SUPERIOR COURT FOR THE DISTRICT OF COLUMBIA
Civil Division

DISTRICT OF COLUMBIA, Department of Insurance, Securities and Banking, Petitioner, v. D. C. CHARTERED HEALTH PLAN, INC., Respondent.	Civil Action No.: 2012 CA 008227 2 Judge: Wright Calendar No.: 15 Next Event: None

THE SPECIAL DEPUTY TO THE REHABILITATOR'S MOTION FOR LEAVE TO FILE A SUR-REPLY

The District of Columbia and William P. White, Commissioner of the District of Columbia Department of Insurance, Securities and Banking ("DISB"), by and through their attorneys, the Office of the Attorney General of the District of Columbia, with Daniel L. Watkins, as Special Deputy to the Rehabilitator, seek leave to file a sur-reply to the Reply to the Petitioner's Opposition to *Party-in-Interest D.C. Healthcare System, Inc.'s Motion for (1) A Stay Pending Appeal of the Order Approving the Asset Purchase Agreement, Plan of Reorganization and Related Matters; and (2) Injunctive Relief.* The Party-in-Interest raises several new matters in its Reply which the Petitioner, through the Special Deputy, should have an opportunity to address. The sur-reply is attached as Exhibit A.

Consent for this motion is not necessary as the only party is the Petitioner as the Respondent is in Rehabilitation. The Party-in-Interest has expressed its opinion about this motion in a Praecipe filed March 22, 2013.

Respectfully submitted,

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Attorney General for the
District of Columbia

ELLEN A. EFROS
Deputy Attorney General
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CERTIFICATE OF SERVICE

I hereby certify that on this 28th day of March, 2013, a copy of the foregoing was filed and served by email upon:

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SUPERIOR COURT FOR THE DISTRICT OF COLUMBIA
Civil Division

DISTRICT OF COLUMBIA, Department of Insurance, Securities and Banking, Petitioner, v. D. C. CHARTERED HEALTH PLAN, INC., Respondent.	Civil Action No.: 2012 CA 008227 2 Judge: Wright Calendar No.: 15 Next Event: None

ORDER GRANTING
THE SPECIAL DEPUTY TO THE REHABILITATOR'S MOTION FOR LEAVE TO FILE A SUR-REPLY

Upon consideration of the Special Deputy to the Rehabilitator's Motion for Leave to File a Sur-reply, any opposition thereto, and the entire record herein, it is the _____ day of _____, 2013,

ORDERED: That the Motion for Leave to File a Sur-reply is granted; and it is

FURTHER ORDERED: That the Sur-reply is deemed filed as of this date.

_____
Melvin R. Wright
Judge, D.C. Superior Court

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SUPERIOR COURT FOR THE DISTRICT OF COLUMBIA
Civil Division

DISTRICT OF COLUMBIA, Department of Insurance, Securities and Banking, Petitioner, v. D.C. CHARTERED HEALTH PLAN, INC., Respondent.	Civil Action No.: 2012 CA 008227 2 Judge: Melvin R. Wright Calendar: 15 Next Event: None Scheduled

THE SPECIAL DEPUTY TO THE REHABILITATOR'S VERIFIED SUR-REPLY IN RESPONSE TO THE NEW MATTERS RAISED IN THE PARTY-IN-INTEREST D.C. HEALTHCARE SYSTEM, INC.'S REPLY

Preliminary Statement

The District of Columbia and William P. White, Commissioner of the District of Columbia Department of Insurance, Securities and Banking ("Rehabilitator"), by and through their attorneys, the Office of the Attorney General of the District of Columbia, with Daniel L. Watkins, as Special Deputy to the Rehabilitator for D.C. Chartered Health Plan, Inc. ("Chartered"), file this Sur-reply to D.C. Healthcare Systems, Inc.'s ("DCHSI") Reply ("Reply") to the Petitioner's Opposition to DCHSI's Motion ("Motion") for (1) A Stay Pending Appeal of the Order Approving The Asset Purchase Agreement, Plan of Reorganization and Related Matters; and (2) Injunctive Relief. DCHSI's Reply includes new facts and arguments, including

an affidavit from a putative expert, Gregory Serio ("Serio"). This Sur-reply, verified by the Rehabilitator's Special Deputy,[1] will explain that:

- Chartered is neither profitable nor recovering;
- Chartered's problems are not just financial – its owner is under both regulatory and federal scrutiny;
- the Rehabilitator has at all times acted within his statutory authority;
- the Court should disregard the Serio Affidavit as inaccurate and unnecessary; and
- DCHSI is not entitled to a stay.

Notably, DCHSI's Reply failed to fully respond to the arguments in Petitioner's Opposition detailing why DCHSI is not entitled to a stay. Petitioner's Opposition at 15-29.

The Petitioner also wishes to inform the Court that the Department of Health Care Finance ("DHCF") announced on March 27, 2013, that the Office of Contracting and Procurement ("OCP") will submit packages this week to the Council of the District of Columbia with a notice of intent to award the District's three managed care contracts to AmeriHealth, Medstar Family Choice, and Thrive Health Plan, Inc. To allow time for a proper transition of the new health plans, the Centers for Medicare and Medicaid Services ("CMS") has requested that DHCF pursue an extension of the contracts for the current health plans. Accordingly, DHCF intends to submit a request for a 60-day extension to the Council for the period of May 1, 2013 to June 30, 2013 and the new five-year contract will begin July 1, 2013. *See* DHCF Press Release dated March 27, 2013, attached as Exhibit 1. The Court-approved Asset Purchase Agreement with AmeriHealth must be closed well in advance of the new contract effective date, to allow

[1] As with his Verified Memorandum of Points and Authorities in Opposition to DCHSI's Motion filed on March 14, 2013 ("Special Deputy's Verified Memo"), the Special Deputy is numbering the paragraphs of this Sur-reply to facilitate his verifying those that present facts.

time for a smooth transition for Chartered's operations, enrollees, employees and providers. *See* Special Deputy Rehabilitator's Second Status Report filed February 22, 2012 ("Second Status Report") at 1, 7.

WHEREFORE, the Petitioner requests that the Court accept and consider this Sur-reply and deny the Party-In-Interest's Motion for a Stay and Injunctive Relief.[2]

Statement of Facts Opposing Reply's New Facts

Chartered is not profitable and is not recovering.

