavioral health practitioners willing to treat low-income patients for mental health and substance abuse problems is inadequate. The U.S. Health Resources and Services Administration (HRSA) has classified the Anacostia area of the District of Columbia as well as several safety net providers as having shortages of mental health professionals (HRSA 2004).
- The reduced supply of public hospital beds in the District of Columbia has prevented some residents from obtaining proper care for mental illness and co-occurring disorders.
- The District of Columbia's adoption of the Medicaid Rehabilitation Option reportedly has ended reimbursement for preventive services and limited the roles of some mental health professionals.
- Issues with Medicaid recertification sometimes interfere with the continuity of patients' compliance with drug regimens for behavioral health problems. Concern is growing as the number of mental health providers who prescribe such medications continues to increase.

Health leaders were unable to point to any current, comprehensive effort to address the region's mental health needs.

3. Children's Health

Despite significant activity to improve children's health in the national capital area, local health leaders cited the need to expand current programs and services. Implementation of the State Children's Health Insurance Program (SCHIP) in 1998 has produced no significant improvement in District children's health indicators or outcomes. However, local health leaders identified several initiatives that might achieve such improvements:

- In the District of Columbia, the primary care clinics operated by Children's National Medical Center are overloaded. Demand for the District's medical van program (which provides dental and preventive services for children) is estimated to be approximately twice the

program's current capacity. Additional resources for these and similar programs would be of value.

- Parental awareness and access to pediatric vaccinations could be greatly improved—with efforts made to provide vaccinations free of charge to parents well before the beginning of the school year.
- New programs for obesity intervention at an early age might be valuable, as would an expansion of school-based mental health programs that apparently are effective. Programs to promote healthy behavior among pregnant women and mothers also could be of value in improving children's health.
- The school nurse program administered by Children's National Medical Center for the District of Columbia Health Department is straining to accommodate the rising number of medically fragile children (e.g., those with tracheotomy tubes or on oxygen) who are mainstreamed into the public schools.
- A program that provides home visits for prenatal care and infant and preschool immunizations to at-risk children, the Freddie Mac Foundation's Healthy Families DC, might be expanded. Area health leaders view the program as effective in reducing infant mortality.

Low-income children in suburban areas also face important gaps in access to care. In Arlington County, a shortage of pediatricians for all children severely limits access to care for children in low-income families. Unmet demand for pediatric care is estimated at about twice the county's current capacity.¹⁰ Children's access to dental care is a problem throughout the region.

Specific efforts identified as effective potential targets for greater resources or replication included the following examples:

- For a number of years, Arlington County staffed the Women, Infants and Children (WIC) program office with a nurse practitioner who provided standard vaccinations to children when their mothers applied to WIC for food and baby formula. County budget cuts forced an end to this practice.
- Acting on the findings of the county's Fetal Infant Mortality Review Commission, Prince George's County created a women's wellness center, developed outreach activities, and established a toll-free health line. Such an effort might be expanded and replicated across the region.
- With help from Catholic Charities and Kaiser Permanente, Prince George's County created the Medical Care for Children Program to provide free health insurance for 700 low-income

¹⁰ The State Health Access Data Assistance Center (SHADAC) reports that the number of physicians per 100,000 population in Virginia is below the state average nationwide (SHADAC 2003).

children. With the elimination of county funds the program started charging a premium of \$60 per child, resulting in a significant drop in participation. Kaiser Permanente also partners with other jurisdictions in the area to provide reduced-premium insurance coverage.

- Montgomery County operates several small dental clinics that serve children (as well as pregnant woman and seniors) who are uninsured and ineligible for Medicaid. Nevertheless, the county estimates the unfunded need for dental care at \$16 million per year. That amount would support a higher level of Medicaid reimbursement among dentists and implementation of a strategic plan to target second graders for oral health screening and preventive dental care.
- Lead poisoning among children is a concern in suburban areas as homeowners renovate old housing. Screening of two-year-olds for blood lead levels is critical, but insurers have been reluctant to make lead screening a member or community priority.

4. General Access Issues

Although the national capital area's rate of insurance coverage exceeds the national average, gaps in access to primary care, specialty services, dental care, and prescription drugs are still major problems (SHADAC 2004). Including participation in the DC Healthcare Alliance, an estimated 9 percent of District adults were uninsured in 2003. Alexandria's rate of uninsured is informally estimated at about 11 percent.

The DC Healthcare Alliance has made progress in providing services to the uninsured, but the Kaiser Family Foundation survey of adults in the District of Columbia found that only 23 percent of residents familiar with the alliance thought that the organization had improved residents' access to care (Lillie-Blanton 2003). Residents face difficulty in finding affordable individual or small group insurance coverage, particularly if they have prior or ongoing health problems.

Among residents of the Washington, DC metropolitan area, 19.1 percent have no usual source of care (AHRQ 2004). Such gaps may cause residents to delay necessary care and turn to hospital emergency rooms for problems that might have been prevented and care that might be provided in a less costly setting.

In the District of Columbia, more than half of the population (approximately 300,000 residents) live in official primary-care shortage areas (HRSA 2004). Although the District has many more federally sponsored safety net clinics for its population size than the national average (SHADAC 2004), the demand for safety net care exceeds the capacity of the existing clinics, even when supplemented by additional free clinics and mobile health care vans. In 2003, 45 percent of uninsured District adults responding to the Kaiser Family Foundation survey had not made a medical visit in the past 12 months, compared with 11 percent of those with private coverage (Lillie-Blanton 2003).

In the national capital area's suburbs, there is a serious shortage of federally qualified health centers (FQHCs) to serve low-income residents. The deficiency is attributed not to low need but rather to the proximity of low-income neighborhoods to middle- and high-income areas, making it difficult for suburban counties to qualify as medically underserved areas. Suburban Virginia has just one FQHC, which is located in Alexandria; it opened in 2004 after Alexandria received special

designation as a medically underserved area. Likewise, Prince George's County has just one FQHC, and Montgomery County has none (the county's Primary Care Coalition advocates for funding to support safety net clinics).

The Washington, DC, area has a relatively large number of physicians, but relatively few are willing to treat low-income, uninsured residents.¹¹ In the District, the shortage of physicians in general and of specialists in particular is acute in the poorest parts of the city, Anacostia and other parts of Southeast Washington. Local health leaders throughout the region view low reimbursement and administrative complexity as the chief reasons for declining physician participation in Medicaid and inadequate access to health and dental care for the uninsured. In Montgomery County, the high and rising cost of medical malpractice insurance is viewed as a major problem affecting the supply of obstetric services especially.

Several initiatives are underway to address shortages of basic health care services in the region. In general, any of these efforts would welcome the participation of private insurers as collaborators and partners:

- In an effort to expand basic health care services to District residents, the DCPCA is conducting a Medical Home initiative in collaboration with the Office of the City Administrator, the District of Columbia Department of Health, the Brookings Institution, the RAND Corporation, and others. The initiative will develop a citywide assessment of gaps in the primary care safety net, help clinics improve their quality of care and financial and management systems, assist clinics in business and capital planning, and identify debt and equity sources to finance clinic construction and rehabilitation.
- Strategies and incentives are needed to encourage dentists to treat low-income adults and children—both Medicaid beneficiaries and the uninsured. While the District of Columbia and some counties operate free or low-cost dental clinics for uninsured children, adults, and seniors, area health leaders point to a critical need for additional capacity.
- Expansion of pharmaceutical assistance programs for low-income residents also is another critical need. Although the DC Healthcare Alliance covers prescription drugs, a restricted formulary prevents some enrollees' from obtaining needed medications. The District of Columbia has a pharmaceutical assistance program, called AccessRx, which enables low-income, elderly and uninsured residents to obtain prescription drugs at reduced cost. This program is supported through manufacturer rebates, pharmacy discounts and negotiated discounts (Washington DC Resident Resource Center 2004). However, cost is not the only barrier to prescription drugs: in some areas of the District, pharmacies do not stock certain drugs for fear of burglary.
- Arlington County operates a prescription medication program for low-income elderly or disabled residents, but not for most low-income adults and children. Because the application

¹¹ The District of Columbia has approximately four times the national average of physicians per 100,000 population while Maryland has approximately the national average. The number of physicians per 100,000 population in Virginia is below the national average (SHADAC 2003).

process for the assistance programs offered by pharmaceutical companies is complex and varies by company, a staff person dedicated to this task can facilitate access and save practitioners' time. The Arlington County Health Department employs a staff member to perform this function. Such a program could be extended to other low-income adults and children and also replicated throughout the region.

- Local health leaders report the lack of affordable health insurance as a basic problem throughout the region, especially in suburban areas where programs like the DC Healthcare Alliance are unavailable to low-income residents. Some advocated deeply discounting premiums for low-income individuals and families to enroll them in private coverage (such as the “dues subsidy” programs that Kaiser Foundation Health Plan operates for low-income adults and children, described in Chapter II), as well as deeper premium discounts for coverage available to “uninsurable” individuals.¹² Others suggested that a small-group subsidy program could be of value in encouraging employers to offer and contribute to coverage.
- Some services (such as dental care and prescription drugs) may be difficult to obtain even for those enrolled in insurance programs. Local health leaders suggested targeted outreach and discounted insurance to address these problems, as well as creation of an health care ombudsman to help residents navigate the complex system of coverage and available services.¹³

5. Language and Cultural Competency

The Washington, DC region's considerable and growing racial and ethnic diversity presents an increasing challenge for the effective delivery of health care services. Immigrants to the Washington, DC metropolitan area speak a vast array of languages and originate from numerous countries with varied cultural traditions. Across the national capital area, 18 percent of residents are foreign-born, and 22 percent speak a language other than English at home (AHRQ 2004). To be effective, the delivery of care—as well as public health campaigns and public health education—must be culturally appropriate, delivered in several languages, and targeted to relatively low reading levels. Area health leaders cited problems with health care providers who are not respectful of low-income patients from diverse cultural backgrounds or are unable to communicate effectively with such patients. Probably related in part to these problems, 37 percent of the lowest-income respondents to the Kaiser Family Foundation survey of District adults rated the services they received as fair or poor compared with 13 percent of residents with higher incomes (Lillie-Blanton 2003).

¹² At present, GHMSI is the insurer of last resort for District and Northern Virginia residents who otherwise are denied private individual coverage. In the District, GHMSI is charged with allocating as much as 1 percent of its total premium income to “rate stabilization” for these individuals. In Maryland, uninsurable individuals may enroll in the state high-risk pool, which is subsidized by an assessment on all insurers in the state.

¹³ Advocates of creating a position of health care ombudsman in the District estimate that it would cost \$500,000 per year. The current proposal would rely on a tobacco tax for funding.

In the Maryland and Virginia suburbs, an even higher percentage of the population is foreign-born or speaks a language other than English at home (AHRQ 2004). In Arlington County, approximately one-third of residents—and the majority of low-income residents—speak English as a second language. Developing adequate interpretation for care is a significant challenge: approximately 80 percent of services provided by the Arlington County Health Department are in languages other than English.

Differences in access to coverage and cultural adaptation to the concept of health insurance drive differences in health insurance coverage among the area's racial and ethnic groups at the same income levels. Latinos in the District of Columbia are less likely to be insured than either the District's African American or white population (Lillie-Blanton 2003).

A number of efforts have been mounted to address the significant and growing need for care appropriate to a multicultural population. For example:

- Some District organizations attempt to meet the needs of Latinos by operating safety net clinics in their neighborhoods. For example, the Children's National Medical Center added a health center in the Adams Morgan/Columbia Heights neighborhood of the District to better serve the Hispanic population.
- Montgomery County operates Project Delivery, a prenatal care program for the county's undocumented immigrants, but sees a growing need for public health surveillance for tuberculosis and other infectious diseases among the county's large refugee population.

However, by all accounts, the demand for culturally competent care greatly exceeds the area's capacity to provide it.

6. Quality of Care

Perceptions of health care quality in the Washington, DC metropolitan area are mixed. Except in the case of care provided by physicians and health professionals whose mission is to serve the low-income population, low-income residents generally view quality as poor and sporadic. In fact, area providers generally have not focused on quality improvement. One health department director observed that efforts to improve health care quality must be "practical and supportive to be fair." Local health leaders view hospitals as generally unable to influence the behavior of community doctors and possibly not sufficiently aggressive in their efforts to reduce inpatient medical errors. Employers in the Washington, DC area have not yet joined forces to address health care quality, though the Washington Board of Trade has recently established a Health Care Taskforce to consider health care quality improvement.

Failure to coordinate primary care compromises the quality of care and care outcomes for insured and uninsured residents alike. Some insurers do not cover preventive care (such as vaccinations) when delivered by internists, although enrollees may select an internist as their primary care physician. Low-income residents often delay care or do not adhere to care plans, particularly with respect to filling prescriptions. Several health leaders estimated that many of the quality issues for low-income residents are fundamentally access issues.

Poor communication between providers and public health agencies also compromises the quality of response to health problems, if not the quality of care. One health leader indicated that many physicians in Virginia do not communicate reportable diseases (for example, food-borne illnesses) to their local health department, frustrating the department's ability to intervene and prevent further illness. Failure to report suspicion of other and less common illnesses (such as SARS or anthrax infection) can lead to serious public health problems if a health department is unable to inform physicians of elevated risk and provide guidelines for treatment.

Area health leaders generally believe that insurers could be highly effective—and more effective than others in the health care system—in improving the quality of care, including coordination of primary care. For example:

- The insurance industry reportedly supports a statewide effort in Virginia to reduce medical errors, though there is little apparent activity at the local level, which is where quality improvements need to occur.
- The Institute of Medicine report, the Delmarva Foundation reports and other literature offer several recommendations for quality improvement. Area health leaders view insurers as ideally situated to develop systems and incentives that will encourage providers to heed these recommendations, including coordinated collection of data and sharing of best practices among providers.
- Area health leaders viewed health insurers as uniquely situated to improve communication between emergency departments and outpatient providers, especially about drug errors and interactions. Efforts to develop more effective screening tools and incentives for pharmacies to identify medication errors were identified as areas in which insurers should be more involved.

7. Emergency Preparedness

Despite extensive efforts to improve emergency preparedness across the Washington, DC metropolitan area, local health leaders voiced concerns about the likely adequacy of health providers' response to an area-wide emergency. For example, some leaders questioned the advisability of an emergency response that relies on volunteer physicians and other health professionals without obtaining in advance their commitment to serve during a crisis. Others observed that attention to hospital preparedness generally has superseded attention to preparedness among individual practitioners. As a result, many practitioners may lack the information needed to recognize an illness and to provide appropriate initial and follow-up care. For example, a breakdown in communication to private practice clinicians resulted in the widespread ordering of tests for anthrax in 2001 following contamination of the District's main post office and other sites. With local laboratories overwhelmed with anthrax tests, many of which were clinically inappropriate, results were delayed for cases in which anthrax infection was a probable diagnosis.

Many local health leaders see the potential for insurers to play an important role in developing an area-wide capacity for effective emergency response:

- Insurers have a unique line of access to residents and health care providers to offer information about the appropriate response to the release of biological agents and other

emergency events. For example, they could arm plan members with information and distribute clinical guidelines and testing protocols to providers. They could make the same information available more broadly to residents and providers in the community, thereby reducing crowding in emergency departments when people do not know where else to turn for diagnosis or care during an incident. Finally, they could adopt and enforce a policy of not reimbursing for tests that clearly do not meet clinical guidelines.

- Insurers could coordinate with—and help replicate—existing systems to communicate with providers about suspected public health emergencies or emergencies in progress. For example, Arlington County has developed a “blast fax” system that automatically faxes information to all physicians, hospitals, and pharmacies in the county. (In meetings with providers, the county determined that all health providers routinely use faxes to communicate with insurers and pharmacies but that relatively few use Internet communication.)

Area health leaders viewed all of these activities as consistent with the interests of insurers’ members, as well as the interests of the larger community.

C. INFRASTRUCTURE FOR ENGAGING THE COMMUNITY

There is a general consensus that the District dominates the national capital area’s concerns, although the District accounts for less than 20 percent of the area’s population. The District government has not been viewed as effective in providing leadership to address the health care problems of District residents, much less those that residents of the metropolitan area have in common.¹⁴ Without a strong leader, the region lacks both the focus and structure needed to make significant progress in health care promotion, to meet public health goals, and to champion needed service expansion.

Area health leaders expressed considerable interest in the role that dominant insurers such as Group Health and Medical Services, Inc. (GHMSI) might play in helping the region improve communication and coordination of health goals and strategies. Many area health leaders believe that larger-scale, regional initiatives are needed as well as stronger regional leadership and accountability. But they emphasize that specific approaches to common problems must recognize the circumstances of individual communities, including cultural and political differences and differences in the availability of services.

Given local governments’ recent and deep budget cuts, several health leaders expressed concern that, if additional private resources were available for community health needs, local governments would pull back on their existing initiatives or spending. One suggested that a maintenance-of-effort agreement should be part of any significant change in leadership or strategy, thus ensuring net increases in funding and initiatives for the community. Many suggested greater participation by both employers and insurers as essential to improving health care across the region.

¹⁴ For example, the Kaiser Family Foundation Survey of District of Columbia adults found that a higher percentage of District residents rated the District of Columbia government as “fair or poor” in addressing health care problems, rather than “excellent or good” (Lillie-Blanton 2003).

At least two organizations are now attempting to coordinate approaches and responses to various regional concerns across jurisdictions within the metropolitan area: the Washington Council of Governments (which coordinates across local governments) and the Washington Board of Trade (a regional “chamber of commerce” organization).¹⁵ To date, neither has taken on improvements in health status or health care provision as strategic areas. Each organization and its efforts related to health are described briefly below.