1. Chartered is not currently profitable; nor is it recovering from the troubles that forced the company into rehabilitation. Chartered's unaudited 2011 financial statements, filed on April 13, 2012, required the Department of Insurance, Securities and Banking ("DISB") to take action under D.C. Official Code § 31-3851.06. DISB exercised its discretion to give Chartered a chance to solve its capitalization issues. *See* D.C. Official Code § 31-3851.06(c). In response, Chartered submitted a Risk Based Capital ("RBC") Corrective Action plan by which Chartered and DCHSI proposed to correct Chartered's RBC deficiency by:

- negotiating a $10 million surplus note (akin to a subordinated debt instrument) "prior to June 29th, 2012";
- completing the "process of [DCHSI's contributing]" the "Company's home office building" to Chartered "[p]rior to July 28th, 2012"; and
- completing the proposed "acquisition of the company or as an alternative the transfer of its insurance operations to another District of Columbia HMO."

In conjunction with the RBC plans, Chartered made representations suggesting that the last goal – the proposed acquisition of the company or transfer of its insurance operations to another

[2] A separate motion seeking leave to file this Sur-reply is being filed simultaneously. DCHSI, however, failed to seek leave to file its Reply, in violation of both the Superior Court Rules and this Court's Standing Order. The Court therefore has additional grounds to disregard the facts and arguments set forth in the Reply.

HMO – would be achieved prior to the October 15, 2012 due date for its second quarter financial filings. *See* D.C. Chartered Health Plan, Inc., Corrective Action Plan filed with DISB on May 5, 2012, at 2 *and* June 29, 2012, Letter from Chartered to DISB at 2, 4, attached as Exhibits 2 and 3. *See also* D.C. Chartered Health Plan, Inc., 2011 RBC Corrective Action Plan filed with DISB on May 25, 2012, attached as Exhibit 4.[3] Chartered and DCHSI were unable to achieve *any* of the RBC Plans' substantive goals during the *six* months after Chartered fell below the Mandatory Control Level. Now, however, DCHSI criticizes the Rehabilitator for not being able to achieve in approximately six weeks what DCHSI itself was unable to achieve in six months.

2. Chartered's September 30, 2012, financial statement shows that, without the $12 million retrospective premium receivable that the DHCF contests and, in any event, is unavailable to pay claims, Chartered experienced a loss of $11 million through the first nine (9) months of 2012. Special Deputy's Verified Memo at 15.

3. Chartered's downward trend continues. Its year-end financial statements will show that Chartered experienced approximately $15 million in losses in the 4th quarter of 2012, averaging about $5 million per month, primarily due to (a) processing and paying a significant backlog of claims that pre-date the rehabilitation, and (b) higher than anticipated provider claims due to flu, asthma and respiratory infections.

4. Finally, Chartered (a) projects incurred but not reported (IBNR) claims at approximately $45 to $50 million as of December 31, 2012; (b) is using Medicaid contract payments to meet current obligations and will not have liquid assets to pay the IBNR claims when the contract ends; (c) owes premium tax to the District of approximately $5 million; and (d) will continue to incur administrative costs of rehabilitation, including the attorneys' fees

[3] Although RBC plans generally are considered confidential and privileged, and are marked as such, D.C. law allows the Commissioner to use them "in furtherance of any regulatory or legal action brought as a part of the Commissioner's official duties." D.C. Official Code §31-3851.08(a).

necessary to pursue the retrospective premium claims. As such, Chartered needs to recover most, if not all, of the $60 million claim with DHCF just to cover its liabilities.

Chartered's problems are not just financial: its owner Jeffrey Thompson is under regulatory and federal scrutiny.

5. Jeffrey Thompson's legal problems and questionable related-party transactions contributed to Chartered's downfall and then impaired the Rehabilitator's chances of finding a buyer for Chartered.

6. As has been widely reported, "Thompson and his intersecting political and business interests have been under a microscope since March 2, [2012] when federal agents raided his home and offices. His name was later featured on subpoenas delivered to the campaigns of several D.C. Council members." The Washington Post, "Jeffrey Thompson steps down from Chartered Health Plan" (April 16, 2012) (Mike DeBonis).[4]

7. Thompson's resignation as Chartered's chairman on April 6, 2012, did not insulate the company from Thompson's ongoing problems. *See* Letter from Chartered to DISB dated April 12, 2012, attached as Exhibit 5. A few days after Thompson resigned,

> Wayne Turnage, director of the District's Department of Health Care Finance, told a D.C. Council committee that as long as D.C. Chartered Health Plan remains in Thompson's hands, it should not expect to continue managing the health care of low-income city residents after its contract expires in May 2013. "If a sale does not happen, it is unlikely we would allow Chartered to keep its current contract for a number of reasons," Turnage said. He would not elaborate on the reasons, though the panel's chairman, David A. Catania (I-At Large), referred to "a certain cloud" being over the company.

The Washington Post, "If Thompson doesn't sell Chartered, it will likely lose D.C. health-care contract" (April 19, 2012) (Mike DeBonis).

[4] These newspaper articles are cited only to indicate information available to potential or prospective buyers or investors.

8. Rather than challenge Director Turnage's stated position, as DCHSI and Thompson now contend the Rehabilitator should have done, DCHSI and Thompson tried unsuccessfully to sell the company. *See* Exhibit 3.

9. Chartered's situation worsened when, on September 27, 2012, its new outside auditor[5] informed DISB that (a) it had found unsupported, questionable related-party transactions, and (b) Chartered's previously reported capital and surplus had been overstated by at least $3 million dollars. *See* Special Deputy's Verified Memo at 3.

10. Based on the new auditor's findings, Director Turnage informed Chartered's board of directors that, unless the company consented to a rehabilitation order, he would end the District's relationship with Chartered and move its enrollees to other Medicaid contractors. *See* Washington Business Journal, "D.C. to seize assets, control of Chartered Health Plan" (October 19, 2012) (Ben Fischer); *see also* DCHSI Motion, Exhibit 4 at 2-3.

11. While Chartered consented to rehabilitation, DCHSI and Thompson have yet to explain, or to reimburse Chartered for, the questionable related-party transactions that the new auditor identified in September 2012. Special Deputy's Verified Memo at 4. Adverse publicity and speculation regarding the related-party transactions and the investigation of Thompson effectively prevented both Thompson and the Rehabilitator from selling Chartered or finding interested investors.

Argument

The Rehabilitator has at all times acted within his statutory authority.

12. DCHSI incorrectly asserts that the Rehabilitator is effecting a liquidation of Chartered. This is a rehabilitation, not a liquidation. *See generally* Receiver's Handbook for

[5] Chartered's prior outside auditor resigned without explanation shortly after federal investigators raided Thompson's home and office.