1. Washington Council of Governments

The Washington Council of Governments (COG) brings together elected officials and agency heads from across the several jurisdictions comprising the Washington, DC, area. COG is primarily financed through federal funds for transportation and air quality issues, but member dues and outside grants allow the COG board to convene a Human Services Policy Committee. COG focuses on issues that are clearly cross-jurisdictional, such general HIV/AIDS education (posting educational messages on the Metro rail and bus system), developing regional emergency preparedness, and developing strategies to address West Nile virus and drunk driving. COG is less likely to take on issues viewed as local, such as health care access, cost, or quality.

2. Washington Board of Trade

The Washington Board of Trade includes 1,200 member organizations in the District of Columbia, Virginia, and Maryland. Many of its members are small businesses. Comprised of CEO-level leaders from member organizations, the board’s Potomac Conference is charged with fostering collaboration among private, government, and not-for-profit employers across the region. In June 2004, the Potomac Conference established a Health Care Taskforce, responding to employers’ concerns about escalating health care costs. The Health Care Taskforce is primarily funded by foundation grants but expects that member organizations will fund specific activities to achieve employer cost savings. The task force includes several area health care insurers and providers as members.

The Health Care Taskforce has established four interconnected work groups—employer coalition, regional workforce, regional wellness, and health policy—to address issues of access, cost, and quality. The employer coalition work group will partner with Leapfrog and other employer groups, determine whether to create a regional employer coalition, and evaluate strategies to create value-based purchasing. The regional workforce work group will address the supply of qualified health care workers in the region and the coordination and expansion of training efforts and job placement programs. The wellness work group will study and develop workplace health education and promotion activities and incentives. A primary goal of the health policy work group will be the

¹⁵ Other organizations engaged in working across jurisdictions in the metropolitan area include the Business Group on Health (which has linked local health departments and major corporations to address various health promotion issues), the National Commission for Health Education Credentialing, and the Delmarva Foundation (which has interest and experience in quality oversight). Area health leaders also pointed to perhaps less likely partners in improving community health, including parks and recreation departments, which have jurisdiction over a wide range of community spaces and facilities.

development of a regional medical record system as well as advocacy for medical liability tort reform (specifically, caps on jury awards).

D. SUMMARY AND DISCUSSION

Information from surveys, analyses of available public health data, and discussions with community health leaders all indicate that health status, access, and quality issues warrant substantial and coordinated attention and investment across the region. Many of residents' most debilitating and costly health problems—HIV/AIDS, chronic diseases, obesity, and behavioral health problems—might be addressed with targeted health education to change behaviors and improve access to culturally competent providers and services.

Local health leaders believe that the area's health insurers could be key players in several roles that few have yet developed broadly or at all. GHMSI might meet its obligation to promote and safeguard the community health by providing leadership, dedicating significant resources, and achieving measurable outcomes in any or several of these areas. For example:

- Insurers can engage residents in healthier lifestyles and facilitate access to health care services. They can develop and disseminate best practices for ongoing quality improvement, and diagnostic and care protocols for management of public health emergencies. The area's largest insurers have developed educational materials for their own members that would be equally valuable to the broader community if distributed through the area's safety net clinics or in the "community wellness centers" that some local health leaders envision. Such materials include information about patient management of specific chronic illnesses (such as hypertension and diabetes) and guidance about behavioral health (such as smoking cessation, safe sex, nutrition, and physical activity).
- The need for greater capacity to deliver care to uninsured and underserved populations throughout the region is apparent. Local health leaders cited the need for more clinics, greater incentives for providers to serve low-income and uninsured adults and children, more language interpreters, and more training in cultural competency.
- Many local health leaders identified the inability of patients—insured or uninsured—to "use the system" effectively as a serious problem of wasted resources and opportunities to support and improve health status. In some instances, insurers themselves have erected administrative barriers that frustrate the appropriate use of primary care—such as disallowing reimbursement for vaccinations when provided by a specialist—including internists who are designated primary care providers. Failure to coordinate primary care and failures of access to prescription drugs are obvious sources of low-quality care and unnecessary cost in the region.
- Affordable health insurance is a critical issue, especially in the area's suburbs where general affluence masks a significant and apparently rising number of uninsured residents. Some health leaders suggest that insurers are well-positioned to improve the efficiency and quality of care and therefore reduce cost. But few have made a real effort to do so. To date, GHMSI has not attempted to develop a subsidized insurance product such as Kaiser offers in the national capital region.

- Area health leaders saw important roles for health insurers in educating both the public and health care providers in how to respond to public health emergencies and how to coordinate with public health departments. They viewed the area's prominent health insurers as potential partners and leaders in emergency response—roles that area health insurers generally, and GHMSI in particular, have not developed.

Finally, several topics raised in our discussions with area health leaders may offer growing opportunities for partnering with area health insurers. Prominent among these topics are problems related to the health and health care of the region's elderly population. One area health leader emphasized the importance of increasing the availability of in-community care and setting standards for that care; another focused on the importance and implications of clinical and practical efforts to prevent falls at home as well as in hospitals and nursing facilities. As the new Medicare Advantage program develops and larger numbers of Medicare beneficiaries enroll in private health insurance plans, insurers will become essential community partners also in meeting the health needs of the national capital area's growing elderly population.

II. LEARNING FROM OTHERS: EXAMPLES OF COMMUNITY BENEFIT

A. BACKGROUND AND METHODS

While many nonprofit health plans may pursue community benefit mission, there is no common source of information about how many plans do so, or how they implement, fund, and maintain community benefit mission in a highly competitive market. In this chapter, we describe the context and implementation of community benefit mission by four nonprofit health plans. These include Kaiser Permanente—GHMSI’s major competitor in Washington, DC and a significant competitor throughout the national capital area—and three nonprofit plans located in other states: Harvard Pilgrim Health Care (with business primarily in Massachusetts, but also in Maine and New Hampshire), InterMountain Health Care, or IHC (with business primarily in Salt Lake City, Utah), and Highmark Blue Cross and/or Blue Shield Companies (with business in Western and Central Pennsylvania).

While we selected Kaiser Permanente as a major local competitor, Harvard Pilgrim, IHC and Highmark were of interest for a number of reasons. First, each enjoys a generally positive reputation as strong corporate citizens in their communities. Our goal was to understand better the specific activities that supported their reputations: how they identified and prioritized among community needs, and developed an effective response to community need. Second, each holds roughly the same share of their market or less than GHMSI holds in Washington, DC—although unlike GHMSI, none is the largest insurer in the state. By selecting nonprofit insurers of approximately equal or smaller size, we hoped to identify plans that had comparable or even fewer resources to pursue community benefit than GHMSI might have. Such plans may offer feasible models of community benefit for GHMSI, illustrating the kinds of processes and programs that GHMSI could pursue to improve community health.

B. MARKET POSITIONS OF SELECTED PLANS

While each of the selected plans holds a significant share of its primary market (defined at the state level), none is as dominant in that market as GHMSI is in Washington, DC (Table 1). Their statewide markets are similar, however, to GHMSI’s position in the national capital area—including the District, as well as Montgomery and Prince Georges counties in Maryland, and Alexandria, Arlington, Fairfax, and Prince Williams counties in Virginia. Each holds about one-third of its primary market. Both Kaiser and Harvard Pilgrim hold much lower shares of the market outside their primary service areas (respectively, California and Massachusetts).

TABLE 1
PREMIUM VOLUME AND MARKET SHARE OF SELECTED NONPROFIT
HEALTH INSURANCE PLANS, 2001

Plan name	State	Reported major medical premiums earned (millions)	Group market share	Non-FEHBP group market share	Individual (nongroup) market share
Group Hospitalization & Med Services	DC	\$1,095.2	47.0%	31.7%	47.5%
Kaiser Foundation Health Plan, Inc.	CA	\$10,295.6	31.0%	31.0%	22.4%
Kaiser Foundation Health Plan, Inc.	DC	\$467.6	19.7%	26.2%	41.8%
Highmark, Inc.	PA	\$3,539.0	33.0%	33.0%	47.4%
IHC Health Plans Inc	UT	\$547.0	30.3%	30.3%	55.0%
Harvard Pilgrim Health Care Inc	MA	\$1,354.4	27.6%	27.6%	19.4%

Source: Mathematica Policy Research, Inc. Estimates from NAIC data.

Several dimensions of these plans' business are relevant to understanding their comparability to GHMSI. First, GHMSI's total premium volume—including its FEHBP, non-FEHBP group, and nongroup business—is about in the middle of the range of the plans that we studied. In 2001, GHMSI wrote more than twice as much business in the District as Kaiser and twice as much as IHC wrote in Utah. In terms of total premium volume, GHMSI was most like Harvard Pilgrim in Massachusetts.

Second, in comparison to GHMSI, none of the comparison plans write even nearly as much Federal Employee Health Benefit Plan (FEHBP) business as GHMSI. In fact, it is GHMSI's FEHBP business that most distinguishes its group market business. Absent that business, GHMSI also held about one-third of the group health insurance market in 2001, as did Highmark, IHC, Harvard Pilgrim, and Kaiser in California. In the District, GHMSI's non-FEHBP group market share was about 20 percent more than Kaiser's.

Third, in the District, GHMSI's 47-percent share of the nongroup health insurance market is comparable to most of the plans we studied—including Kaiser in both California and the District and Highmark. IHC wrote more than half of the nongroup market in Utah in 2001. Nongroup insurance is widely viewed as a difficult business, likely to attract high-cost enrollees and entail high administrative cost. GHMSI is a designated insurer of last resort in the District and in Northern Virginia, as Highmark is in Western Pennsylvania. As Blues plans, both also enjoy a name recognition that attracts individual membership.

In contrast, Harvard Pilgrim, IHC, and Kaiser are diversified health plans; each offers PPO and POS products, as well as HMO coverage. Harvard Pilgrim's principal market is in Boston, but it also serves urban and small-town communities in Maine and New Hampshire. In Massachusetts and Maine, all insurers are required to offer coverage to individual applicants (a requirement called guaranteed issue). The wide spreading of individual risk in these states probably explains Harvard Pilgrim's relatively low enrollment in individual coverage.

IHC is an integrated health system that operates a network of hospitals, as well as staff-model ambulatory care centers and clinics. IHC facilities are located in the most populous area of the state—Salt Lake City, which includes nearly 45 percent of Utah's total population—contributing to

higher individual enrollment. Likewise, Kaiser operates several facilities within the District, as well as in suburban Maryland and Northern Virginia. However, neither IHC nor Kaiser are insurers of last resort: both can deny coverage to individual applicants, but they nevertheless accept as much or more of the nongroup market as GHMSI or Highmark.

Finally, it is striking that Kaiser, Harvard Pilgrim, and IHC all originated as clinic- or hospital-based integrated health care plans. Each continues to rely on its provider network to implement some part of its community benefit mission. However, the community benefit activities we probed in this report are *in addition* to those that these insurers pursue to meet the community benefit obligations of their nonprofit hospitals and therefore are analogous to the activities that GHMSI might pursue in developing its community benefit mission.

C. DEVELOPMENT OF COMMUNITY BENEFIT MISSION

Each of the plans we investigated emphasized the role of corporate mission in developing their community benefit activities. Remaining rigorously true to mission—and redirecting activities to update mission—was important to each. Similarly, working with the community to ground and leverage the plans' community benefit was seen as essential to each of the plans. The activities that constitute the health plans' community benefit programs, and their processes for identifying and prioritizing community benefit needs, are described below.

1. Commitment to Community benefit

All of the plans have a strong, stated commitment to community benefit and undertake a variety of community benefit activities.

- **Harvard-Pilgrim Health Plan** organizes its community benefit mission and activities through a nonprofit foundation, the Harvard Pilgrim Health Care Foundation. Established in 1980,¹⁶ the Foundation's articulated mission is to prevent illness and promote better health through medical education, research, and community benefit. Harvard Pilgrim Foundation has been in operation since 1980; in 1992, it created the nation's first joint academic department between a health plan and a medical school—the Department of Ambulatory Care and Prevention at Harvard Medical School. The Department operates research and education programs that include teaching at community-based sites, research in Medicaid medical management (especially for children with asthma or diabetes), and work with community clinics. In January 2004, the Foundation launched The Institute for Linguistic and Cultural Skills to reduce health disparities via cross-cultural and interpreter training programs for health clinicians, nurses, and others.

The Foundation also operates grant programs in Massachusetts, Maine, and New Hampshire to fund community-based activities in four areas: (1) reduction of health disparities, (2)

¹⁶ The Harvard Pilgrim Health Care Foundation originated as a foundation of the Harvard Community Health Plan (a staff model HMO), before it combined with Pilgrim Health Care (an independent practice association, or IPA). The Foundation developed from the closing of a community clinic that had been the basis for Harvard Community Health Plan.

obesity, (3) HIV/AIDS, and (4) youth and families. These include funding a national conference on health disparities, hosting a statewide coalition of agencies and residents to reduce disparities related to cancer diagnosis and treatment, and supporting a local Boys and Girls Club that focuses on healthy lifestyles and nutrition.

- **Highmark** operates the Caring Foundation, which gained national prominence in the 1980s for operating a low-cost health insurance program for children; this program ultimately became the model for the State Children's Health Insurance Program (SCHIP, in Pennsylvania called simply CHIP).¹⁷ In 1992, Highmark created Special Care to provide an affordable health care option to low-income adults. Special Care served as the model for the Commonwealth's adultBasic program, which was launched in 2003 with funds from the state's tobacco settlement.¹⁸ The Caring Foundation donates funds to administer and conduct outreach for Pennsylvania's CHIP and adultBasic programs. In 2003, Highmark made available a \$100 voucher to anyone on the waiting list for enrollment in adultBasic (an estimated 90,000 adults) good at community health centers, which scale charges to family income; 6,000 people accepted.

In addition, the Caring Foundation operates the Caring Place, a grieving center for children and adolescents in two locations (in Pittsburgh, Erie, and the Harrisburg area). It also operates a small Health Education Center (organized as a 501(c)(3)) focusing on underserved, vulnerable populations and health disparities.

- **IHC** operates two community-oriented foundations, the IHC Foundation and the Intermountain Community Care Foundation (ICCF).¹⁹ The IHC Foundation provides grants to fund primary health care for the underserved and/or uninsured population; maternal and fetal health and children's health care are a primary focus of IHC Foundation grants. ICCF sponsors "community health partnerships," funding four IHC community and school clinics and nine community clinics and federally qualified health centers (FQHCs). ICCF provides approximately half of the operating budgets of the two FQHCs in Salt Lake

¹⁷ This program included an evaluation component, conducted in cooperation with the University Of Pittsburgh School of Public Health that developed information influential to the passage of SCHIP. Such information included the results of reducing delayed care and unmet needs, and having a primary care provider; as well as impacts on enrolled children's environment for general development (such as parental restrictions on playground activities) associated with having health insurance.

¹⁸ AdultBasic is administered by the Pennsylvania Insurance Department with funds from Pennsylvania's tobacco settlement. Individuals eligible for adultBasic must be uninsured, ineligible for Medicaid or Medicare, and have family income below 200 percent of poverty. Highmark estimates that one-third of enrolled adults have income below 100 percent of poverty. The program covers preventive care, physician services, diagnostics, inpatient and outpatient hospital care, and emergency care. The premium is \$30 per adult per month; care for preexisting conditions is covered. Highmark Blue Shield is the adultBasic contractor in two of four regions in Pennsylvania. Approximately 25,000 people are in Special Care, and another 22,200 people are enrolled in adultBasic in Western Pennsylvania.

¹⁹ Several of the IHC hospitals also operate separate fund-raising foundations specifically to benefit those hospitals.

City, and IHC hospitals do “virtually all” of the FQHCs’ lab tests at reduced cost. IHC hospitals also provide significant charity care, some associated with the activities of the Foundation Programs.

- **Kaiser Foundation Health Plan – MidAtlantic (Kaiser)** operates a number of programs directly, similar to its parent corporation, Kaiser Permanente. Kaiser Permanente has a corporate philosophy and long history of community benefit integrated into the company’s day-to-day operations; it does not operate a separate foundation. Kaiser’s community benefit activities include subsidized Kaiser membership for uninsured children below 250 percent of poverty in five counties in Maryland and Virginia (Montgomery, Prince Georges, Fairfax, Loudon, and Prince Williams) and in the District of Columbia. Kaiser also operates heavily subsidized “bridge” programs for adults and families below 250 percent of poverty in Baltimore City and several Maryland counties with proximity to Kaiser medical centers, as well as a subsidized program for adults below 250 percent of poverty in Baltimore County.²⁰
²¹ In total, these programs enroll approximately 3200 adults and children in the District, Maryland, and Northern Virginia.

Kaiser operates two additional programs with a community focus: a Community Health and Impact Grants program and an educational theatre program for children and adolescents. Kaiser community grants program provides funding for initiatives that address access to care, preventive care, health education, and health literacy—this year with a special emphasis on childhood obesity. Applicants compete for funding. The educational theatre program employs professional actors who provide free performances to schools and community organizations on topics ranging from basic health education (for young school children), peer pressure and violence (for middle-school students), and HIV/AIDS (for high-school students).²² In addition, Kaiser has provided funding to various safety net clinics, as well as Northern Virginia (NOVA) Community College to give allied health professionals “hands on” training in a new clinic for uninsured Northern Virginia residents.²³

2. Identifying and Prioritizing Community Needs

Each of the health plans relies on its board and relationships with the community to identify and prioritize its community benefit activities. In Massachusetts—Harvard Pilgrim’s principal market—

²⁰ For qualified adults and families with income below 175 percent of poverty, Kaiser subsidizes 95 percent of the premium; for others below 250 percent of poverty, Kaiser subsidizes 90 percent of the premium. The program offers Kaiser’s standard comprehensive benefit. The program operates in all Maryland counties except Ann Arundel county, where Kaiser does not have a medical facility.