Insurance Company Insolvencies at 448 (National Association of Insurance Commissioners, 2009) (describing how the model acts that have been adopted in most U.S. jurisdictions, including the District, do not require that a rehabilitation plan provide that the insurer emerge from rehabilitation as a going concern). Here, the Plan of Reorganization effects a legitimate rehabilitation by revitalizing and transferring Chartered's Medicaid business, notwithstanding the fact that it contemplates a winding down of Chartered's remaining operations. Rehabilitation plans typically revitalize and preserve a troubled company's business by transferring the company's business and assets to a new entity. *See* Couch on Insurance (3rd ed.) §§ 5:24 & 5:27 and authorities cited in Special Deputy's Verified Memo at 17-18. Dissenters who, like DCHSI and Thompson, focus on what will happen to the troubled company "have no legal cause for complaint simply because the commissioner determines to rehabilitate rather than liquidate." *See* Couch on Insurance (3rd ed.) § 5:29. *See also* In re American Investors Assurance Company, 521 P.2d 560, 561-62 (Utah 1974) (cited in Special Deputy's Verified Memo at 17-18), which relied on the landmark rehabilitation case, Carpenter v. Pacific Mutual Life Insurance Company of California, 74 P.2d 761 (Cal. 1937), aff'd, Neblett v. Carpenter, 59 S. Ct. 170, reh. denied, 59 S. Ct. 355 (U.S. 1938).

13. Contrary to DCHSI's contention, the Rehabilitator has vigorously pursued Chartered's claims against DHCF. At the outset of the rehabilitation, the Special Deputy met with outside counsel to understand and evaluate the claims. He retained a consulting actuary to help prosecute them—something that Chartered and its owner had not done themselves. He submitted revised claims to DHCF, seeking a greater recovery than Chartered had sought prior to rehabilitation. He met numerous times with Director Turnage to discuss the claims and their possible resolution. He informed CMS about the claims, as CMS is the federal agency that funds

70% of the District's Medicaid program and presumably would be asked to fund any resolution of the claims. He briefed the D.C. Council regarding the claims and their impact on Chartered and providers.

14. DCHSI faults the Rehabilitator for not seeking Court approval before deciding that Chartered would forgo submitting a bid. That assertion shows DCHSI still misunderstands how rehabilitations work. A rehabilitator charged with responsibility for managing and trying to restore a troubled company's business must make all manner of decisions—from routine to strategic. Of necessity, he has discretion to act according to his best judgment without having to bring every decision to the Court for pre-approval. Otherwise a rehabilitator and the company that he seeks to revive would be paralyzed. For Chartered to have bid on a new Medicaid contract on December 3, 2012 would have been pointless, given Chartered's legal and financial problems. Instead, the Rehabilitator chose the best alternative available under the circumstances, and proceeded to negotiate the asset purchase agreement with AmeriHealth, subject to Court approval.

15. As an officer of the Court entrusted with authority to manage a troubled company under extremely difficult circumstances, the Rehabilitator, in consultation with his advisors, exercised the best judgment that he could and kept the Court apprised and involved as effectively as those circumstances reasonably permitted, all in keeping with his statutory duties. The Rehabilitator's actions and plan for Chartered are consistent with established rehabilitation law, did not require him to file a petition for liquidation, and will produce the best possible outcome for Chartered's constituents and the District. *See* Special Deputy's Verified Memo at 17-18.

The Court should disregard the Serio Affidavit as inaccurate and unnecessary.

16. In its Reply, DCHSI attached the Serio Affidavit to add expert opinions for the first time.[6] The Rehabilitator submits that expert testimony is neither necessary nor helpful in this context, and that the testimony in the Serio Affidavit is, in fact, incorrect.

(a) The Serio Affidavit has misstated the impact of the $60 million allegedly owed Chartered by DHCF.

(b) It fails to consider the negative effect of the federal investigation of Thompson as Chartered's former chairman and as DCHSI's sole shareholder.

(c) The conclusion that AmeriHealth paid $5 million for Chartered's assistance in preparing an RFP response and nothing for Chartered's assets is at best uninformed. *See* DCHSI Reply, Exhibit 1 at 12. AmeriHealth is self-evidently skilled and experienced at preparing RFP responses and being awarded Medicaid contracts. AmeriHealth is paying $5 million for the acquired assets, including among other things Chartered's name, other intellectual property, existing Medicaid contract and provider agreements. *See* Second Status Report at 5. The Letter Agreement entered into on November 30, 2012 was to protect Chartered against the possibility that AmeriHealth might be awarded a Medicaid contract but not close on the Asset Purchase Agreement.

Indeed, it appears that the Serio Affidavit fails to consider many, if not all, of the facts described above and in paragraphs 1 through 11. For these reasons alone, the Court should disregard the Serio Affidavit.

17. Rather than examine all the facts presented above, the Serio Affidavit attacks the actions of the Rehabilitator and intimates that there are conflicts of interest. The Serio Affidavit

[6] If the Court deems expert assistance necessary, the Special Deputy is himself an expert in insurance rehabilitations. For the Court's information, the CV of Special Deputy Dan Watkins is attached hereto as Exhibit 6.

asserts that the Rehabilitator and DHCF acted in concert to weaken Chartered because Chartered is a substantial creditor of the District. *See* DCHSI's Reply, Exhibit 1 at 14. But the purported conflict here may be unavoidable: since Chartered has only one source of income from the District of Columbia, any court-appointed rehabilitator likely would be forced to act against the very jurisdiction that appointed him. Even if the Rehabilitator has a conflict of interest – which the Petitioner does not concede – it would not affect the outcome here and therefore is immaterial. *See, e.g.*, Brown v. Associated Ins. Consultants, 672 So.2d 324, 329 (La. App. 1996) (finding harmless error by trial court when it denied motion, based on alleged conflict of interest created by assertion of claim against one defendant insurer by another entity for which Commissioner was serving as liquidator, for recusal of insurance commissioner and appoint an ad hoc rehabilitator; even assuming the challenged claim would have been successfully contested by another person serving as rehabilitator, defendant insurer would still have been found to be insolvent by millions of dollars). More to the point, if any conflicts exist they lie with the Respondent: Thompson breached his fiduciary duty to Chartered by orchestrating the unexplained related-party transactions and DCHSI put its own interests ahead of Chartered's by failing to pay, since at least 2010, approximately $2.8 million that it owes Chartered under a Tax Allocation Agreement. This argument is simply a continuation of DCHSI's and Thompson's effort to blame Chartered's failure on someone other than themselves.

18. Furthermore, it bears repeating, because DCHSI refuses to acknowledge and the Serio Affidavit failed to consider the point, that the Rehabilitator requested DHCF to extend the existing deadlines for the Medicaid RFP process so that Chartered could have additional time to identify potential investors and provide for a less hurried process for selecting Medicaid

providers for new contracts with the District. *See* Special Deputy's Verified Memo at 8. DHCF declined to extend the deadlines.

19. Moreover, the Court has already addressed any concerns about how the claims against DHCF will be handled. The Rehabilitation Order provides that Chartered's claims against DHCF cannot be settled without this Court's approval. Emergency Consent Order of Rehabilitation at 2. That requirement was included at DCHSI's insistence to ensure that any settlement is fair and reasonable to Chartered.