²¹ Kaiser’s program in Baltimore City provides all primary care in Kaiser’s medical centers; the Baltimore County Health Department arranges separately for hospitalization and specialty care.

²² Actors are trained in facilitation skills, and conduct conversational sessions with even very young children following the performances. Fairfax County has selected Kaiser’s educational theatre series as the only non-county program allowed in its school system.

²³ The Kaiser Permanente Medical Mall is a “state of the art” clinic that operates near Springfield Mall in Northern Virginia.

the state (in cooperation with health plans and community leaders) has developed guidelines that formalize this process.^{24 25} IHC and Kaiser Permanente operate community benefit programs without specific state guidelines or requirements that affect their processes for defining or implementing specific programs. Highmark operates with a court order to provide community benefit as a condition of a corporate merger; that order identifies a series of activities—all or most ongoing activities of Highmark and/or its Caring Foundation—by which Highmark might (or must) meet its community benefit obligation.²⁶

- **Harvard Pilgrim** draws information from a number of sources to assess health care needs in its market area, including an automated health status indicator system (called MassCHIP) developed by the Massachusetts Department of Health²⁷ and current health services and health policy research that the Foundation itself may fund.²⁸ Senior Foundation and health

²⁴ In Massachusetts, the guidelines offered by the Attorney General call upon HMOs to formalize their approach to community benefits planning and to collaborate with the communities they serve to identify and create programs to address unmet needs. These include: (1) adopting and making public a Community Benefits Policy Statement; (2) making senior management of the HMO responsible for developing the Community Benefits Program, including resource allocation and regular evaluation; (3) seeking assistance and participation from HMO members and the community in developing and implementing the HMO's Community Benefits Program and in defining the targeted population and health care needs to be addressed; and (4) assessing the health care needs and resources of target populations, particularly lower- and moderate-income communities, and considering the health care needs of a broad spectrum of age groups and health conditions (<http://www.cbsys.ago.state.ma.us/pubs/hccbhmoguide.pdf>, accessed October 1, 2004).

²⁵ The Attorney General makes a wide range of material available electronically, including the current version of the guidelines; HMO community benefits annual reports, corporate annual reports, and contact information; a searchable database of access information about each HMO's community benefits programs and extractable HMO benefits program data; a "links library" to support HMOs and community organizations in planning and implementing community benefits initiatives; information about of the AG's Community Benefits Advisory Task Force; and summary descriptions and contact information related to other states' community benefits initiatives (<http://www.cbsys.ago.state.ma.us/healthcare/hccbindex.asp>, accessed October 1, 2004).

²⁶ A court order related to the 1996 consolidation of Pennsylvania Blue Shield and Blue Cross of Western Pennsylvania requires Highmark to "annually dedicate to social or charitable health care endeavors 1.25% of its direct written premium" and to provide a summary report to the Department of Insurance of "its charitable and benevolent endeavors" refers to the merger of those companies. The order identifies a number of activities that would represent fulfillment of Highmark's obligation—including the Special Care program, the Caring Program for Children, 65 Plus and Security Blue (Medicare risk programs), participation in SCHIP, and annual open enrollment, and activities of the Caring Foundation.

²⁷ Specifically, the Behavioral Risk Factor Surveillance System (BRFSS) conducted by the Centers for Disease Control and Prevention (CDC) (<http://masschip.state.ma.us/>, accessed October 1, 2004).

²⁸ For example, in its 2004 annual community benefits report, the Foundation mentioned its reliance recently on the *Common Health for the Commonwealth: Massachusetts Trends in the Determinants of Health* study issued by the Massachusetts Health Council and funded in part by a Foundation grant. The study examined Massachusetts' performance on a number of Healthy People 2010 leading indicators and identified possible policy solutions that could be implemented.

plan staff participate in a number of health-related advisory committees, and also host a number of community forums. The latter include the AIDS Action Committee and the Massachusetts Department of Education's AIDS Advisory Panel; the Massachusetts Health Council; and the Massachusetts Violence Prevention Task Force, Workgroup on Suicide Prevention. Harvard Pilgrim also participates in the Massachusetts Health Funders' Network.

"From any one of those seats we have a birds-eye view of what is going on among stakeholders in health care and a basis for conversation with the community about what is important to people in Massachusetts" (Fuccillo 2004). In addition, in 2000, the Foundation tapped a number of "key informants" (including local, state, and regional public health officials, community leaders, medical educators, and executives from other philanthropic organizations (such as the United Way) to understand their sense of the Foundation's contributions to the community and to advise the Foundation board on a set of strategies going forward. The Foundation board also takes an active role in the needs assessment process.

- A significant share of the **Highmark** Caring Foundation's community benefit activities relates to Highmark's statutory obligation to bid for Pennsylvania's CHIP and adultBasic programs. However, the Caring Foundation also relies on informal networking with social service agencies and others to identify community needs.

Highmark's Caring Foundation sees itself as "an incubator for ideas, ...building partnerships with the community" (LaValee 2004). Relying on a very small staff, the Foundation director generates ideas that the Foundation board (including Highmark's chief operating officer and its senior vice president of corporate affairs) prioritizes.

- **IHC's** two community-oriented Foundations also develop their community benefits using an informal process of networking. In 2003, the IHC Foundation changed its perspective on its activities to emphasize interaction and partnership with the communities that IHC serves. Foundation staff members communicate regularly with various local agencies, and twice per year the IHC Foundation solicits grant applications. The IHC Foundation Board establishes priorities for Foundation activities and grants. Because the IHC Foundation's endowment funds were generated through health care (the closure of a nonprofit hospital), the Board has focused both Foundations' activities exclusively on the provision of health care. However, there is growing interest in an "upstream vision of health" (Thompson 2004) that includes health education, potentially implemented in cooperation with local school systems and existing state and local agency programs.
- In California, **Kaiser Permanente** has begun to integrate into its community benefits planning with the needs assessment that the state requires of Kaiser Permanente's nonprofit hospitals. But in Kaiser's Mid-Atlantic region, the environment is very different: there are no statutory guidelines for nonprofit health plans' community benefit and Kaiser's operations are not hospital-based. Consequently, the process is more strategically focused around subsidized coverage for low-income adults and children and grant making. It relies heavily on networking—working formally and informally with various organizations and agencies—to identify needs and to understand what other organizations may be attempting to address them. Kaiser's network "partners" include Mary's Center for Maternal and Child

Care, Catholic Charities, the Baltimore County Health Department, the Fairfax County Office of Partnerships, Northern Virginia Family Services in Loudon County, and the health working group of regional grant makers.

Kaiser's general priorities for community benefit are established at the corporate level. They include coverage for low-income people, partnership with the safety net, community health initiatives,²⁹ and development and dissemination of knowledge—including educational programs to train technicians and nurses (like that at NOVA Community College), many placed in underserved communities to address both the health care and economic needs of the community.

3. The Cost and Funding of Community Benefit

Each of the health plans we investigated determines its own level of funding for community benefit, and these levels varied substantially across plans. The sources of funding also varied; they included endowment funds and corporate funds allocated on a matching basis or as an annual decision by the corporate board.

- **Harvard Pilgrim** Health Care has the ultimate authority and responsibility for approving the Harvard Pilgrim Foundation's budget. When the Foundation was formed in 1980, it established a community-benefit funding goal of 1.5 percent of revenue, but it was never implemented. Since 1995, Harvard Pilgrim has allocated to the Foundation a baseline amount of \$4.5 million per year. Including other funds available to the Foundation, its 2003 direct expenses totaled \$5.9 million.³⁰ The Foundation allocates 60 percent of its budget to community teaching and research, and 30 percent to community benefit; 10 percent is allocated to administration of the Foundation. The Foundation's direct expense budget for community benefits programs in 2004 is \$6.0 million. Harvard Pilgrim also contributes substantially (as do other insurers in Massachusetts) to the state's uncompensated care pool

²⁹ For example, Kaiser Permanente encouraged all regions to support local health departments to apply for CDC's *Steps to a Healthier US* grants. It participated in 13 applications, one of which was funded. Kaiser Permanente funded another eight programs for one year to support re-application for CDC funding. A centerpiece of the *Steps* initiative is the 5-year cooperative agreement to fund states, cities, and tribal entities to implement chronic disease prevention efforts. These efforts focus on reducing the burden of diabetes, overweight, obesity, and asthma and addresses three related risk factors—physical inactivity, poor nutrition, and tobacco use. The FY 2003 initiative distributed \$13.6 million to 12 applicants. Funds went to four states representing 15 small cities or rural communities (average award: \$1.5 million), one tribal consortium (award: \$250,000), and seven large cities (average award: \$1.04 million). These 23 communities will implement community action plans to reduce health disparities and promote quality health care and prevention services (<http://www.cdc.gov/nccdphp/steps/index.htm>, accessed October 1, 2004).

³⁰ In 2003, Harvard Pilgrim also provided funding for the Community Health Center Enhancement Fund, a grant program created in 1998 (when Harvard Pilgrim entered into an affiliation agreement with the Neighborhood Health Plan) to enable community health centers to improve their ability to provide care for their communities in an increasingly competitive environment. In 2003, Harvard Pilgrim provided approximately \$400,000 in grants to community health centers, completing its 5-year, \$15 million commitment to the Fund.

(in 2003, \$12.3 million)—together with its baseline allocation, totaling approximately 1 percent of earned premium.

- **Highmark's** expenditures for community benefit are defined by its 1996 consolidation agreement following the merger of Pennsylvania Blue Shield and Blue Cross of Western Pennsylvania. That agreement requires the company to expend 1.25 percent of its direct written premium for community benefit, an estimate that the company claims to exceed substantially and consistently. In 2003, Highmark estimates that it expended \$96.1 million for health care and health coverage associated with its role as insurer of last resort and enrollment in Highmark's Special Care program for low-income adults against \$7.1 billion in total revenues—approximately 1.3 percent.

Other direct expenditures for community benefit—including the Caring Foundation budget—are much smaller. The Caring Foundation raises half of its budget through grants, contracts, and donations; Highmark matches these dollar for dollar and donates the services of the Foundation director and staff.

- **IHC** estimates its annual community benefits at \$180 million (in 2002), including payments for charity care and a lower operating margin than is usual among for-profit health plans. IHC's budgeted operating margin for 2002 and 2003 was 2 percent, maximizing the value “returned to the community in the form of improved facilities, better services, and lower patient charges” (Intermountain Health Care 2003). IHC was the only plan we investigated that included reduced margin in its calculation of community benefit. In 2002, IHC's estimated community benefit net of the uncompensated care provided by its hospitals was an estimated 7.9 percent of its gross funds available from all “nonpatient activities”—including health insurance premiums, investment income, donations, and other resources.
- **Kaiser Permanente's** national organization has a target level of community benefit of 3 percent of revenues, not to exceed 50 percent of net income. However, regions may consider their own circumstances in meeting this target.

In the Mid-Atlantic region, Kaiser's community benefit activities will exceed an estimated \$8.4 million in 2004. Three-quarters of this amount is associated with Kaiser's county-partnership programs of reduced-premium enrollment for uninsured adults and children ineligible for Medicaid or SCHIP. In 2004, Kaiser made additional grants totaling \$800,000 to community organizations to provide health care, pharmacy, food assistance, and health screening and education to low-income residents in the District, Maryland, and Northern Virginia. Finally, Kaiser's educational theatre program operates on a budget of \$1.0 to \$1.2 million per year. A rough sum of these expenditures indicates that Kaiser will spend 1.5 to 2 percent of 2004 premium revenues in the Mid-Atlantic region on community benefit activities.

D. COMPETITION AND COMMUNITY BENEFIT

In very competitive markets, it may be difficult for one plan to initiate significant community benefit without losing its financial edge. This perspective on markets assumes that prices are set at minimum levels for corporate survival. However, none of the plans that we investigated believed that competition precluded significant attention and dedication of corporate resources to

community benefit. Instead all recognized that the costs of community benefit were absorbed into the companies' general cost structures and, arguably, in their prices over the long term—although all recognize that it takes some level of client education in an era of fast-rising health care costs to have them appreciate the long-term wisdom of community benefit.

In only one location—Massachusetts—were nonprofit insurers required to report community benefit activities and expenditure in a standardized and comparable format. Massachusetts' guidelines for community benefit do not require a minimum level of expenditure, but do require a level of transparency (with comparable reporting formats) that helps the public to understand the plans' relative investment in community benefit.

- In recent years, **Harvard Pilgrim** has weathered serious financial problems.³¹ Nevertheless, the Foundation focused on continuing community benefit and minimizing disruption in its activities. “One of the benefits of having direct guidance from the AG [is that] it does provide us a good, safe place to do our best work” in a competitive market (Fuccillo 2004). Harvard Pilgrim recognizes that its Foundation's efforts are “overshadowed” by the new Foundation budget of its much larger competitor, Massachusetts Blue Cross and Blue Shield. However, it will “continue to put [its] best foot forward to address health needs and provide resources...though [it] cannot match [BCBS's] scale.”
- **Highmark's** consolidation agreement to expend a fixed percentage of revenues for community benefit has built this expenditure into its operations. “[Highmark] needs to succeed” to have capacity to provide community benefit, but “it's possible to succeed at business and [also] serve mission” (LaValee 2004).
- **IHC** “leads the way in giving dollars and services to the state of Utah” in part in an attempt to balance its roles as a hospital system and a health plan. As a major provider of charity care in the state, IHC is concerned that the burden of increases in unmet need and deferred care ultimately would fall largely on its shoulders. “It's a balance between money and mission” (Thompson 2004). Necessarily, IHC is “careful” about adverse selection. To reduce the unnecessary use of emergency services in IHC's and other hospitals, IHC funds culturally appropriate community clinics and “teaches them to use their resources wisely as a primary medical home.” Service to the community, “whether it's money or [people] assets, we think it improves our competitive position.”
- **Kaiser Permanente's** national organization has “worked hard to distinguish [its] mission-driven activities from [its] business purposes” (Baxter 2004). Still, it is becoming “much

³¹ Harvard Pilgrim (then Harvard Community Health Plan) was in receivership from January through June of 2000, and currently is under “administrative supervision,” a status in which the Attorney General would review any major expenditure, merger, or acquisition on behalf of the receivership. The company attributes its financial problems to difficulties with systems integration during rapid growth following the 1995 merger of Harvard Community Health Plan and Pilgrim Health Care, as well as having acquired the Rhode Island Group Health Association in 1991, with its financial problems. It attributes its turnaround to withdrawing from Rhode Island, outsourcing claims and information technology, recontracting with providers and vendors, and various other operational and systems improvements.

more proactive about saying you can't have healthy members in a toxic community. We have a responsibility to be broader."

With respect to Kaiser's activities in its mid-Atlantic region, that perspective continues. "If you are a nonprofit plan, you have an obligation to community. Competition is baked into your business. But you get a lot of benefit [from being nonprofit]; it would cost you not to be nonprofit. So you have obligations" (Mathews 2004).

E. SUMMARY AND DISCUSSION

Each of the plans that we investigated has an extensive history of community benefit, and each offers a window on how a significant community benefit mission might be developed and implemented. Each of the plans defines its community benefit role in consultation with the community in some way—although the processes typically are informal. It is striking that all but one originated as a clinic- or hospital-based integrated health care plan, and they continue to rely on their provider networks to implement some part of their community benefit mission. However, the community benefit activities we probed in this report are in addition to those that they pursue to meet their nonprofit hospital community benefit obligations. In these organizations especially, the culture of community benefit resonates with a sense of commitment to community health improvement as well as improved access to care. All of the plans see access to care as an essential issue, and all attempt to improve access in important ways—by serving public programs, funding and supporting health clinics, and/or substantially subsidizing plan enrollment for low-income children and adults.

The annual level of resources these plans devote to community benefit typically ranges from 1 to 2 percent of earned premium. Each balances the priorities of managing a sound financial operation and pursuing their community benefit mission somewhat differently, but all have a commitment to protecting and developing funding for community benefit.

None regards competition as a compelling constraint on community benefit, although of course all recognize the fundamental importance of maintaining the health plan's financial integrity. In general, each regards competition as "baked into the business" and community benefit as an essential part of the health plan's mission.

Whether the plan is disadvantaged by pursuing such a mission depends fundamentally on the nature of competition—which in all health insurance markets is monopolistic: consumers can distinguish among products, and one or two large insurers are price leaders (we document this market behavior in the next chapter). In such markets, competing insurers may vary their margins in a variety of ways—for example, by adjusting product design, improving the efficiency of case and disease management, restructuring provider contracts, reducing administrative cost, or altering the level and timing of internal financing decisions. As a result, plans that pursue community benefit mission typically have many avenues for financing it that neither disadvantage policyholders nor jeopardize their competitive standing, and they are accustomed to financing community benefit as a component of their business. In Massachusetts, one plan mentioned the value of the "level playing field" in Massachusetts that results from the state having developed clear guidelines for nonprofit health plan community benefit and standard public reporting.