20. Finally, DHCF prudently decided that the District's largest government contractor – which receives over $360 million in public funds annually – would not be eligible for a new Medicaid contract if it was under Court-ordered rehabilitation or controlled by someone who is under federal investigation. DCHSI and Thompson must have understood DHCF's position, even though Mr. Serio does not; otherwise they would have challenged it before their Reply.

DCHSI is not entitled to a stay.

21. DCHSI cites Dist. of Columbia v. Group Ins. Admin., 633 A.2d 2, 8 (D.C. 1993) ("*GIA*") for the proposition that this Court has authority to order emergency relief forcing the rebidding of a public contract. But DCHSI pays scant attention to the *GIA* court's instruction that "[i]n the field of government procurement the courts must be sedulous to heed the admonition that their authority to vacate and enjoin action that is illegal must be exercised with restraint les[t] the courts fall into the error of supposing that they may revise 'action simply because [they] happen to think it ill-considered, or to represent the less appealing alternative solution available.'" *Id.* at 22 (citations omitted).

22. Additionally, DCHSI ignored the burden that it must carry to obtain such relief. *GIA* reminds us that a party seeking the "extraordinary remedy" of an injunction must "clearly demonstrate":

> (1) that there is a substantial likelihood he [or she] will prevail on the merits; (2) that he [or she] is in danger of suffering irreparable harm during the pendency of the action; (3) that more harm will result to him [or her] from the denial of the injunction than will result to the defendant from its grant; and, in appropriate cases, (4) that the public interest will not be disserved by the issuance of the requested order.

633 A.2d at 21 (citations omitted; bracketed material in original). Applying those factors here, DCHSI cannot show a likelihood of success on the merits—much less a substantial one—because Chartered simply did not qualify to bid on and receive a contract and could not have been brought into compliance for all the reasons the Rehabilitator has discussed here and throughout this proceeding.

23. Before awarding injunctive relief a court must determine that *more* harm will result to the movant from the denial of the injunction than will result to the nonmoving parties from its grant. That was not the case *GIA* and is not the case here. Comparing the possible effects of an injunction on QDP with the harm that GIA might suffer in the absence of an injunction, the trial court in *GIA* found only that "neither party will be harmed appreciably more than the other by the court's decision." *Id.* at 23. However, the trial court should have added into this calculus not only the extra time and effort that would be expended by the District in rebidding the contract, but also the substantial confusion and claim-processing delays that the District's employees would suffer as a result of this process. *Id.* (citing Amalgamated Transit Union v. Donovan, 554 F.Supp. 589, 599 (D.D.C. 1982)(court must consider harm not only to party opposing injunctive relief but also to those parties not before court who may be interested in proceedings). Here, the interested parties who are not before the Court include, of course, Chartered's enrollees, employees, providers and other D.C. residents.

24. DCHSI also argues that a stay is necessary to protect Chartered's employees from the Rehabilitator's "ill-advised gamble," because they "will lose their jobs if AmeriHealth is not

awarded the contract." DCHSI Reply at 5. In light of the DHCF's press release, that argument is moot.

25. In short, DCHSI failed to demonstrate the factors allowing the Court to grant it the extraordinary remedy of a stay.

CONCLUSION

For the reasons stated above, and those contained in the Special Deputy's Verified Memo filed on March 14, 2013, the Rehabilitator respectfully requests that the Court deny DCHSI's Motion.

VERIFICATION

I verify under penalty of perjury that the facts set forth in the Preliminary Statement and numbered paragraphs 1-11, 13, 16(c), 18, 19 and 20.

Daniel L. Watkins, Special Deputy to the Rehabilitator

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on this 28th day of March, 2013, a copy of the foregoing was filed and served by email upon:

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SUPERIOR COURT FOR THE DISTRICT OF COLUMBIA
Civil Division

DISTRICT OF COLUMBIA, Department of Insurance, Securities and Banking, Petitioner, v. D. C. CHARTERED HEALTH PLAN, INC., Respondent.	Civil Action No.: 2012 CA 008227 2 Judge: Wright Calendar No.: 15 Next Event: None

MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT OF THE THE SPECIAL DEPUTY TO THE REHABILITATOR'S MOTION FOR LEAVE TO FILE A SUR-REPLY

The Petitioner seeks leave to file a sur-reply because the Party-In-Interest's Reply[1] introduces additional facts, including, but not limited to, an affidavit from a putative expert, Gregory V. Serio (Serio), and several misstatements or distortions of the factual record that the Petitioner and its Special Deputy has not had an opportunity to address. The Court should grant the Petitioner's motion in order to allow the Rehabilitator to address these new facts and correct the record.

Argument

The decision to grant leave to file a sur-reply is within the discretion of the court and while sur-replies are not favored, they are allowed when a reply is filed "leaving a party … unable to contest matters presented to the court for the first time.'" *Hoskins v Napolitano*, 842 F. Supp. 8 (D.D.C. 2003) (quoting *Ben-Kotel v Howard University*, 319 F.3d 532, 536 (D.C. Cir.

[1] Since the Superior Court Rules and this Court's Standing Order are silent as to replies, a motion for leave to file is required for both replies and sur-replies. The Party-in-Interest failed to seek leave of court to file its reply.

2003); *Alexander v. FBI*, 186 F.R.D. 71, 74 (D.C.C. 1998)). A sur-reply may be necessary whether the new matter asserted is factual or a new legal argument is raised. *See also Franek v. Walmart Stores, Inc.*, 2009 WL 674269, at *19 n. 14 (N.D.Ill. Mar.13, 2009) (recognizing that a sur-reply might be appropriate "when a moving party ' sandbags' an adversary by raising new arguments in a reply brief").

The Party-in-Interest's Reply, in addition to other new facts, attached as Exhibit 1, a 17-page affidavit of Serio, which purports to offer an expert opinion about the actions of the Special Deputy. The incorporation of the Serio affidavit alone should suffice to satisfy the applicable standard for filing a sur-reply.

A limited review of Serio's "List of Reviewed Materials" would indicate that Serio has not been provided all the information necessary to render his opinions. Without the opportunity to respond to these new facts, at a minimum, the Petitioner would be extremely prejudiced. Additionally, the Party-in-Interest asserts that Chartered is financially sound by distorting the financial statements provided in the record. Finally, the Party-in-Interest argues that the Special Deputy is liquidating Chartered rather than rehabilitating it which also distorts the factual and legal record. Responding to these new facts also necessitates a sur-reply to correct the record.

Conclusion

For the reasons stated above, the sur-reply is necessary to address and correct the Reply's errors. The Court should grant the Special Deputy leave to file a sur-reply and deem the attached sur-reply filed.