In summary, possibly the clearest themes that emerged from our investigation of these insurers is the fundamental importance of developing both a clear and uncompromising commitment to community benefit, and an open and cooperative relationship with the community to identify needs and opportunities. An ongoing dialog with the community is itself an essential element of success. In each health plan, key informants emphasized that it is essential to cultivate an active relationship with the community in order to understand where additional resources might have real impact—and equally important to communicate clearly how the plan has chosen to target its resources, the amount of resources it will expend, and the results that it expects to achieve.

III. GHMSI'S FINANCIAL CAPACITY FOR COMMUNITY BENEFIT

A. INTRODUCTION AND METHODS

In a highly competitive market, the ability of insurers to undertake significant community benefit and remain financially sound is an important concern. As GHMSI is the dominant insurer in the national capital area, maintaining its solid financial position is perhaps of greater concern than it might be were it one of many very small insurers in the market. But GHMSI's size also raises legitimate public expectations about its role in the community and GHMSI's capacity to pursue significant community benefit may also be greater.

In this chapter, we attempt to balance these perspectives: we investigate GHMSI's financial performance in the national capital area, and estimate its financial capacity to undertake substantial community benefit, well beyond the magnitude of its current investment. The analysis is presented in three sections. First, we describe GHMSI's position in its market area in substantial detail—both in the national capital area overall and separately in each jurisdiction that GHMSI serves (the District of Columbia, suburban Maryland, and Northern Virginia). We also consider the distribution of GHMSI's total business by major line: participation in the Federal Employees Health Benefit Program (FEHBP)—nearly all of which is attributed to the District as the source of federal employment—and its non-FEHBP business, including private group and individual coverage, and various other types of coverage with lower enrollment (for example, Medicare supplement).

In the second section, we assess the extent of competition in the national capital area from an economic perspective. In perfectly competitive markets, all sellers are price takers—that is, none have the capacity to price differently from the other. But in more concentrated markets, sellers are able to differentiate both products and pricing. We investigate the extent to which GHMSI demonstrates the price-setting behavior that is indicative of market power. We conclude that GHMSI does have such power, and that GHMSI's pricing behavior indicates an ability to initiate community benefit unilaterally, even in a market that GHMSI itself may perceive to be very competitive.

In the final section, we develop a simple simulation of GHMSI's financial situation, were it to undertake significant expenditure to support community benefit over the next several years. Any simulation of this type requires recognition of the underwriting cycle—a cyclical pattern of gains and losses that insurers experience locally and nationally. Based on a general industry consensus about the duration and amplitude of underwriting cycles, we project the current cycle to 2008, its likely lowest point. We then use alternative scenarios of community benefit expenditures to simulate the impact on GHMSI's projected financial condition.

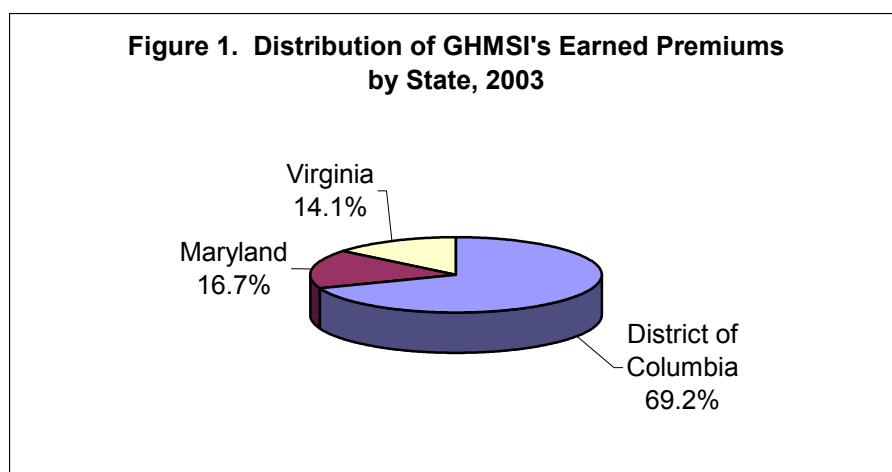
Our analysis is based on financial reports from the major insurance carriers writing coverage in the District of Columbia, Maryland, and Virginia. We analyzed 2001 National Association of Insurance Commissioners (NAIC) data to select the largest insurers in each jurisdiction. We then contacted the District of Columbia Department of Insurance, Securities and Banking; the Virginia Bureau of Insurance; and the Maryland Insurance Administration to confirm that these carriers accounted for the largest part of the market in each area. Each jurisdiction provided to us the

financial information that every carrier filed annually, as was available from 1998 through 2003.³² Because GHMSI serves only Montgomery and Prince George's counties in Maryland and Alexandria, Arlington, Fairfax, and Prince William counties in Virginia, we allocated other carriers' state-level data to counties as needed to support comparison with GHMSI in those counties.³³

B. GHMSI'S BUSINESS AND MARKET

1. Market Position

In 2003, GHMSI earned \$1.89 billion in health insurance premiums. In 2003, nearly 70 percent of its premiums—\$1.3 billion—were earned in the District of Columbia (Figure 1). GHMSI's business in Maryland (\$316 million) exceeded that in Virginia (\$267 million) in 2003. GHMSI's business in Maryland and Virginia respectively accounted for 17 percent and 14 percent of the company's total earned premiums in the national capital area.



2. Lines of Business

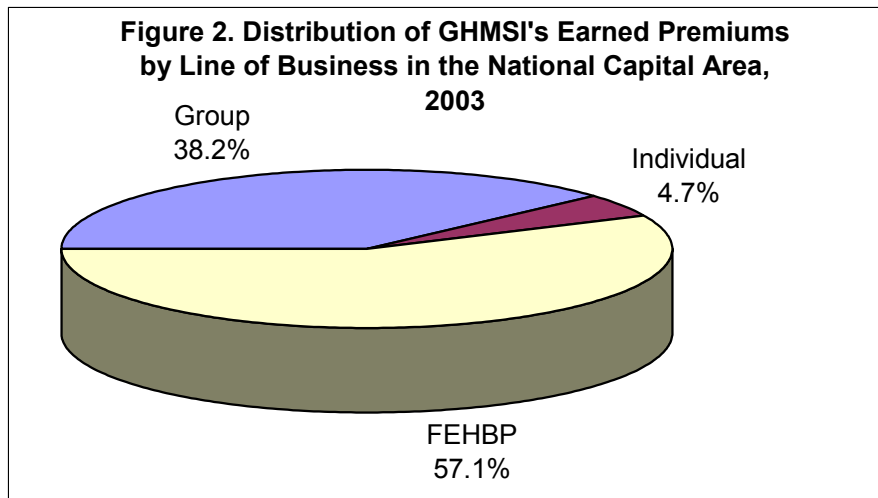
GHMSI is the largest FEHBP insurer in the national capital area, and FEHBP represents the largest share of GHMSI's business. In 2003, FEHBP accounted for 57 percent of GHMSI's earned premiums (Figure 2). All of this business was associated with FEHBP nominally written in the

³² The NAIC filing format differs by type of insurer and among years for each type of insurer. We attempted to use reported items that were defined consistently among years and companies, and calculated values as necessary to maintain consistent definitions. The District, Maryland, and Virginia have very different capacity for housing reported information; the number of years and companies that we obtained from each state varied. The analysis was designed to accommodate these complexities.

³³ For HMOs, state-level reported data were allocated to counties by enrollment (as reported in *InterStudy Competitive Edge—HMO Directory 2003*). State-level data for all other carriers were allocated to counties in proportion to the total population in the state. The final database included 1998-2003 observations of 41 insurers writing coverage in the District, and 2000-2003 observations of 18 insurers each in Maryland and Virginia. The insurers included in each jurisdiction are listed in Appendix C.

District of Columbia, although many of GHMSI's FEHBP policyholders reside in Maryland or Virginia.

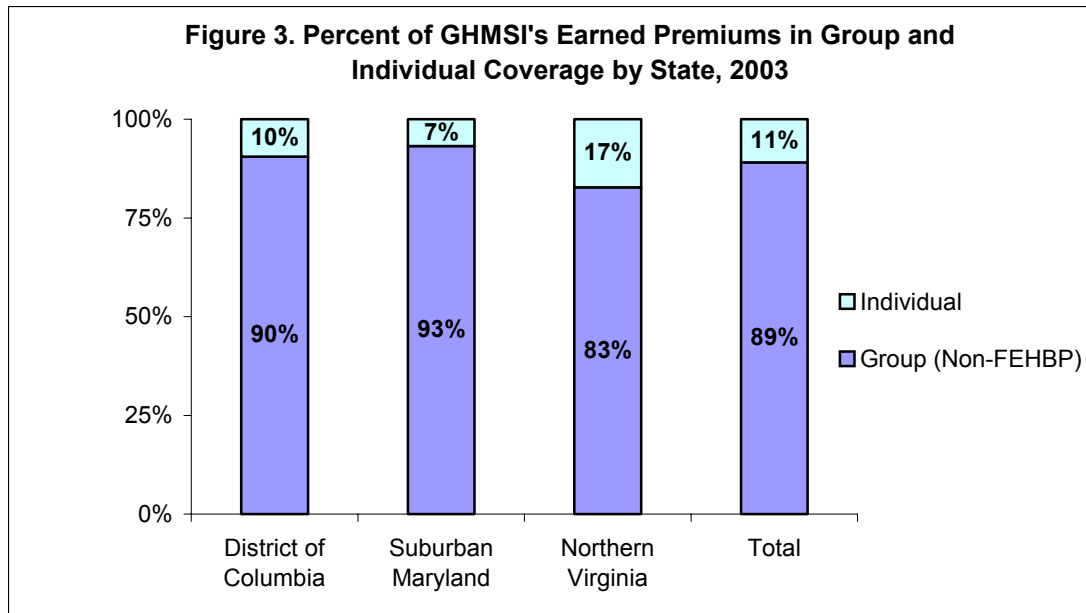
About 38 percent of GHMSI's earned premiums in 2003 were associated with group coverage other than FEHBP. Much, although not all, of this business is probably associated with small- and moderate-sized employer groups. Less than 5 percent of GHMSI's total business is associated with individual enrollment.



In the District and in Northern Virginia, GHMSI (or CareFirst) is the carrier of last resort in the individual market. In this capacity, GHMSI must periodically offer open enrollment without underwriting.³⁴ In 2003, individual coverage accounted for about 10 percent of GHMSI's non-FEHBP earned premiums in the District and 17 percent of non-FEHBP premiums in Northern Virginia (Figure 3). In Maryland, where a state-operated high-risk pool accepts uninsurable individuals, GHMSI's individual business accounted for just 7 percent of earned premiums.

GHMSI also writes various smaller products, including Medicare supplement, dental coverage, and others. The premium volume for these products is relatively small; it is included in totals for GHMSI and the other carriers described here, but not presented separately.

³⁴ Other carriers may deny coverage to new applicants at any time (although all must renew coverage once it is first issued) or offer coverage that is priced according to health status and may permanently exclude coverage for specific conditions or body systems. When not in an open enrollment period GHMSI and CareFirst also may deny coverage, offer substandard coverage, or rate up for health status. Open enrollment policies cannot permanently exclude coverage for specific conditions or body systems, but they are much more expensive than underwritten coverage.

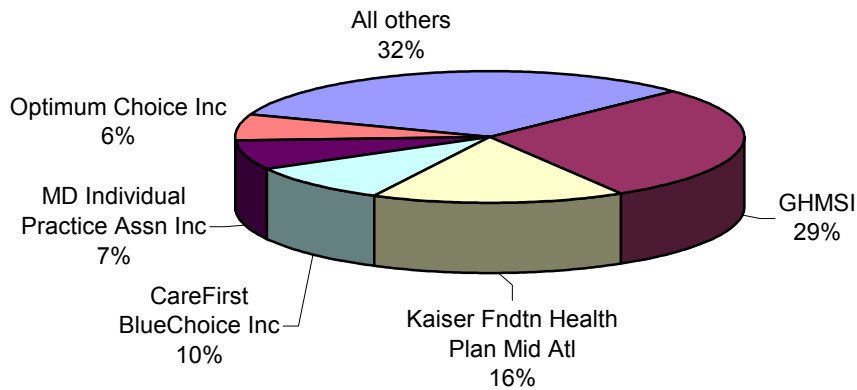


3. Major Competitors

Because insurers are fundamentally financial intermediaries, earned premium is in general considered a good measure of their size and also their market share. With \$1.9 billion in earned premiums, GHMSI is the largest insurer in the national capital area, holding 29 percent of the combined FEHBP, other group, and individual markets in 2003 (Figure 4). With its for-profit affiliate—CareFirst Blue Choice—CareFirst accounted for nearly 40 percent of the combined market in the national capital area. The mid-Atlantic region of the Kaiser Foundation Health Plan (Kaiser) is GHMSI's largest competitor in the national capital area, but it is only about half GHMSI's size in the combined market. In 2003, Kaiser earned less than \$1.1 billion in premiums and held about 16 percent of the area health insurance market.

In the District, GHMSI is the largest FEHBP insurer as well as the largest non-FEHBP insurer. With \$1.3 billion earned premiums, GHMSI held approximately 42 percent of the District's combined health insurance market in 2003. The District's non-FEHBP market (including other group coverage and individual coverage) is less concentrated, with smaller insurers taking somewhat larger market share. Nevertheless, GHMSI also holds nearly a quarter of this market (23 percent) (Figure 5).

Figure 4. Distribution of Earned Premiums Among Major Insurers in the National Capital Area, 2003



Kaiser is GHMSI's largest competitor in the District, as it is regionally. But Kaiser is about half the size of GHMSI, accounting for 19 percent of the District's health insurance market in 2003 (Figure 5). Kaiser is a somewhat closer competitor in the non-FEHBP group and individual markets in the District (holding 18 percent, compared to GHMSI's 23 percent). The District's largest for-profit carrier, Optimum Choice, holds 15 percent of the nonFEHBP market in the District, but does not participate in FEHBP.³⁵

In suburban Maryland, GHMSI holds a much smaller share of the market (15 percent) than in the District (Figure 6). Again, Kaiser is the closest competitor to any of the CareFirst companies in Maryland—but it is smaller than each of them. Kaiser held an estimated 10 percent of suburban Maryland's total health insurance market and 11 percent of the non-FEHBP market in 2003.

GHMSI also is the largest insurer in Northern Virginia, although it competes more closely with the second largest insurer—Kaiser—than in either the District or suburban Maryland (Figure 7). In Northern Virginia, GHMSI and Kaiser each hold an estimated 19 percent of the total health insurance market and 20 percent of the non-FEHBP market. HealthKeepers is the closest competitor to GHMSI and Kaiser in Northern Virginia, but it is about half their size, holding an estimated 11 percent of the market in 2003.

³⁵ All other insurers—including Aetna, MAMSI, and United Healthcare—each held less than 5 percent of the market in GHMSI's market area in 2003. In Maryland, including territory outside of GHMSI's market area, these competitors held slightly greater market share—together, about 18 percent of the market in 2003.

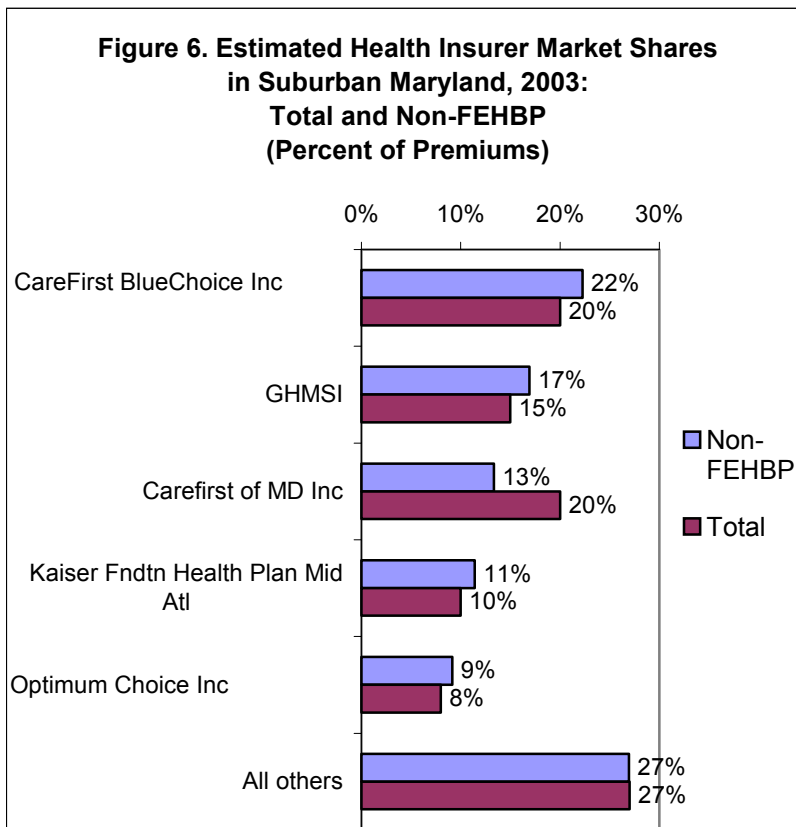
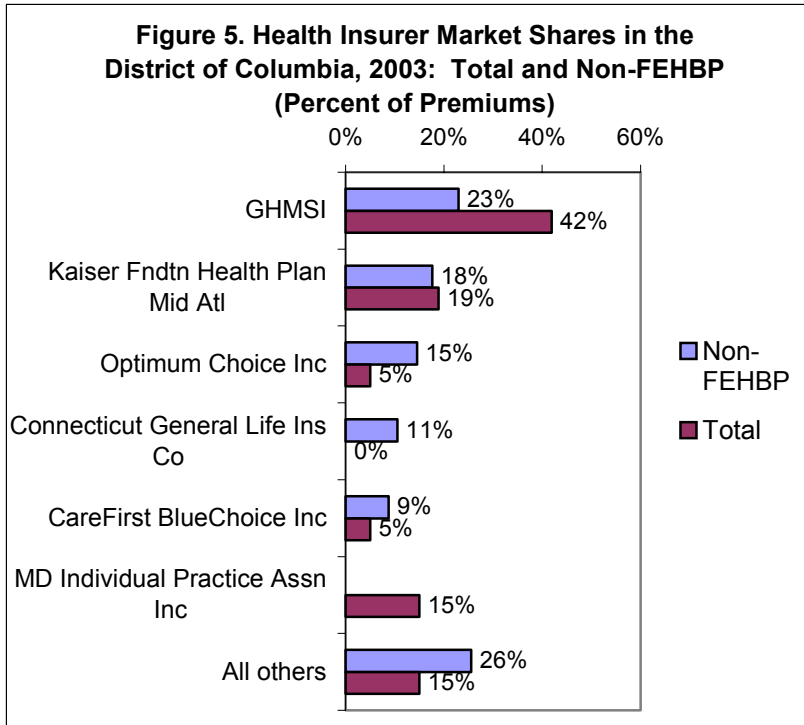
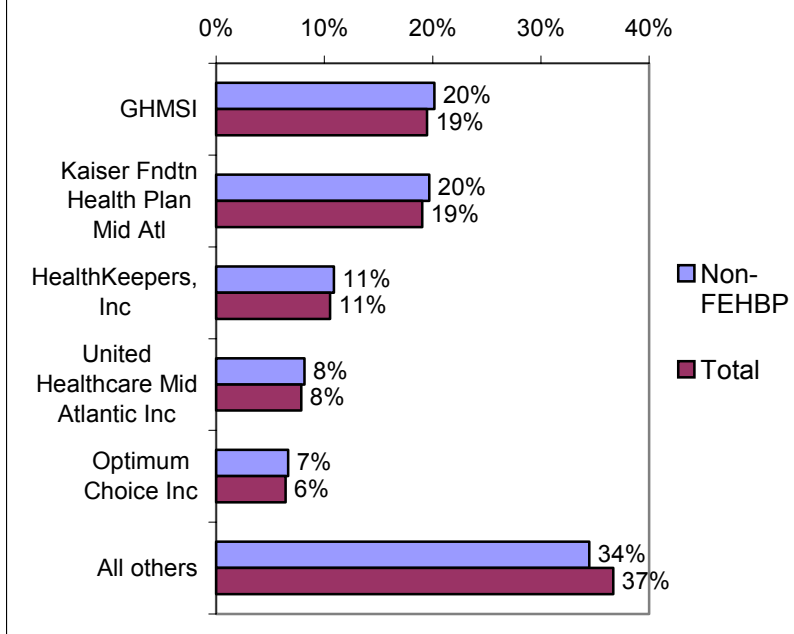


Figure 7. Estimated Health Insurer Market Shares in Northern Virginia, 2003: Total and Non-FEHBP (Percent of Premiums)



4. Changes in GHMSI's Earned Premiums and Market Position

Since 1999, GHMSI's earned premium revenue has grown steadily, at an average rate of 15 percent per year. The rate of growth in GHMSI's earned premium has ranged from 20 percent in 2000 to 10 percent in 2003—but it has been significant in each year.

GHMSI's earned premium revenue has grown much faster in suburban Maryland and Northern Virginia than in the District. From 1999 to 2003, GHMSI more than doubled its premium revenue in suburban Maryland—growing at an average rate of 40 percent per year, compared to 27 percent in Northern Virginia and 10 percent in the District (Table 1).

TABLE 1
GHMSI'S EARNED PREMIUMS: TOTAL AND DISTRIBUTION BY STATE, 1999-2003

	Total	District of Columbia	Suburban Maryland	Northern Virginia
Total earned premiums, 2003 (\$millions)	\$1,891.2	\$1,308.7	\$315.7	\$266.8
Average annual rate of growth, 1999-2003	14.6%	9.6%	40.0%	27.0%
<i>Percent of GHMSI's market:</i>				
1999	100.0%	82.8%	7.6%	9.5%
2001	100.0%	73.9%	12.8%	13.3%
2003	100.0%	69.2%	16.7%	14.1%
Non-FEHBP earned premiums, 2003 (\$millions)	\$788.6	\$239.9	\$297.9	\$250.7
Average annual rate of growth, 2001-2003	21.0%	17.2%	29.1%	16.4%
<i>Percent of GHMSI's market:</i>				
2001	100.0%	32.5%	33.1%	34.4%
2003	100.0%	30.4%	37.8%	31.8%

Source: MPR analysis of data provided by the District of Columbia, Maryland, and Virginia.

Note: Premiums earned in suburban Maryland and Northern Virginia are estimated from state-level data. FEHBP premiums were reported separately in 2001-2003, but not in earlier years.

The very fast growth of GHMSI's business in Maryland is consistent with a significant increase in its non-FEHBP business in Maryland, at least in the later years for which GHMSI reported FEHBP premiums separately (2001-2003). During this time, GHMSI's non-FEHBP premium revenue increased at an average rate of 29 percent per year in Maryland. In the District and Virginia, non-FEHBP premium growth was slower, averaging 17 percent and 16 percent per year, respectively. Following five years of much slower growth of premium revenue, the District accounted for a smaller share of GHMSI's total earned premiums in 2003 than in 1999—dropping from 83 percent in 1999 to 69 percent in 2003.

The distribution of enrollment in GHMSI across the District, suburban Maryland, and Northern Virginia is similar to the distribution of earned premiums. In 2003, enrollment in the District accounted for 69 percent of GHMSI's total enrollment—reflecting the high proportion of FEHBP enrollment allocated to the District (Table 2). Non-FEHBP enrollment is more evenly distributed among jurisdictions: 37 percent is in suburban Maryland, 32 percent in Northern Virginia, and 30 percent in the District.

TABLE 2
GHMSI'S NUMBER OF MEMBERS: TOTAL AND DISTRIBUTION BY STATE, 2001-2003

	Total	District of Columbia	Suburban Maryland	Northern Virginia
Total members, 2003 (thousands)	710.9	68.8%	17.7%	13.5%
Non-FEHBP members, 2003 (thousands)	256.8	30.1%	37.3%	32.6%

Source: MPR analysis of data provided by the District of Columbia, Maryland, and Virginia.

The overall distribution of GHMSI's business may continue to change. Although the numbers of enrollees in the District and Virginia are likely to remain significant, suburban Maryland's faster average rate of growth in enrollment from 2001 to 2003—with very little loss of non-FEHBP enrollees in 2003—suggests that suburban Maryland may account for a growing percentage of GHMSI's total business and members in future years.

Across GHMSI's market area, its business—in terms of both total premium revenue and total membership—has continued to grow, though its recent loss of non-FEHBP enrollment in the District and in Northern Virginia is striking. It seems apparent that much if not all of this loss has related to steep increases in average premiums in this segment of its business. Between 2002 and 2003, GHMSI increased its average premiums by 25 percent across the national capital area, from 23 percent in the District to more than 28 percent in suburban Maryland (Table 3). At the same time, non-FEHBP enrollment declined 11 percent in the District and nearly 12 percent in Northern Virginia (Table 4). In Maryland, GHMSI's non-FEHBP enrollment remained flat.

In markets that are as concentrated as those in the national capital area, fast premium growth creates a problem of affordability, with employers and individuals increasingly unable or unwilling to maintain coverage—resulting in growing numbers of uninsured. Fast premium growth may indicate a failure of competition to constrain prices. The following section addresses this issue.

TABLE 3
GHMSI'S EARNED PREMIUMS PER MEMBER
AND ANNUAL RATES OF GROWTH: 2001-2003^A

	Total	District of Columbia	Suburban Maryland	Northern Virginia
Total earned premiums per member, 2003	\$2,660.2	\$2,675.6	\$2,509.9	\$2,778.7
Annual rate of growth:				
2001-2002	8.5%	7.0%	10.0%	18.9%
2002-2003	15.7%	9.9%	34.2%	26.5%
Non-FEHBP earned premiums per member, 2003	\$3,071.3	\$3,105.1	\$3,108.5	\$2,997.4
Annual rate of growth:				
2001-2002	na ^b	na ^b	6.8%	20.7%
2002-2003	25.4%	22.9%	28.4%	24.4%

Source: MPR analysis of data provided by the District of Columbia, Maryland and Virginia.

^a Information on the number of members is available only for 2001 and subsequent years.

^b The number of members in the DC group market was misreported in 2001.

C. MARKET POWER

The concentration of a health insurance market among just a few insurers offers simple evidence that it is not perfectly competitive. However, this observation alone does not indicate the extent of market power that the largest insurers enjoy. In a perfectly competitive market, each firm would be a price taker; a seller would not survive if it set prices above those of its competitors. As a seller gains market power, it is able to set prices that are different—and higher—than other sellers in the market. In markets that are concentrated among a few sellers (a situation called oligopoly), the largest sellers will tend to move prices together; smaller sellers may “shadow price,” or set rates near or just below that of the largest insurers and underwrite (deny or limit coverage) to achieve that price.

TABLE 4
ANNUAL RATES OF GROWTH IN GHMSI ENROLLMENT: 2001-2003^A

	Total	District of Columbia	Suburban Maryland	Northern Virginia
Rate of growth in total enrollment:				
2001-2002	5.0%	2.8%	17.4%	2.1%
2002-2003	-5.0%	-2.9%	-5.7%	-13.6%
2001-2003 average	0.0%	-0.1%	5.8%	-5.8%
Rate of growth in non-FEHBP enrollment:				
2001-2002	na ^b	na ^b	22.3%	2.1%
2002-2003	-7.7%	-10.9%	-0.6%	-11.9%
2001-2003 average	na ^b	na ^b	10.8%	-4.9%

Source: MPR analysis of data provided by the District of Columbia, Maryland, and Virginia.

^a Information on the number of members is available only for 2001 and subsequent years.

^b The number of members in the DC group market was misreported in 2001.

Health insurance markets typically do not fit the conventional model of competition. They typically are concentrated. In addition, insurers vary their products in complex ways—with different cost sharing provisions, benefit coverage, drug formularies, and provider networks. These practices make comparison of prices very difficult for consumers. Given the complexity of the product, consumers often lean heavily on the insurer's reputation and perceived experience, reinforcing the market power of larger and established insurers.

From an economist's perspective, the price of insurance is measured not as the observed price that consumers pay, but the difference between the average premium paid and the average medical benefit received. Risk aversion determines the economic price that consumers are willing to pay. Groups or individuals who are risk-neutral would remain uninsured if the premium exceeded the expected benefit—that is, if the economic price were non-zero. Risk-averse consumers are willing to pay a higher economic price, which covers the insurer's administrative cost and contributes to surplus (or unobligated funds). All else being equal, we expect that insurers with market power are able to charge higher economic prices to risk-averse consumers, and systematically do so.

1. Understanding Insurer Pricing

Rising economic prices may indicate two characteristics of the market. For an individual insurer, increases in the economic price of insurance suggest growing market power. However, when all insurers increase (or decrease) economic prices, it more likely indicates the progress of an underwriting cycle.

Since the 1960s, when data to measure insurers' financial status became available, the health insurance industry has exhibited a repeating pattern of underwriting gains (positive premium revenues net of claims cost and administrative expense) in several years followed by several years of underwriting losses (negative net premium revenues). Called an underwriting cycle, this

phenomenon is driven by both forecasting error—especially in anticipating medical costs—and imperfect competition.³⁶

For decades, the underwriting cycle followed a very consistent pattern: three years of gains followed by three years of losses. During the 1990s, however, the cycle apparently lengthened and its amplitude declined, reducing differences between the cycle’s top and bottom. This change generally has been attributed to the introduction of managed care, but it may also relate to the growing concentration of health insurance markets and, therefore, greater market power exerted by the largest insurers. In either case, industry experts expect underwriting cycles to be still more muted in the current decade.

Since 1998, GHMSI’s aggregate economic price (total premiums earned minus medical claims incurred) has risen as a percent of premiums—from 8.6 percent to 11.4 percent, reaching as high as 15.5 percent in 2000 (Table 5).^{37 38} Moreover, GHMSI’s economic price is three to five times as high as that of its nearest competitor, Kaiser. Optimum Choice—a for-profit company that has been gaining market share quickly—shows an economic price that is steadily approaching GHMSI’s, suggesting that it may be shadow pricing GHMSI as it gains market share.

It is notable that GHMSI’s economic price for its non-FEHBP business is much higher than that for its total business, and it is growing much faster. This pattern suggests that GHMSI may be pricing more competitively in the FEHBP program than the general market—behavior that is unsurprising given FEHBP’s efforts to structure a price-competitive market for federal employees. Indeed, there is no reason to expect that FEHBP carriers would *not* set prices higher in the general market, where there is less consumer information available to support true competition. In contrast, Kaiser—a smaller but significant FEHBP carrier—sets economic prices for FEHBP and non-FEHBP enrollees at about the same level in the national capital area.

³⁶ The dynamic of an underwriting cycle is as follows: In periods of underwriting gain, some insurers may seek to gain market share by reducing prices. In a competitive market, other insurers will follow suit to protect their market share, causing a general reduction in economic prices that for many may generate underwriting losses. Economic prices will continue to decline until a lead insurer (with market power) increases economic prices to restore at least “break even” revenues. As other insurers follow suit, economic prices will rise—and will continue to rise as insurers take underwriting gains as compensation for the “bad years.” At some point, the cycle will repeat, as one or more insurers attempts to gain market share at the top of the cycle. Because health care costs may be rising throughout the cycle, consumers typically experience these cycles as accelerations or reductions in the rate of increase in the observed price of health insurance.

³⁷ This measure is equal to one minus the insurer’s medical loss ratio. A loss ratio is defined as the insurer’s total medical losses divided by its premium revenues.

³⁸ In order to capture companies’ pricing behavior with more precision, state-level premium and claims data are used for this analysis, not the county-level estimates reported earlier.

TABLE 5
ECONOMIC PRICE AS PERCENT OF PREMIUMS EARNED IN THE DISTRICT,
MARYLAND, AND VIRGINIA: TOTAL AND NON-FEHBP PREMIUMS OF
SELECTED MAJOR INSURERS, 1998-2003

	GHMSI		Kaiser		Optimum Choice	
	Total	Non-FEHBP	Total	Non-FEHBP	Total	Non-FEHBP ^a
1998	8.6%	na	Na	na	na	na
1999	11.1%	na	Na	na	na	na
2000	15.5%	na	3.9%	3.9%	8.4%	8.4%
2001	10.0%	17.7%	0.2%	-0.8%	9.1%	9.1%
2002	10.3%	16.4%	2.6%	1.8%	9.6%	9.6%
2003	11.4%	18.9%	3.0%	3.0%	13.4%	13.4%

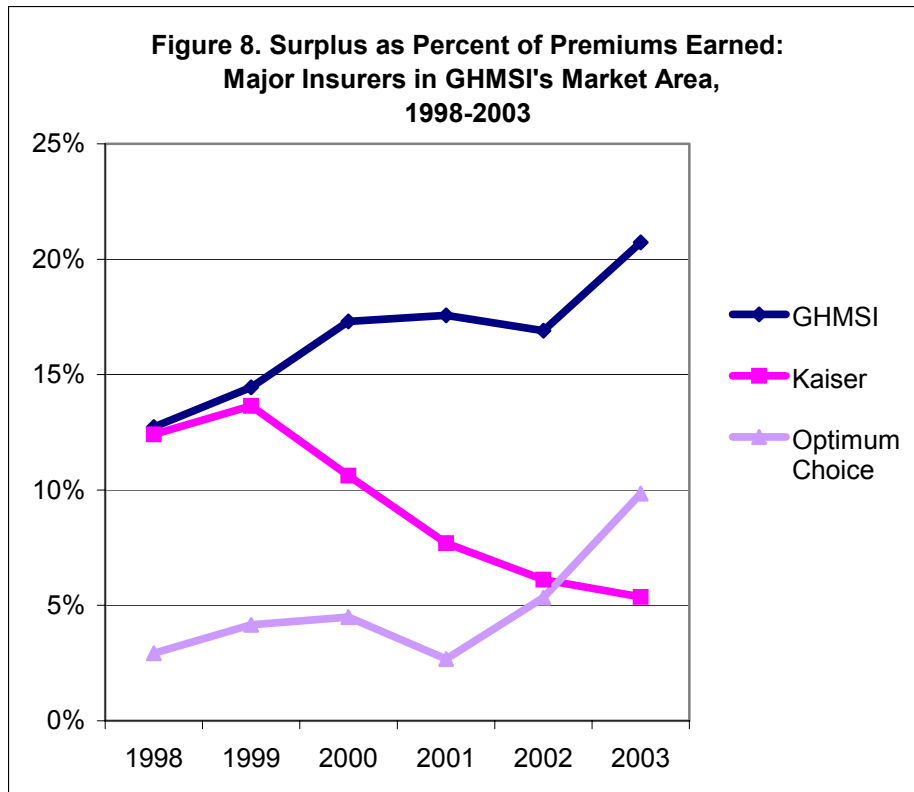
Source: MPR analysis of data obtained from DC, Maryland, and Virginia.

^aBecause Optimum Choice has very little FEHBP business, estimates of total and non-FEHBP prices are the same.