Respectfully submitted,

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Deputy Attorney General
Public Interest Division

/s/ Stephane J. Latour
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Chief, Civil Enforcement Section

/s/ E. Louise R. Phillips
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Attorney for the D. C. and the Commissioner

EXHIBIT 1

GOVERNMENT OF THE DISTRICT OF COLUMBIA

Department of Health Care Finance

PRESS RELEASE

FOR IMMEDIATE RELEASE: Wednesday, March 27, 2013
CONTACT: Dorinda White, 202.727.9226; dorinda.white@dc.gov

Department of Health Care Finance Announces Intent to Award Three Managed Care Contracts for New Five Year Program

Notice of Intent to be Submitted this Week to District Council for Approval
60-Day Extension Sought For Current Contracts

(WASHINGTON, D.C.) – The Department of Health Care Finance today announced that the Office of Contracting and Procurement (OCP) will submit packages this week to the Council of the District of Columbia with a notice of intent to award the District's three managed care contracts to AmeriHealth Mercy Family of Companies, Medstar Family Choice, and Thrive Health Plan, Inc. Upon approval, the contracts will take effect July 1, 2013 and will include one base year and four option years.

"We began this process with the goal of revamping our managed care program in the shadows of national health care reform recognizing the many challenges and opportunities posed by the new law." said DHCF Director Wayne Turnage. ***"Our primary objective was to populate our managed care program with health plans committed to managing the cost effective delivery of care to Medicaid and Alliance beneficiaries with the overarching of goal of improving patient outcomes. We are very pleased with the outcome of this important procurement and look forward to a collaborative partnership with these health plans."***

AmeriHealth Mercy Family of Companies (AMFC), is a national leader in Medicaid managed care and other health care solutions for the underserved. AMFC operates in 14 states and serves more than 4.7 million Medicaid, Medicare, and CHIP members through its Medicaid managed care products, pharmaceutical benefit management services, behavioral health services and other administrative services.

Medstar Family Choice is a Maryland-based plan that has been ranked number 17 in the nation among Medicaid HMOs by the National Committee for Quality Assurance.

Thrive Health Plan, Inc. is a new entrant into the District's managed care program. Its senior management team has significant experience in and knowledge of the Washington, DC health care delivery system. The Thrive Health Plan cites its strength as a "hands-on approach to coordinating care" and is committed to improving the health outcomes of District residents.

To allow time for a proper transition of the new health plans, the Centers for Medicare and Medicaid Services has requested that DHCF pursue an extension of the contracts for the current health plans. Accordingly, DHCF will submit a request for a 60-day extension to Council for the period of May 1, 2013 to June 30, 2013 and the new five-year contract will begin July 1, 2013.

For more information on the Department of Health Care Finance, please visit www.dhcf.dc.gov.

# # #

EXHIBIT 2

Corrective Action Plan

On April 13 2012, DC Chartered Health Plans, Inc. ("Chartered") filed its 2011 Health Annual Statement and Risk-Based Capital (RBC) Report with the DC Department of Insurance, Securities and Banking (DISB). The Company reported Total Adjusted Capital ("TAC")[1] of $1,441,940. The RBC Authorized Control Level("ACL")[2] for Chartered at year ending 2011 is $13,950,377. Pursuant to DC Code § 31-3851.01 et seq., Chartered's TAC balance is below the Mandatory Control Level RBC ("MCL"), by $8,323,324 which is 70% of the RBC Authorized Control Level or $9,765,264.

The Company's 2011 operating loss of 14,962,584, caused both a significant loss in TAC and a reduction to the Company's RBC Ratio. This is the first time that Chartered's TAC is below its Authorized Control Level since the adoption of the District of Columbia (the "District") "Health Organizations RBC Amendment Act of 2002" which was effective with the 2002 Annual Statement Filing.

DC Chartered Health Plan, Inc										
Risk Based Capital Results										
	12/31/11	12/31/10	12/31/09	12/31/08	12/31/07	12/31/06	12/31/05	12/31/04	12/31/03	12/31/02
Total Adjusted Capital	1,442	17,445	13,760	19,724	21,620	20,277	15,365	11,369	9,257	6,610
Authorized Control Level (ACL) RBC	13,950	10,895	9,053	6,280	5,545	4,378	3,212	2,923	2,572	2,015
RBC Ratio	10.3%	160.1%	152.0%	314.1%	389.9%	463.2%	478.3%	388.9%	359.9%	328.0%

The Company believes that the conditions leading to the 2011 operating loss and the decline in the Company's TAC were events systemic to the Medicaid managed care business in the District. However, it is our belief that the proposed initiatives summarized below, will return Chartered to a positive operating income position in 2012 and subsequent years, and increase the Company's RBC Ratio above any RBC Action Level Event. Chartered has developed a short-term strategy to increase it TAC above the MCL RBC Level and is in the

[1] DC Official Code § 31-3851.01(22) states "Total Adjusted Capital" means the sum of: (A) A health organization's statutory capital and surplus as determined in accordance with the statutory accounting applicable to the annual financial statements required to be filed: and (B) such other items, if any, as the RBC instructions may require.

[2] DC Official Code § 31-3851.01(3) states "Authorized Control Level RBC" means the amount of capital required under the risk-based capital formula in accordance with RBC instructions."

process of developing financial forecasts and assumptions as part of its comprehensive RBC Plan that will show the Company increasing its TAC above the RBC Company Action Level.

Listed below is the Company's strategy for increasing its TAC beyond the MCL over the next 90 days and other initiatives to further enhance the Company's RBC position during 2012. We have also included as an Appendix to this Corrective Action Plan, a Summary of the Pharmacy Benefit Contract Appeal we filed with the District of Columbia.

1) Approved Surplus Note for $10 Million

Chartered is in discussion with two companies about establishing a surplus note in the estimated amount of $10 million. If a Surplus Note is agreed to by the parties and approved by DISB, this, along with the projected increase in surplus from operations through the second quarter, it is anticipated that Chartered's TAC will increase above the $9.8M MCL amount.

Anticipated date of Completion - Prior to June 29th, 2012

2) Surplus Contribution of Building

The Company's home office building located at 1025 15th Street NW is in the process of being contributed to the Company as a surplus contribution by the parent holding company, DCHSI. Based on the accounting guidance in SSAP Nos. 72, 95 and 25 the Building will be contributed based on its fair market value which is currently $10.7M net of a mortgage of approximately $7.0M. This surplus contribution will directly impact the Company's surplus position in the approximate amount of $4.0M which includes certain leasehold improvements that will be capitalized once the transaction is consummated. Along with the issuance of a Surplus Note, positive operating results through the first two quarters, and the contribution of the building, the Company's expects it TAC to be at or above the ACL of approximately $14.0M.