2. Insurer Surplus

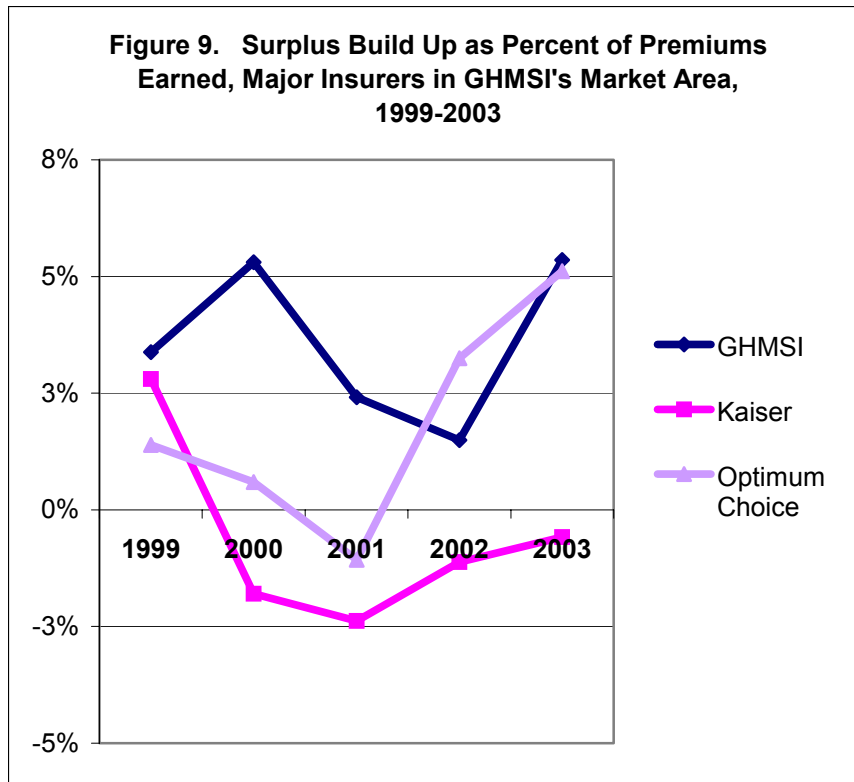
To understand GHMSI's higher economic pricing, it is instructive to look at a major component of its price: unassigned funds, or surplus. An insurer's surplus is its "capital on hand" after all liabilities have been deducted from assets. Insurers create surplus over time, as accumulated annual underwriting gains and losses. In 2003, GHSMI held \$392 million in surplus, equal to 21 percent of premiums (Figure 8).

GHMSI's high levels of surplus suggests that its pricing is consistent with market power—that is, GHMSI is not setting the lowest possible price as would occur in a competitive market. Indeed, its level of surplus relative to premium far exceeds that of both Kaiser and Optimum Choice. While Kaiser's surplus as a percent of premium was also about 13 percent in 1998, it has declined continuously since then. In 2003, Kaiser held a surplus of approximate \$70 million—just 5 percent of earned premiums. Optimum Choice's surplus as a share of premiums is higher than Kaiser's but it has been consistently lower than GHMSI's.



The change in surplus from the prior year is a measure of the addition to current-year economic prices associated with the current-year build-up of surplus. From 1998 to 2003, GHMSI increased the level of its surplus continuously (not shown), at an average rate of 27 percent each year. GHMSI's surplus build-up raised its premiums by an average of 3.6 percent each year during this period—accounting for 26 percent of the total increase in premiums between 1998 and 2003 (Figure 9). In 2000—when GHMSI priced very high relative to medical cost—the addition to surplus accounted for more than 5 percent of earned premiums and fully half of the increase in premiums from 1999.

In contrast, Kaiser's addition to surplus has been negative and decreasing since 1999, although it has attempted to regain surplus since 2001. In effect, Kaiser “gave back” to enrollees about 1 percent of premiums in the form of surplus reduction in 2003. Optimum Choice also has built substantial surplus since 2001, generally increasing surplus in tandem with GHMSI. Like GHMSI, its addition to surplus accounted for about 5 percent of earned premiums in 2003.



3. Surplus Relative to Regulatory Standards

Insurers measure the capital they hold in terms of the risk associated with its investment. Each insurer reports two risk-based capital measures: total adjusted risk-based capital (TAC) and authorized control level (ACL) risk-based capital. Developed by the National Association of Insurance Commissioners (NAIC), the risk-based capital formula establishes a measure of surplus for every insurer that adjusts for the risk inherent in its contractual obligations and asset portfolio; the calculation of risk-based capital is the same for nonprofit and for-profit companies.³⁹

Insurance commissioners use risk-based capital measures to gauge an insurer's financial condition and risk of insolvency. When an insurer's TAC falls to 200 percent of ACL risk-based capital (called the "company action level"), the insurance department typically intervenes to place the insurer under regulatory control as a precaution against insolvency. Most companies maintain their TAC above this level.

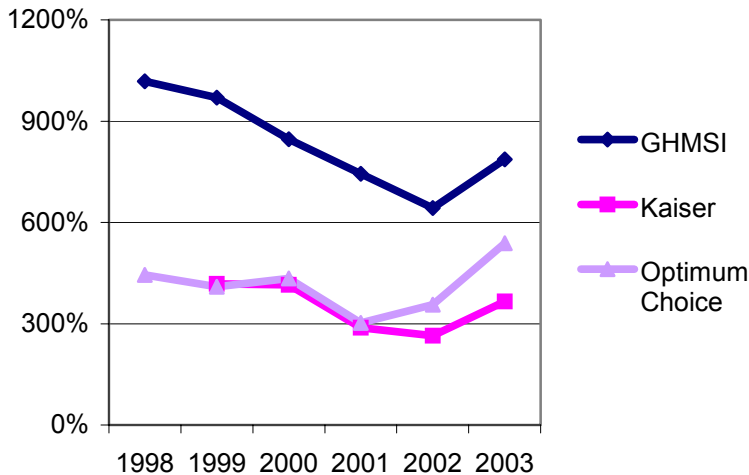
³⁹ For health companies, TAC is usually equal to reported surplus plus other types of capital held. This typically includes capital stock if the insurer is a stock company, as well as surplus notes (that is, capital contributed by a parent corporation that may be repaid upon notification of the regulatory authority). Commercial (life) companies use a more complicated formula to calculate risk-based capital, but their TAC is usually also greater than reported surplus.

The Blue Cross Blue Shield Association (BCBSA) has its own risk-based capital requirements for Blue Cross plans. BCBSA requires companies using its name to maintain risk-based capital equal to at least 375 percent of the ACL level, compared to NAIC's 200-percent "action" level (Serota 2004).

Whatever the reason, GHMSI's TAC is significantly higher than its non-Blues competitors, but it is also much higher than 375 percent of ACL risk-based capital. Between 1998 and 2003, GHMSI's TAC ranged from 1,018 percent to 643 percent of ACL risk-based capital, averaging 835 percent over the six-year period (Figure 10). This is twice the average that either Kaiser or Optimum Choice maintained over the same period. Both Kaiser and Optimum Choice averaged a TAC level at about 400 percent of ACL, although Optimum Choice's TAC accelerated to 538 percent of ACL in 2003.⁴⁰

⁴⁰ CareFirst has suggested that an appropriate measure of surplus would be surplus per enrollee, and that by this measure, GHMSI's total reserves average out to \$405 per member—"less than the cost of one visit to a hospital emergency room." While evocative, this approach to measuring the adequacy of insurer surplus is unique: the literature never assesses surplus adequacy by this kind of measure. Moreover, no regulatory authority proposed such a standard, nor does recent correspondence from the Blue Cross and Blue Shield Association (BCBSA) to the Insurance Commissioner of Pennsylvania on this topic (Serota 2004).. Such a standard would imply that GHMSI's current high surplus—and also that of all other insurers—should be maintained or even increased as a precaution against all subscribers using a hospital emergency room visit in the same year or events that GHMSI officials also have mentioned to explain need for high surplus—an extraordinarily severe flu season or major terrorist attack. . It further would imply that GHMSI could not responsibly use its surplus for any reason other than for medical expense, although it apparently does intend to use substantial surplus for other purposes such as capital investments, new product development, and information technology improvements.

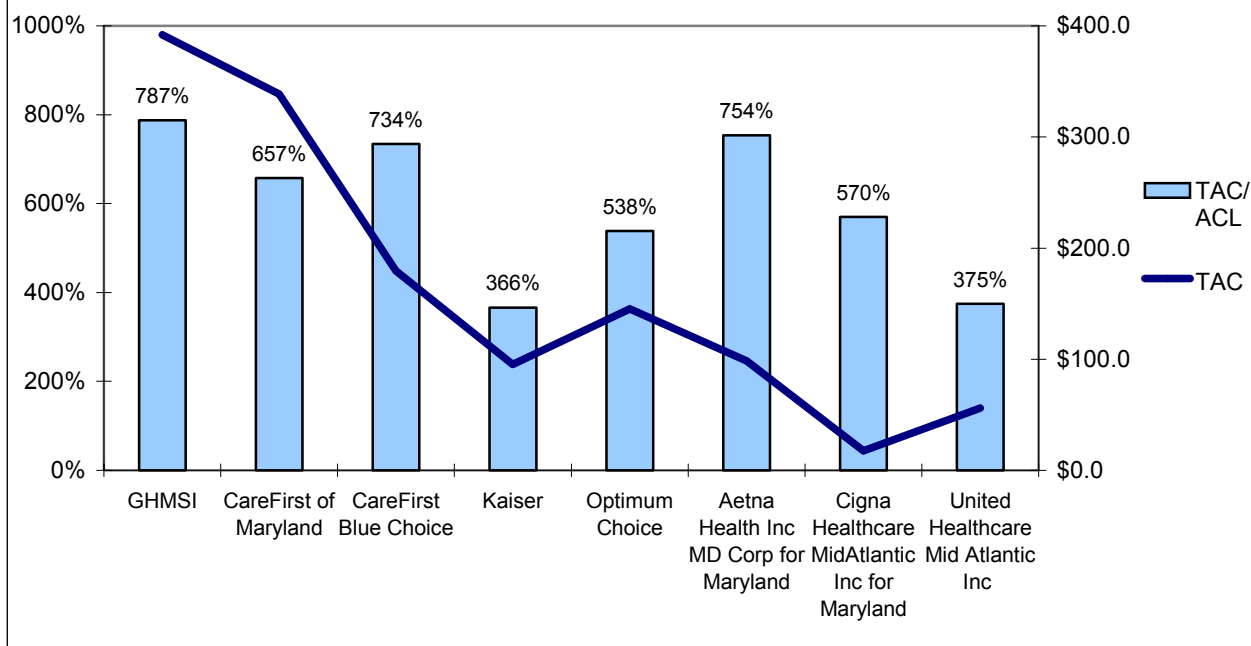
Figure 10. Total Adjusted Capital as Percent of Authorized Control Level Risk-Based Capital: Selected Major Insurers 1998-2003



In 2003, GHMSI's TAC relative to ACL also exceeded that of the other large CareFirst companies and CareFirst's primary commercial competitors in Maryland (Figure 11). Only Aetna—with a much smaller share of the market than GHMSI—held about the same TAC relative to ACL as GHMSI or other CareFirst companies.⁴¹

⁴¹ Like the CareFirst affiliated companies, companies with a national affiliation or parent company—such as Aetna and United Healthcare—may move capital between the company and its affiliate or parent in the form of either donated capital or a “surplus note.” While either is unusual, surplus notes are more customary among companies with national affiliation. A surplus note represents an obligation to repay, but is repayable only upon notification of the regulatory authority.

Figure 11. Total Adjusted Risk-Based Capital (TAC in \$millions) and TAC per Authorized Control Level (ACL) Risk Based Capital: GHMSI, Other CareFirst Companies, and Selected Insurers in CareFirst's Market Area, 2003



In summary, compared to normal regulatory measures and the practices of its competitors, GHMSI has substantially higher surplus that it might draw down for community benefit. The difference between GHMSI's level of TAC and 400 percent of ACL—approximately the average among GHMSI's major competitors—was \$193 million in 2003.

4. Statistical Analysis of Market Power

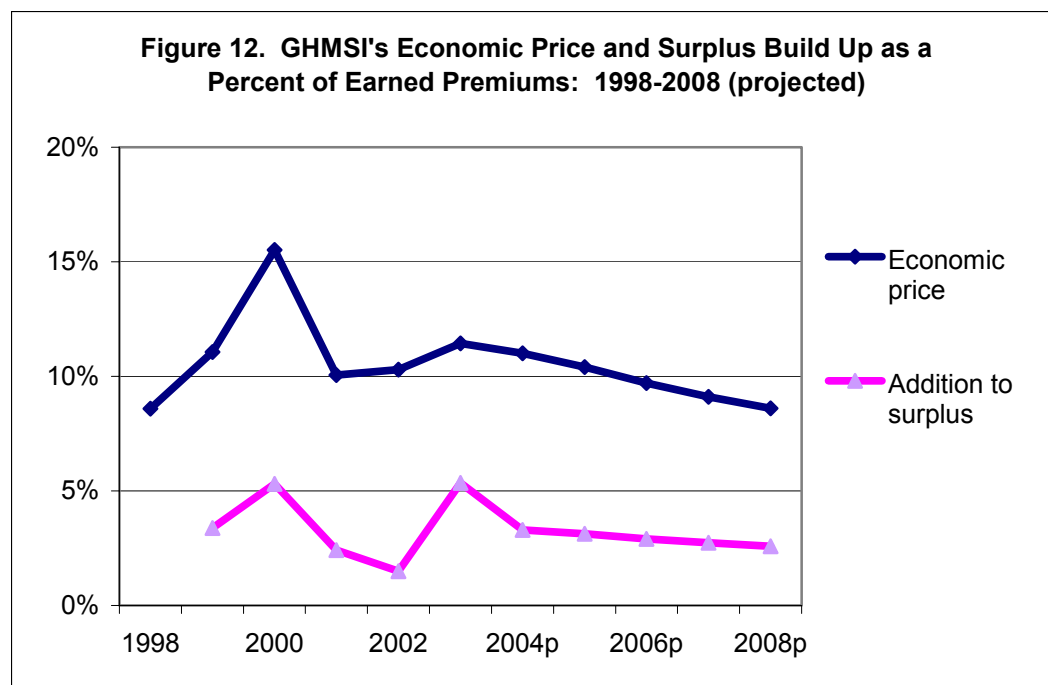
To measure the effect of market power on economic prices in the national capital area, we modeled insurers' economic prices as a function of a series of company-level explanatory variables. The model controlled for the time period of the observation (a proxy for the underwriting cycle) and other factors that may affect economic prices, including TAC levels relative to ACL. Insurer size was included to gauge market power. We estimated a simple clustered linear regression model using company-level data, pooling all major insurers in the national capital area from 1999 to 2003. The specification of the model and statistical results are summarized in Appendix D.

To the extent that the market is competitive (and insurers are price takers), we hypothesized that differences in company operations would not influence economic prices significantly. However, the results of this analysis offer strong statistical evidence that large insurers in the District, Maryland, and Virginia charge higher economic prices than mid-sized insurers. But the smallest insurers also charge higher economic prices (even controlling for differences in administrative cost), shadow-pricing the area's largest insurers.

As the largest insurer in the national capital area, GHMSI exerts substantial market power, and its economic prices are higher. Specifically, we estimate that market power accounted for \$13.8 billion of GHMSI's economic prices between 1998 and 2003 (relative to Kaiser)—averaging 2.1 percent of earned premium per year. GHMSI's use of market power probably also raised the level of prices that smaller insurers charged as they shadow-priced GHMSI's products.⁴²

D. FEASIBILITY OF GHMSI'S PROVIDING GREATER COMMUNITY BENEFIT

In this section, we offer a simple simulation to measure the financial impact on GHMSI of undertaking substantially greater expenditures for community benefit. In order to make reasonable projections of any insurer's financial performance, it is necessary first to project the underwriting cycle in order to understand how the market environment—and the insurer's surplus from which additional expenditure would be financed—is likely to change. Since at least 2000, the insurance industry has been on the rising side of the underwriting cycle, but it seems likely that 2003 will be the last year of expansion; in 2004 and at least through 2007, the premiums are likely to increase at a rate much closer to the rate of increase in medical costs as the industry moves into the down-side of the underwriting cycle.⁴³

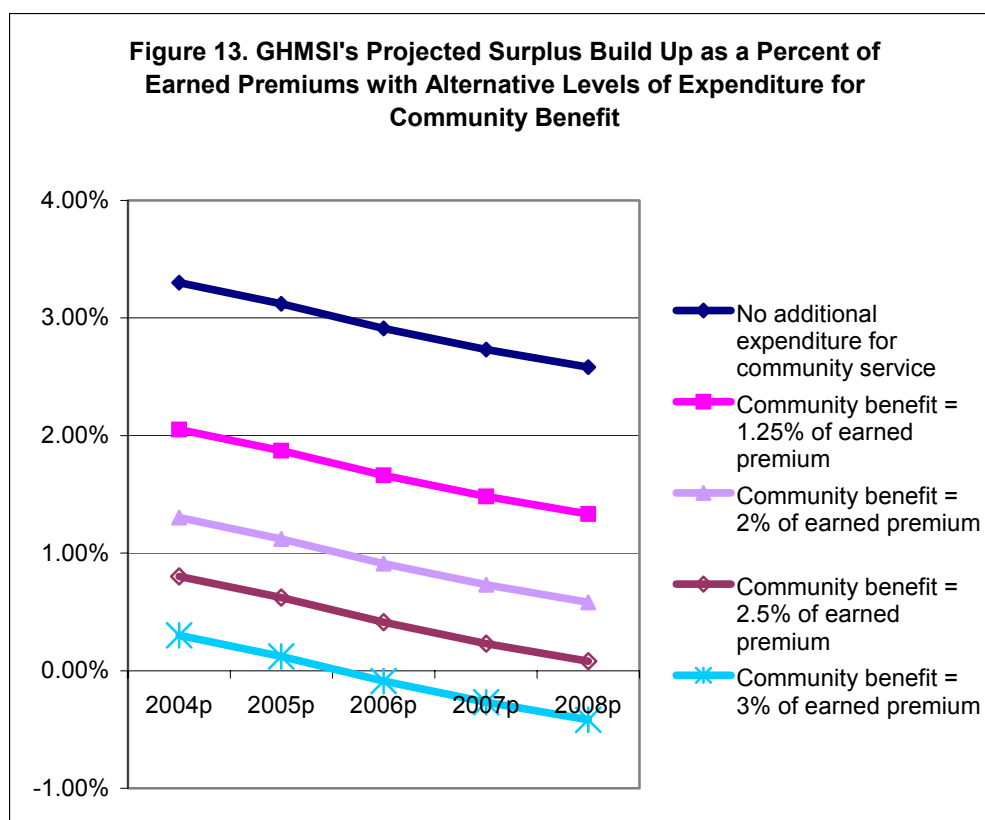


⁴² In addition, we find that insurers with greater FEHBP business appear to charge lower economic prices in that segment of their market, consistent with significantly greater competition in the FEHBP market—and therefore charge lower economic prices overall. However, both for-profit insurers and insurers in Virginia charge significantly higher economic prices (relative to Maryland insurers), all else being equal. Insurers in the District appear to price similarly to those in Maryland.