Anticipated date of Completion - Prior to July 28th, 2012

3) Quality Assurance Overpayment Recoveries

As a result of our recent implementation of a new quality assurance overpayment identification process conducted by specialized outside vendor, Chartered has identified approximately $6 million dollars in which provider overpayments have been identified. These overpayments are anticipated to be collected from providers in the second quarter of 2012. In addition it should be noted that the quality assurance overpayment identification process will continue in which we anticipate significant recoveries. Below is a summary schedule that identifies current recovery receivables included in our first quarter 2012
statements.

Vendor/ Contractor	Description	Recovery Receivable
Varis	DRG medical records review audits: based on a review of inpatient medical records to determine the actual procedures performed versus DRG billed and paid.	$ 419,194
Optimity	Hospital claims rate audit: based on a review of rates billed and paid to providers for all services compared to the rates in the providers' contacts.	3,206,733
Optimity	Emergency room claims audit: based on payments made that were % of bill paid that should have been paid as ER visit case rates.	427,343
Optimity	DRG base rate and weight adjustment hospital audits: based on payments which were paid at a higher rate and weight creating an overpayment to providers.	1,107,008
Optimity	Mental Health Audit: based on indivdual provider fee schedules where the mental health benefits manager, Beacon, paid providers incorrect rates.	814,387
		$ 5,974,665
Footnote:	*The recovery receivable represents claim overpayments to providers priot to March 31, 2012, that we have identified as a result of our claims quality assurance review process.*	

Anticipated Surplus Contribution $5,974,665.00
Anticipated date of Completion - Prior to June 30th, 2012

4) Medicaid Contract Rate Adjustment

Chartered signed a Medicaid contract renewal with the District of Columbia government for the period August 1, 2011 through April 30, 2012. This renewal included an increase in the premium capitation rates. Further, the District of Columbia has proposed additional increases in premium capitation rates for the new contract year May 1, 2012 through April 30, 2013.

We are conservatively estimating that the membership for the Medicaid and Alliance lines of business will not have a significant increase for the year 2012 Therefore this increase in revenue reflects the changes in the movement of members between age cells during the remaining eight months of 2012 and the first four months of 2013.

Projected 2012/2013 Premium revenue without rate increase May 1 2012	$376,961,463
Projected 2012/2013 Premium revenue with rate increase May 1 2012	$388,011,137
Increase in revenue attributable to rate increase	$ 11,049,674

Less expected administrative cost for incremental increase (6%)		662,981
Anticipated Increase in revenue		10,386,693
Expected Revenue increase per month	$	865,558
Expected Revenue for 2012 (Eight Months)	$	6,924,462

Anticipated date of Completion - Prior to December 31st, 2012

5) Hospital Cost Savings Initiatives

Hospital costs are projected to decrease during 2012, partly due to the execution of a new contract with Children's National Medical Center (CNMC) signed in September 2011. The principal changes in rates result in a reduction of the cost of services provided Chartered members from 52.4% of billed charges in the prior contract to 46.8% from August 2011 through July 2012, then to 44.6% for the remainder of the three-year contract.

Comparing the claims data for the 8½ months prior to the contract signing to the claims data for the 3½ months after, the CNMC contract is expected to yield net savings in 2012 of $3.6 million. Chartered is also in the process of negotiating contracts with Providence Hospital and George Washington University Hospital. We anticipate these contracts will be executed by June 2012. The estimated hospital cost savings are listed below

Savings via renegotiation of other hospital contracts:

	Estimated Savings in 2012	
Hospital/Initiative	PMPM	Amount
Providence Hospital (contract renegotiation)	$0.63	$ 500,000
Children's Hospital (new contract effective. 9/15/11)	$3.02	$3,588,225
George Washington University Hospital(contract renegotiation)	$2.02	$1,600,000

The projected cost savings from hospital contracts $5,688,225

Chartered contracted with DC Immediate and Primary Care (DCIP), which provides expanded service primary and urgent care hours. DCIP opened in the District of Columbia with one office in a strategic location available to Chartered's members. Additional offices are planned in 2012. Chartered implemented an initiative to inform and encourage member to take advantage of the services offered in lieu of the hospital emergency rooms. In addition, Chartered contracted with Nurse Response, its 24-hour nurse advice line, to contact members who have used the emergency rooms frequently in the recent past (which did not result in an admission); to establish a program with each member to make a nurse available to them 24 hours per day; and, to coordinate the member's emergency needs with their assigned primary care provider. In 2012, it is anticipated that Chartered was able to redirect 57 members who visit the ER more than 11 times in the past year, 395 who visited 6 – 10 times, and 1,792 who visited 3 – 5 times, resulting in a cost avoidance of approximately $2.5 million.

The projected cost savings for contracting with DCIP	$2,500,000
Anticipated Hospital Cost Savings	$8,188,255

Anticipated date of Completion - Prior to December 31st, 2012

6) Increased Savings from Pharmacy Changes -

Chartered implemented a change in its drug formulary to eliminate certain high cost prescription drugs and replace them with the lower cost generic equivalent. This implementation occurred in September 2011 and based upon results provided by Caremark, these measures will yield pharmacy savings.

Anticipated Pharmacy Change Savings	$2,100,000

Anticipated date of Completion - Prior to December 31st, 2012

Corrective Action Plan Summary

Corrective Action Proposals	2012 Savings	Implementation Date
Surplus Notes	$ 10,000,000	6/30/2012
Building Transfer	4,000,000	7/28/2012
Quality Assurance Recoveries	5,974,665	6/30/2012
Contract Rate Modification	6,924,462	12/31/2012
Hospital Cost Savings	8,188,225	12/31/2012
Pharmacy Savings	2,100,000	12/31/2012
Total Projected Savings	$37,187,352,	

Appendix Footnote: Pharmacy Benefit Contract Appeal

Chartered initiated an appeals process with the District of Columbia government regarding certain pharmacy benefits under the Medicaid Contract. Chartered has requested that the District of Columbia review the Contract's pharmacy rates and believes that it is entitled to a rate adjustment for the 2010-2011 Contract year for losses incurred through October 31, 2011 and projected through April 30, 2012. This appeal was filed with the DC Government of Contracts and Appeals Board in April 2012 and since the Company has not received an official response to this Appeal from the District of Columbia government, we included this amount as a footnote in this plan.

To the extent the Company Chartered is able to negotiate a settlement with the District of Columbia government DHCF for this a retrospective rate adjustment, the Company will book a receivable per the guidance in SSAP No. 84 – *Certain Health Care Receivables and Receivables under Government Insured Plans* and SSAP No. 66 – *Retrospectively Rated Contracts*.

Anticipated date of Completion - *December 31st, 2012*

Exhibit 3

Friday, June 29, 2012

Philip Barlow
Associate Commissioner of Insurance
District of Columbia Department of Insurance,
Securities and Banking
Union Center Plaza
810 First Street, N.E., Suite 701
Washington, DC 20002
Philip.barlow@dc.gov

Re: **DISB's Limited Scope Examination and Request for Additional Information**

Dear Mr. Barlow:

This is in response to your letter dated June 25th, 2012, in which the DC Department of Insurance, Securities and Banking ("DISB") requested a status report on the short term strategy to increase the Total Adjusted Capital ("TAC") of DC Chartered Health Plan, Inc. ("Chartered") above the Mandatory Control Level Risk Based Capital balance ("MCL"). Chartered's MCL Balance is $9,765,000, which is 70% of Authorized Control Level Risk Based Capital Balance of $13,950,000. In your letter you cited that Chartered acknowledged it would comply with increasing its TAC above the MCL in its letter of May 5th, 2012. We note that the documentation provided in Chartered's comprehensive RBC Corrective Action Plan submitted on May 29th, 2012 supersedes the Corrective Action Plan documentation provided in our May 5th, 2012 response. The status update, which is included as an integral part of this letter, will focus on the items numerated on page 29 of the RBC Corrective Action Plan dated May 29th.

Prior to providing this status update, Chartered wants to clarify its understanding of the statutory provisions governing this request for additional information. All previous DISB requests for documentation relative to Chartered's RBC balance, focused on the company being in compliance with the provisions of DC Code § 31-3851.04, which includes in § 31-3851.04(a)(2), a provision that grants the Commissioner the authority to perform an examination or analysis of the assets, liabilities, and operations of the health organization, including a review of its RBC Plan. However, the June 25th, 2012 letter cites for the first time DC Code § 31-1403. We were not aware that DISB was performing a limited scope examination of Chartered, pursuant to DC Code § 31-1403, as stated in your letter.

Further, as required by DC Code § 31-1403(a), Chartered has not been made aware of DISB's issuance of an examination warrant which appoints examiners and details the scope of the examination. When previous statutory examinations were conducted, Chartered received such examination warrant prior to the commencement of the examination. Based on this understanding and previous correspondence provided by DISB relative to the RBC issue, we will assume that the reference to DC Code § 31-1403 as statutory guidance for this request was incorrectly cited.

Relative to Chartered's strategies to increase its TAC above MCL, we have been working on implementing these initiatives, but we have experienced delay primarily due to discussions that are being conducted by DC Healthcare Systems, Inc, ("DCHSI") the owner of Chartered, with several investment groups about the possible acquisition of the company or as an alternative the transfer of its insurance operations to another District of Columbia licensed HMO.

The three initiatives in the RBC plan filed May 29th include: 1) Chartered reporting positive net income for the period ending June 30th, 2012; 2) Chartered's parent, DCHSI, is in the process of making a surplus contribution to Chartered of the building located at 1025 15th Street, NW, Washington, DC; and 3) the issuance of a Surplus Note with a face value of $5M to $10M with potential investors and with the prior approval of DISB. A summary of Chartered's status on these issues are as follows:

1) Chartered's 2nd Quarter 2012 Net Income

Based on our preliminary results, Chartered anticipates a 2nd Quarter underwriting gain of $600K, which increases the company's capital and surplus balance ("TAC") to approximately $2.9 million for the year.

2) Chartered parent, DCHSI, surplus contribution of home office building

Pursuant to your request, attached is a copy of the building's market value documentation which is a current offer on the building in the amount of $10.7 million along with the value of leasehold improvements in the amount of $274K. (See Attachment 1). Since the building has line of credit of approximately $7 million, the date of the proposed transfer is contingent upon the bank's approval of the transaction. Further, the value of the home office building has been integrated in the price being discussed with potential investors attempting to acquire Chartered. Therefore, although we cannot definitively provide an anticipated date of the transfer of the building to Chartered, we can, however, assure DISB that if the transfer of the building does not occur prior to the acquisition letter of intent being finalized, it will be detailed in Holding Company Systems Form A filing submitted to the Department.

Finally, we believe the transfer or the execution of the letter of intent will occur before the date Chartered is required to file its 2nd Quarter 2012 financial statement, which is August 15, 2012. The determination of which financial statement this surplus contribution will be reported on is based on Statutory Statement of Principles (SSAP No. 9R) which covers the subject of 'Subsequent Events.' According to SSAP No. 9R, subsequent events are defined as events or transactions that occur subsequent to the balance sheet date, but before the issuance of the statutory financial statements. Chartered will confer with its auditors to determine whether the surplus contribution, if executed after June 30th, but before the August 15th required reporting date, can be appropriately reported in the 2nd Quarter 2012 financial statements.

3) Issuance of Surplus Note

DCHSI has been in active negotiations with several investors concerning the acquisition of Chartered. It is our understanding from the attorneys representing DCHSI that the prospective investors would prefer to be the party issuing the surplus note rather than having this investment provided by another investor. This concern from potential investors has understandably limited Chartered's ability to attract interest in this surplus note. Therefore, since we believe that the same parties/entities will issue the surplus note and acquire the company, we believe it is more appropriate to summarize the actions of the potential investors of Chartered. (See Attachment 2).

It should be noted that DCHSI have held meetings with several investment groups to discuss the acquisition of Chartered. Several of these groups are performing appropriate due diligence on the company and are evaluating the risk exposures relative to the new owner of Chartered continuing as a participant of the latest District of Columbia Medicaid contract. We believe after the due diligence is completed and the Form A filing has been submitted to DISB for review and approval, the prospective owner of Chartered will enter into a surplus agreement with the company for an amount that will bring Chartered's capital and surplus above the MCL. While we await the completion of this due diligence process, Chartered has attached a surplus note format for your review and approval. (See Attachment 3). The HMO Act in the District of Columbia Code does not have statutory provisions for approving surplus notes, but the format used is similar to the one used in the states of Florida and New York.

Finally, Chartered representatives met with you and your colleagues to discuss the statutory accounting and reporting on the pharmacy retrospective claim which has been submitted to the District of Columbia. We appreciate your willingness to provide guidance relative to this issue.

Chartered continues to provide satisfactory health services to its enrollees, as well as successfully manage its relationships with health care providers and others in the community. It should be noted that the 2nd Quarter 2012 financial statement is required to be filed on August 15th, 2012. Since the proposed sale of the company will be contingent upon the new owner having sufficient capital to meet the requirements of DC Code § 31 -703(g)(1)(A), Chartered requests that DISB grant it permission to modify the due date for compliance with the short-term strategies for getting above the MCL, to the August 15th, 2012 date. In the interim, Chartered will provide DISB will updates on DCHSI talks with investors and when the Form A document will be filed.