⁴³ General industry trends are reported in CMS (2003).

We used the trajectory of the last underwriting cycle to project the probable length and depth of current underwriting cycle. This method is consistent with all available economic and industry literature about the current stage of the underwriting cycle, but may project a lower position in 2008 than will occur, as the literature also suggests that future underwriting cycles may be shallower than those in the past. Specifically, we assumed that the low point of the current cycle will be 2008, and that GHMSI's economic price in 2008 will equal its economic price in 1998—about 8.6 percent of earned premium (Figure 12). This compares to a projected economic price of 12 percent of earned premium in 2004 and about 9.7 percent of earned premium in 2006. GHMSI's surplus build-up from 2004 to 2008 also is likely to slow.

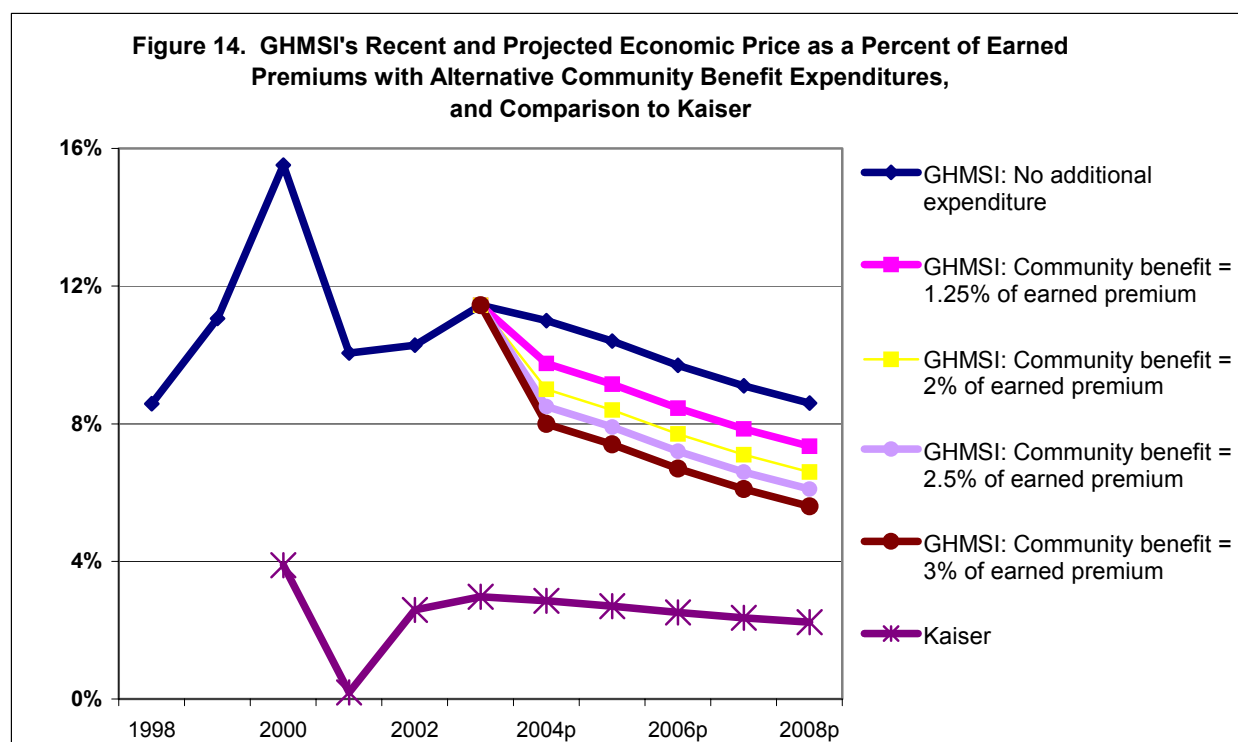
To simulate the potential impact of GHMSI undertaking additional annual expenditures to support community benefit mission, we considered the range of other nonprofit plans' actual expenditures for community benefit (1.25 percent to 3 percent of premiums) as well as the margin on GHMSI's premiums associated with their market power (about 2 percent of premiums). We then calculated the potential impact of these levels of annual expenditure on GHMSI's financial position in terms of its impact on surplus build-up—in effect, assuming GHMSI's annual expenditure for community benefit would not be financed by raising observed prices, but by reducing their economic price and annual surplus build-up.



We estimate that, despite a downturn in the underwriting cycle, GHMSI is likely to have sufficient latitude within its current pricing structure to continue to accumulate surplus—even with higher levels of expenditure for community benefit. Projected surplus build-up in 2008 with no additional expenditure for community benefit exceeds 2.6 percent of earned premium (Figure 13). With additional community benefit expenditure equal to 2 percent of earned premiums, GHMSI's

projected surplus build-up in 2008 still would equal 0.6 percent of earned premiums. With an additional annual expenditure for community benefit of approximately 2.5 percent of earned premium, GHMSI would continue to build surplus until 2008 at a declining rate, and the ratio of surplus to current premiums would decline. Nevertheless, we estimate that in 2008—the likely low point in the underwriting cycle—GHMSI would maintain a level that far exceeds that of its competitors.

Our calculations indicate that GHMSI could finance additional community benefit within its current economic price, so that observed prices might rise due only to increases in medical benefits paid. In addition, because GHMSI's past and current expenditure for community benefit is reflected in its current and projected levels of surplus, all estimates are in effect measures of *additional* expenditure that GHMSI would make for community benefit.



GHMSI's projected economic price net of new expenditure for community benefit under alternative assumptions about expenditure for community benefit is reported in Figure 14. For purposes of comparison, we also project Kaiser's economic price using the same extrapolation methods described above.

Even with higher levels of expenditure for community benefit, GHMSI is projected to maintain much higher economic prices than Kaiser, net of the new expenditure. Assuming alternative levels of expenditure for community benefit, GHMSI's 2008 net economic price is projected to range from 5.6 percent to 7.4 percent of earned premium—compared with 2.2 percent for Kaiser. We conclude that devoting additional funding to community benefit in the range illustrated here would not affect GHMSI's competitive viability or financial soundness.

Finally, we extended our simulation analysis to project both the level of TAC as a percent of ACL risk-based capital that GHMSI might experience if it were to reduce its surplus build-up by spending greater amounts for community benefit, and the amount of community benefit that allocation of alternative percentages of earned premium might yield. We assume a baseline trajectory of surplus reduction on the downside of the underwriting cycle that mirrors GHMSI's surplus buildup from 1999 to 2003, as well as accelerated growth of ACL relative to premium. Our projection of ACL relative to premium proxies the arithmetic formula by which ACL is actually calculated and, we expect, overstates future ACL. As a result, our projected ratios of TAC to ACL probably are conservative.

Table 6 summarizes the results of the simulations with respect to projected TAC as a percent of ACL risk-based capital. The purpose of this exercise is not to project these relationships with precision, but rather to understand the general magnitudes and sensitivity of TAC relative to ACL that might occur, were GHMSI to retrace the same general financial path that it took from 1998 through 2003, with the underwriting cycle depressing total premium growth from 2004 through 2008.

TABLE 6
GHMSI'S PROJECTED TOTAL ADJUSTED RISK-BASED CAPITAL (TAC) AS A PERCENT
OF PROJECTED AUTHORIZED CONTROL LEVEL (ACL) RISK-BASED CAPITAL
WITH ALTERNATIVE ASSUMPTIONS ABOUT TOTAL PREMIUM GROWTH
AND COMMUNITY BENEFIT EXPENDITURE: PROJECTED 2004 AND 2008

Additional annual community benefit expenditure as a percent of earned premium	Average Annual Growth in Total Premium:					
	8 percent		10 percent		15 percent	
	2004p	2008p	2004p	2008p	2004p	2008p
0 percent	823%	974%	836%	942%	794%	940%
2 percent	775%	681%	748%	580%	728%	516%
2.5 percent	756%	599%	729%	503%	710%	443%
3 percent	738%	518%	710%	427%	691%	371%

Note: Supporting detail is provided in Appendix E.

The results of this exercise indicate that GHMSI would continue to accumulate surplus, but at a declining rate (as shown earlier in Figure 14), if it did not make additional expenditures for community benefit. Within the premium growth rates that we modeled (averaging 8 to 15 percent per year), GHMSI would continue to have substantially higher levels of TAC relative to ACL compared to either the BCBS or NAIC “early warning” standard: from 794 percent to 823 percent in 2004, rising to 940 percent to 974 percent in 2008. Everything else being equal, GHMSI's TAC/ACL ratio is likely to be lower if its total premiums grew faster—in part because the simulation assumes that ACL will accelerate with faster premium growth, but also because GHMSI may be called upon to spread its accumulated surplus over a larger premium base.

If GHMSI makes additional expenditures for community benefit, it is likely still to achieve significant levels of surplus—without increasing observed prices net of increases in medical benefits paid. With an expenditure of 2 percent of premiums for community benefit, GHMSI might still hold surplus equal to 516 percent to 681 percent of ACL, depending on total premium growth. Only with additional expenditures for community benefit equal to 3 percent of premium with 15

percent average annual premium growth through 2008 does it seem likely that GHMSI might need to raise its premiums to consumers to maintain the BCBS standard. However, even that relatively unlikely scenario produces a ratio of 371 percent—still substantially greater than the NAIC minimum for all insurers and approximately equal to the BCBS minimum.⁴⁴

The degree to which GHMSI should approach these minimum amounts is, of course, a matter of GHMSI's legitimate needs for greater levels of surplus. However, it is notable that GHMSI now holds capital at a level that substantially exceeds that of its largest competitors (as well as its Maryland CareFirst affiliates), while its potentially most significant needs for capital on hand—to cope with unforeseen health expenditures or a fall in return to investments—are common to all insurers in the market.

Projected levels of GHMSI's annual expenditure for community benefit associated with the assumptions explored above are reported in Table 7. If it used a 2-percent of premium rule, GHMSI would spend \$41 million for community benefit in 2004 (assuming low growth in total premiums) and as much as \$44 million (assuming high premium growth from 2003 to 2004). Our projections indicate that expenditures in 2008 would likely be in the range of \$56 million to \$76 million, depending on average premium growth. With an additional annual commitment of 3 percent of premium, assuming moderate average annual growth of total premiums (10 percent), GHMSI might allocate an additional \$100 million to community benefit by 2008 without increasing consumer premiums relative to baseline projections.

TABLE 7
GHMSI'S PROJECTED ADDITIONAL EXPENDITURE FOR COMMUNITY BENEFIT
WITH ALTERNATIVE ASSUMPTIONS ABOUT TOTAL PREMIUM GROWTH AND COMMUNITY
BENEFIT EXPENDITURE AS A PERCENT OF EARNED PREMIUM: PROJECTED 2004 AND 2008
(\$ millions)

Additional annual community benefit expenditure as a percent of earned premium	Average Annual Growth in Total Premium:					
	8 percent		10 percent		15 percent	
	2004p	2008p	2004p	2008p	2004p	2008p
2 percent	\$40.8	\$55.6	\$42.4	\$66.7	\$43.5	\$76.1
2.5 percent	\$51.1	\$69.5	\$53.0	\$83.3	\$54.4	\$95.1
3 percent	\$61.3	\$83.4	\$63.5	\$100.0	\$65.2	\$114.1

Note: Supporting detail is provided in Appendix E.

⁴⁴ In addition, we simulated the impacts on GHMSI's projected TAC relative to ACL, if it were to make substantial expenditure over the next several years for capital investment, new product development, and information technology improvements. CareFirst has suggested that the magnitude of its expected commitment of surplus for these purposes is \$300 million over three years. Presuming that GHMSI's share of this commitment would be as much as half of the CareFirst total (\$150 million), we projected GHMSI's TAC in 2008 to be approximately 410 percent of ACL, assuming 10 percent annual premium growth and an annual commitment of 2 percent of premium to community benefit. This is 9 percent higher than the 375 percent minimum that BCBSA requires.

E. SUMMARY AND DISCUSSION

Like many health insurance markets across the country, the national capital area's market is concentrated. In 2003, GHMSI accounted for 29 percent of the market, including its very large business as an FEHBP carrier in the region. Kaiser is GHMSI's nearest competitor, though only about half GHMSI's size. Taken together, Kaiser, MD IPA, and Optimum Choice hold about the same market share as GHMSI.

GHMSI is the largest insurer in the District, and a major insurer in Maryland and Virginia as well. Even excluding its substantial FEHBP business, GHMSI held nearly one-third of the market in the District and more than half of the market in suburban Maryland. GHMSI controls about 20 percent of the market in Northern Virginia.

Over the last five years (for which data were available), GHMSI's premium revenue has grown at an average rate of 15 percent per year. In both suburban Maryland and Northern Virginia, its premium growth has been much faster— respectively averaging 40 percent and 21 percent per year.

For non-FEHBP enrollees, average premiums have grown very fast, and enrollment has dropped. For non-FEHBP enrollees, average (per enrollee) premiums increased more than 25 percent from 2002 to 2003. Average premium increases ranged from 23 percent in the District to 28 percent in Maryland. At the same time, enrollment dropped 3 percent in the District, 6 percent in suburban Maryland, and nearly 14 percent in Northern Virginia. It is likely that at least some of those leaving GHMSI enrollment in response to steep premium increases became uninsured.

Both the concentration of the market among a few large insurers and GHMSI's very large market share offer simple evidence of a noncompetitive health insurance market, although size alone does not predict that an insurer will use its market power. GHMSI accumulated surplus at an average rate of 27 percent each year from 1998 to 2003. In 2003, GHMSI's accumulated surplus equaled 21 percent of premiums, nearly four times Kaiser's level of surplus relative to premiums. In 2003, GHMSI's surplus build-up accounted for about 6 percent of premiums, while Kaiser "gave back" to enrollees about 1 percent of premiums in the form of surplus reduction.

Much of GHMSI's surplus and surplus build-up may relate to BCBS plans' general practice of holding very high surplus relative to risk-based capital (a measure of an insurer's financial condition). However, between 1998 and 2003, GHMSI's average surplus relative to risk-based capital was more than four times the level that would indicate financial distress, more than twice that of its largest competitors, and twice the level that BCBSA requires of Blues licensees. While none of these measures is necessarily an adequate gauge of GHMSI's specific business and competitive needs for capital, GHMSI's relatively high surplus implies that its competitors were able to offer lower consumer prices for coverage, provide more health care per premium dollar, or both.

Statistical analysis of insurer behavior in the District, Maryland, and Virginia, offers strong evidence that GHMSI does exercise market power in the national capital area. We estimate that GHMSI built nearly \$14 billion into its economic prices between 1998 and 2003 due solely to its market power, equal to 2.1 percent of earned premium.

A simulation of the impact of greater expenditure for community benefit on GHMSI's financial position suggests that it is financially capable of providing greater community benefit. Even at the

likely low point of the underwriting cycle (in 2008), we estimate that GHMSI could allocate as much as 3 percent of premium to community benefit without adjusting observed prices net of medical benefits paid, and still maintain a ratio of total adjusted capital (TAC) relative to authorized control level (ACL) risk-based capital equal to 400 percent or more—approximately the 2003 industry average in GHMSI’s market area (at the high point of the underwriting cycle), and above the BCBS minimum standard of 375 percent. An allocation of 3 percent of premium would yield an estimated \$61 million for community benefit in 2004 assuming low premium growth (8 percent), and as much as \$100 million in 2008, assuming intermediate annual growth in total premiums (10 percent).

However, given our very rough approximation of ACL risk-based capital (which accelerates with faster premium growth), allocating 3 percent of premiums to community benefit might cause observed prices to rise, if medical benefits and, therefore, total premiums rise very fast—in our simulation, 15 percent per year throughout the simulation period. While this high rate of systematic growth is unlikely, observation of its mechanical impact on GHMSI’s need for surplus merely lends support a more obvious point: any rule for allocating a percentage of premiums must be managed with flexibility. Nevertheless, it seems clear that GHMSI could allocate substantially more than it now does to community benefit, and a range of 2 to 3 percent of total premiums per year appears to be a feasible goal for this expenditure.

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APPENDIX A

QUALITATIVE METHODOLOGY

To learn more about the health care needs of the Washington, DC metropolitan area, we solicited input from directors and other leaders of local agencies, organizations, providers, and advocacy groups in the District of Columbia, northern Virginia (Alexandria and Arlington and Fairfax counties) and Maryland (Montgomery and Prince George's counties). We sought to collect information on current health conditions, access issues and health care quality, and related current initiatives and to obtain insights into priorities and potential new strategies.

We collected the information in three ways: a written survey e-mailed to selected area health leaders, a group meeting, and telephone and in-person interviews. The survey consisted of a letter to describe the project, followed by approximately 33 open-ended questions. The questions were organized into four categories: (1) health conditions and behaviors, (2) health care services, (3) quality of care and health insurance coverage, and (4) health care planning.

We distributed the survey twice, first in May 2004 and then in a follow-up in June 2004 to nonrespondents. We received five written responses from 43 individuals to whom we sent the survey, typically via email. We then invited the original sample of health leaders to a breakfast meeting to obtain responses in a semi-structured format. Eight attended that meeting, some of whom had previously completed the survey. To ensure sufficient representation from the District of Columbia, Virginia, and Maryland, we completed nine additional telephone and in-person interviews with area leaders who had not yet responded to the survey or attended the breakfast meeting. In all, we received survey responses or directly interviewed fourteen community leaders. We organized and analyzed the written survey responses, combined with extensive notes from the group meeting and individual interviews, for this summary report.

APPENDIX B

CALCULATION OF DISABILITY-ADJUSTED LIFE-YEARS

Washington, DC area estimates of disability-adjusted life-years (DALYs) were derived from national estimates, adapted to the District of Columbia Metropolitan Statistical Area (MSA) based on information from several sources. Metropolitan-area prevalence estimates for various conditions were obtained from the web sites and publications of Centers for Disease Control (the Behavioral Risk Factor Surveillance System, National Vital Statistics System, Centers for Disease Control HIV/AIDS Surveillance Report) and the Substance Abuse and Mental Health Services Administration (the National Household Survey on Drug Abuse). For some conditions, prevalence estimates for the national capital area were unavailable, and we tabulated the 2002 National Health Interview Survey to obtain national MSA estimates.

National DALY estimates were derived from a collaborative study of the Centers for Disease Control and the Harvard School of Public Health (see Table B-1). We adjusted U.S. average prevalence rates to DC metropolitan area rates to calculate Washington, DC MSA DALYs.

TABLE B.1
ESTIMATED DISABILITY ADJUSTED LIFE YEARS FOR U.S. POPULATION

Rank	Men			Women		
	Condition	DALYs	Percent of Total	Condition	DALYs	Percent of Total
	All conditions	18,314,401	100	All conditions	15,886,327	100
1	Ischemic heart disease	1,969,256	10.8	Ischemic heart disease	1,181,298	6.5
2	Road traffic conditions	933,953	5.1	Unipolar major depression	1,073,911	5.9
3	Lung, trachea, and bronchus cancers	812,675	4.4	Cerebrovascular disease	836,345	4.6
4	HIV/AIDS	773,640	4.2	Lung, trachea, and bronchus cancers	549,963	3.0
5	Alcohol abuse and dependence	736,572	4.0	Osteoarthritis	521,443	2.8
6	Cerebrovascular disease	673,877	3.7	Breast cancer	514,729	2.8
7	Homicide and violence	567,322	3.1	Chronic obstructive pulmonary disease	510,084	2.8
8	Chronic obstructive pulmonary disease	545,350	3.0	Dementia	506,858	2.8
9	Self-inflicted	541,640	3.0	Diabetes mellitus	500,932	2.7
10	Unipolar major depression	477,040	2.6	Road traffic conditions	459,489	2.5
11	Drug use	467,127	2.6	Alcohol abuse and dependence	414,792	2.3
12	Diabetes mellitus	459,247	2.5	Congenital abnormalities	351,553	1.9
13	Osteoarthritis	413,818	2.3	Asthma	270,559	1.5
14	Congenital abnormalities	410,390	2.2	Colon or rectum cancer	234,460	1.3

Source: Michaud, CM, CJL Murray, and CR Bloom, "Burden of Disease—Implications for Future Research," JAMA (285:5), February 7, 2001.

APPENDIX C

INSURERS INCLUDED IN ANALYSIS OF MARKET POWER

District of Columbia	Suburban Maryland	Northern Virginia
Aetna Health Inc MD Corp	Aetna Health Inc MD Corp for	Aetna Health Inc MD Corp
Aetna Life Ins Co for DC	Maryland	Aetna Life Insurance Co
American Natl Ins Co	Aetna Life Ins Co for Maryland	CareFirst BlueChoice Inc
CareFirst BlueChoice Inc	CareFirst BlueChoice Inc for	Cigna Healthcare MidAtlantic
Cigna Healthcare MidAtlantic Inc	Maryland	Inc
Connecticut General Life Ins Co	Carefirst of MD Inc	Group Hospitalization & Med
Corporate Health Ins Co	Cigna Healthcare MidAtlantic Inc	Srvcs
Coventry Health & Life Ins Co	for Maryland	Guardian Life Insurance Co of
Delaware American Life Ins Co	Connecticut General Life Ins Co	America
Fortis Benefits Ins Co	for Maryland	HealthKeepers, Inc.
Fortis Ins Co	Coventry Health Care Of DE Inc	Kaiser Fndtn Health Plan Mid
GE Grp Life Assur Co	Fidelity Ins Co	Atl
George Washington Univ Health	FreeState Health Plan Inc	Mutual of Omaha Insurance
Plan	Group Hospitalization & Med	Co
Golden Rule Ins Co	Srvcs for Maryland	OneNation Insurance
Graphic Arts Benefit Corp	Guardian Life Ins Co Of Amer	Company
Great West Life & Annuity Ins Co	for Maryland	Optimum Choice Inc
Group Hospitalization & Med	Kaiser Fndtn Health Plan Mid Atl	Peninsula Health Care, Inc.
Srvcs	for Maryland	Priority Health Care, Inc.
Guardian Life Ins Co Of Amer	Mamsi Life And Health Ins Co	Southern Health Services, Inc.
Healthy Alliance Life Ins Co	for Maryland	Unicare Health Plan of Virginia
Humana Ins Co	MD Individual Practice Assn Inc	UNICARE Life & Health
John Alden Life Ins Co	Optimum Choice Inc for	Insurance Co
Kaiser Fndtn Health Plan Mid Atl	Maryland	United Healthcare Ins Co
Mamsi Life And Health Ins Co	PHN Hmo Inc	United Healthcare Mid Atlantic
MD Individual Practice Assn Inc	Unicare Life & Health Ins Co for	Inc
Mega Life & Health Ins Co The	Maryland	
Mid West Natl Life Ins Co Of TN	United Healthcare Ins Co for	
Mutual Of Omaha Ins Co	Maryland	
New York Life Ins Co		
Nippon Life Ins Co Of Amer		
Optimum Choice Inc		
Pacific Life & Annuity Co		
Pacificare Life & Health Ins Co		
Pan American Life Ins Co		
Principal Life Ins Co		
Prudential Ins Co Of Amer		
Transamerica Life Ins Co		
Trustmark Ins Co		
Unicare Life & Health Ins Co		
United Healthcare Ins Co		
United Healthcare Mid Atlantic Inc		
United States Life Ins Co In NYC		

APPENDIX D

THE EFFECTS OF SELECTED INSURER CHARACTERISTICS ON ECONOMIC PRICES: MODEL SPECIFICATION

The model was estimated using the following general linear specification:

$$P_{its} = a_{it} + b_1 \text{SIZE}_{its} + b_2 \text{SHARE}_{its} + b_3 \text{FEHBP}_{its} + b_4 \text{IND}_{its} + b_5 \text{RBC}_{its} + b_6 \text{ADM}_{it} \\ + b_7 \text{PROFIT}_{its} + b_8 \text{STATE}_{it} + b_9 \text{YEAR}_{it} + e_{its},$$

with observations specific to the insurer (i), year (t) and state (s) (n=233). The model was estimated using ordinary least squares with year fixed effects and with a “cluster” adjustment to the standard error to account for the observation of the same insurers in more than one year.

The variables were defined as follows (with the sign of the coefficient and levels of significance after cluster adjustment):

P = the insurer’s economic price, defined as total earned premium minus medical losses incurred (dependent)

SIZE = Insurer size, measured as total premiums earned in the District, Maryland, and Virginia, respectively (positive, significant at 0.99)

SHARE = Market share, a categorical variable equal to one for insurers estimated to hold less than 10 percent of the market, and zero otherwise. This measure is an indicator of very small insurer’s propensity to shadow price larger insurers in the market (positive, significant at 0.98)

FEHBP = The insurer’s earned premiums for FEHBP as percent of the sum of FEHBP, non-FEHBP group, and nongroup earned premiums statewide (negative, significant at 0.99)

INDIV = The insurer’s earned premiums for individual coverage as a percent of its total earned premiums in the state (not significant)

RBC = The insurer’s lagged RBC ratio, calculated as the previous year’s TAC as a percent of ACL risk-based capital. This measure, representing the insurer’s financial condition in the prior year, varies by company and year, but is the same across states (not significant)

ADMIN = Administrative cost, calculated as the insurer’s company-wide administrative expenses as a percent of total premiums earned. This measure also varies by company and year, but is the same across states (positive, significant at 0.99)

PROFIT = A categorical variable that equals one if the insurer is for-profit and zero otherwise, and represents the company’s tax status (positive, significant at 0.99)

STATE = A categorical variable controlling for state-specific effects (Maryland= control; VA=positive, significant at 0.99; DC=not significant).

YEAR = A categorical variable controlling for year-specific effects (1998 and 1999 = control).

This specification explained 78.6% of variation (adjusted r^2). Further detail about these results is available upon request.

APPENDIX E

SIMULATED GHMSI SURPLUS AND EXPENDITURE FOR COMMUNITY BENEFIT

TABLE E.1. SIMULATED GHMSI SURPLUS WITH 2 PERCENT OF PREMIUM FOR COMMUNITY
BENEFIT: ALTERNATIVE PREMIUM GROWTH ASSUMPTIONS, 2004-2008
(\$millions)

	Premiums earned	Surplus build-up	Surplus buildup minus % of premium for community benefit	Net total adjusted capital (TAC)	Authorized control level (ACL) risk- based capital	TAC/ACL	Expenditure for community benefit
Low total premium growth (8 percent)							
2004p	\$2,042.5	\$67.4	\$26.6	\$418.6	\$54.0	775%	\$40.8
2005p	\$2,205.9	\$68.9	\$24.7	\$443.3	\$58.3	760%	\$44.1
2006p	\$2,382.4	\$69.4	\$21.7	\$465.1	\$63.0	739%	\$47.6
2007p	\$2,572.9	\$70.3	\$18.8	\$483.9	\$68.0	711%	\$51.5
2008p	\$2,778.8	\$71.7	\$16.2	\$500.0	\$73.4	681%	\$55.6
Intermediate total premium growth (10 percent)							
2004p	\$2,118.1	\$69.9	\$27.6	\$419.6	\$56.1	748%	\$42.4
2005p	\$2,372.3	\$74.1	\$26.6	\$446.2	\$62.8	710%	\$47.4
2006p	\$2,657.0	\$77.4	\$24.2	\$470.4	\$70.4	669%	\$53.1
2007p	\$2,975.8	\$81.3	\$21.8	\$492.2	\$78.8	625%	\$59.5
2008p	\$3,332.9	\$86.0	\$19.4	\$511.5	\$88.3	580%	\$66.7
High total premium growth (15 percent)							
2004p	\$2,174.9	\$71.8	\$28.3	\$420.3	\$57.7	728%	\$43.5
2005p	\$2,501.1	\$78.1	\$28.1	\$448.4	\$66.4	676%	\$50.0
2006p	\$2,876.3	\$83.7	\$26.2	\$474.6	\$76.3	622%	\$57.5
2007p	\$3,307.7	\$90.3	\$24.2	\$498.8	\$87.8	568%	\$66.2
2008p	\$3,803.9	\$98.2	\$22.1	\$520.9	\$100.9	516%	\$76.1

Note: ACL is projected based on the 2003 ratio of ACL to total earned premium. Projections based on low, intermediate, and high premium growth assume that the 2003 ACL/premium ratio is incremented per year by 0.1 percent, 0.15 percent, and 0.2percent respectively.

TABLE E.2. SIMULATED GHMSI SURPLUS WITH 2.5 PERCENT OF PREMIUM FOR COMMUNITY
BENEFIT: ALTERNATIVE PREMIUM GROWTH ASSUMPTIONS, 2004-2008
(\$millions)

	Premiums earned	Surplus build-up	Surplus buildup minus % of premium for community benefit	Net total adjusted capital (TAC)	Authorized control level (ACL) risk- based capital	TAC/ACL	Expenditure for community benefit
Low total premium growth (8 percent)							
2004p	\$2,042.5	\$67.4	\$16.4	\$408.4	\$54.0	756%	\$51.1
2005p	\$2,205.9	\$68.9	\$13.7	\$422.1	\$58.3	724%	\$55.1
2006p	\$2,382.4	\$69.4	\$9.8	\$431.9	\$63.0	686%	\$59.6
2007p	\$2,572.9	\$70.3	\$6.0	\$437.9	\$68.0	644%	\$64.3
2008p	\$2,778.8	\$71.7	\$2.3	\$440.1	\$73.4	599%	\$69.5
Intermediate total premium growth (10 percent)							
2004p	\$2,118.1	\$69.9	\$17.0	\$409.0	\$56.1	729%	\$53.0
2005p	\$2,372.3	\$74.1	\$14.7	\$423.7	\$62.8	674%	\$59.3
2006p	\$2,657.0	\$77.4	\$10.9	\$434.7	\$70.4	618%	\$66.4
2007p	\$2,975.8	\$81.3	\$6.9	\$441.6	\$78.8	560%	\$74.4
2008p	\$3,332.9	\$86.0	\$2.7	\$444.3	\$88.3	503%	\$83.3
High total premium growth (15 percent)							
2004p	\$2,174.9	\$71.8	\$17.4	\$409.4	\$57.7	710%	\$54.4
2005p	\$2,501.1	\$78.1	\$15.5	\$425.0	\$66.4	640%	\$62.5
2006p	\$2,876.3	\$83.7	\$11.8	\$436.8	\$76.3	572%	\$71.9
2007p	\$3,307.7	\$90.3	\$7.7	\$444.5	\$87.8	506%	\$82.7
2008p	\$3,803.9	\$98.2	\$3.1	\$447.6	\$100.9	443%	\$95.1

Note: ACL is projected based on the 2003 ratio of ACL to total earned premium. Projections based on low, intermediate, and high premium growth assume that the 2003 ACL/premium ratio is incremented per year by 0.1 percent, 0.15 percent, and 0.2percent respectively.

TABLE E.3. SIMULATED GHMSI SURPLUS WITH 3 PERCENT OF PREMIUM FOR COMMUNITY
BENEFIT: ALTERNATIVE PREMIUM GROWTH ASSUMPTIONS, 2004-2008
(\$millions)

	Premiums earned	Surplus build-up	Surplus buildup minus % of premium for community benefit	Net total adjusted capital (TAC)	Authorized control level (ACL) risk- based capital	TAC/ACL	Expenditure for community benefit
Low total premium growth (8 percent)							
2004p	\$2,042.5	\$67.4	\$6.2	\$398.2	\$54.0	738%	\$61.3
2005p	\$2,205.9	\$68.9	\$2.7	\$400.9	\$58.3	687%	\$66.2
2006p	\$2,382.4	\$69.4	(\$2.1)	\$398.7	\$63.0	633%	\$71.5
2007p	\$2,572.9	\$70.3	(\$6.9)	\$391.8	\$68.0	576%	\$77.2
2008p	\$2,778.8	\$71.7	(\$11.6)	\$380.2	\$73.4	518%	\$83.4
Intermediate total premium growth (10 percent)							
2004p	\$2,118.1	\$69.9	\$6.4	\$398.4	\$56.1	710%	\$63.5
2005p	\$2,372.3	\$74.1	\$2.9	\$401.3	\$62.8	639%	\$71.2
2006p	\$2,657.0	\$77.4	(\$2.4)	\$398.9	\$70.4	567%	\$79.7
2007p	\$2,975.8	\$81.3	(\$8.0)	\$390.9	\$78.8	496%	\$89.3
2008p	\$3,332.9	\$86.0	(\$14.0)	\$377.0	\$88.3	427%	\$100.0
High total premium growth (15 percent)							
2004p	\$2,174.9	\$71.8	\$6.6	\$398.6	\$57.7	691%	\$65.2
2005p	\$2,501.1	\$78.1	\$3.0	\$401.6	\$66.4	605%	\$75.0
2006p	\$2,876.3	\$83.7	(\$2.5)	\$399.1	\$76.3	523%	\$86.3
2007p	\$3,307.7	\$90.3	(\$8.9)	\$390.2	\$87.8	445%	\$99.2
2008p	\$3,803.9	\$98.2	(\$15.9)	\$374.3	\$100.9	371%	\$114.1

Note: ACL is projected based on the 2003 ratio of ACL to total earned premium. Projections based on low, intermediate, and high premium growth assume that the 2003 ACL/premium ratio is incremented per year by 0.1 percent, 0.15 percent, and 0.2percent respectively.



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