As you are probably aware, I and Mr. David Wolf, Chairman of Chartered Board of Directors met with Commissioner White earlier this week. We want to continue to maintain our open dialogue with the Department..

If you have any further questions, please do not hesitate to contact me.

Regards,

Maynard McAlpin
CEO
Chartered Health Plans

EXHIBIT 4

Table of Contents

D.C. CHARTERED HEALTH PLAN, INC.

1025 15TH Street, NW • Suite LL100 • Washington, DC 20005-2601 • Tel: (202) 408-4720 • Fax: (202) 408-4730

OVERVIEW

DC Chartered Health Plan, Inc. (Chartered) is a Health Maintenance Organization (HMO) established in December 1986 under the laws of the District of Columbia (the "District"). In December 1996, the District passed the HMO Act requiring all HMOs to obtain a license to operate in the District of Columbia. In accordance with the HMO Act, Chartered obtained its HMO license on January 9, 1998. In 2000, a United States Bankruptcy Court sold the stock ownership interest in Chartered and certain other assets to DC Healthcare Systems, Inc. (DCHSI) for $4,000,000 in cash.

Since the acquisition by DCHSI in 2000, Chartered has operated under a government contract with the Department of Health Care Finance (DHCF) to provide health care coverage to the District's Medicaid and Alliance population. The Alliance program provides medical assistance to District residents who are not eligible for federally-financed Medicaid benefits, including non-disabled childless adults, non-qualified aliens and some individuals who are over-income for Medicaid. On May 1, 2008, Chartered was awarded a new five-year contract with the DHCF which expires April 30, 2012. Unison Health Plan of the Capital Area, a subsidiary of UnitedHealth Group, is the only other insurance entity providing Medicaid coverage in the District. Chartered is currently in the process of responding to the DHCF's new proposal for award of a Medicaid contract for the period 2012 through 2017.

In this Corrective Action Plan, we refer to DC Chartered Health Plan, Inc. as "Chartered," "the Company," "we," "us," or "our." In addition, for the purposes of this Plan, "Capital and Surplus" are referred to a "Total Adjusted Capital" or "TAC" since the amounts are the same for Chartered. Statements included in this Plan that are not historical facts are forward-looking statements and involve a number of risks and uncertainties, which could cause actual results to differ materially from those anticipated as of the date of this Plan.

On April 13 2012, DC Chartered filed its 2011 Health Annual Statement and Risk-Based Capital Report with the District's Department of Insurance, Securities and Banking (DISB).

Chartered reported TAC of $1,441,940 and a RBC Authorized Control Level amount of $13,950,377, yielding a 2011 RBC Ratio of 10.3%. Pursuant to DC Code § 31-3851.01 *et seq.*, Chartered's TAC balance is below the Mandatory Control Level RBC ("MCL") by $8,323,324 which is 70% of the RBC Authorized Control Level (ACL) or $9,765,264. Subsequent to the April 13, 2012 filing in a letter dated April 19, 2012, the DISB exercised its discretion under DC Code § 31-3851.06(c) to allow Chartered up to 90 days to remediate the MCL Event. During the 90 day period, the DISB implemented the provisions of D.C. Code § 31-3851.04, which subjects Chartered to the requirements for companies at the "Regulatory Action Level RBC."

CONDITIONS CONTRIBUTING TO THE MANDATORY CONTROL LEVEL

SUMMARY

During 2011 Chartered's TAC declined from $17.4M to $1.4M, primarily from operating losses of $15.0M. In addition, Chartered's ACL RBC requirement increased by $3.1M. In tandem, these items caused a reduction in Chartered's RBC Ratio from 160.1% to 10.3%. While this marks the third consecutive year Chartered's TAC has been below its Company Action Level amount, it is the first time that Chartered's TAC is below its ACL amount since the District's adoption of the "Health Organizations RBC Amendment Act of 2002 (Health RBC Act)" which was effective with the 2002 Annual Statement Filing.

Chartered believes that the conditions leading to the 2011 operating loss and the decline in Chartered's TAC were events systemic to the Medicaid managed care business in the District and were largely beyond Chartered's control. These conditions are not new, nor are they unique to 2011, but rather are the continuation of a trend that began in 2007 and have progressively eroded Chartered's surplus position over the past five years (see Timeline Chart below). During this period Chartered has consistently communicated its concerns to DHCF and in at least two cases, involving dental and pharmacy benefits, Chartered has filed claims with the District's Contract Appeals Board to rectify these specific issues. Consequently, to address the conditions that lead to Chartered's 10.3% RBC Ratio, it is

necessary to review and identify the conditions that cumulatively have placed Chartered in its current financial position.

Overview of Conditions Leading to DC Chartered's Current Financial Position		
Issue	**Impact on Chartered**	**Chartered's Response**
2008		
Medical Assistance Administration (MAA) imposed dental fee schedule in response to Salazar Court Order.	Failure to account for increase in utilization based on new rates escalated Chartered's dental medical costs. The MAA and after it, the DHCF, failed to increase Chartered's capitation rates to keep pace with the ever-growing dental costs.	After numerous requests for resolution of this matter, Chartered filed a claim with the Contract Appeals Board in 2011 and the matter was settled in September of 2011 for $7.5 Million.
Membership increased from 63,309 to 80,923 members attributable to new contract with DHCF and exit of AmeriGroup from market.	AmeriGroup's exit resulted in a significant number of enrollees moving to Chartered giving rise to a significant increase in medical costs. Medical loss ratio increased from 82.3% to 83.9%.	Chartered moved to offset additional medical costs by implementing various administrative cost savings which allowed Chartered to lower its administrative expense ratio from 14.0% to 13.3%.
2009		
Membership continued to increase rising from 80,923 to 88.407 members attributable to new enrollees added to Medicaid population, open enrollment, and continued attrition related to exit of AmeriGroup from market.	Membership increase triggered RBC excessive growth charge and underwriting ratio increasing from 84% to 94% had a negative effect on H-2 Underwriting Risk. Higher H-2 & excessive growth charge caused ACL to increase from $6.2M to $9.0M with TAC decreasing from $19.7M to $13.8M/	Chartered moved to offset additional medical costs by implementing various administrative cost savings which allowed Chartered to lower its administrative expense ratio from 14.0% to 13.3%.
Chartered began to incur "adult" dental claims for first time with dental claims rising from 9% to 17% of professional service costs.	Rate not changed to compensate for increase in benefits causing dental costs to increase from $10.00 PMPM in 2008 to $22.25 PMPM in 2009. Dental program funding deficit estimated in the range of $10 to $13 million in 2008 and 2009, significantly impacting financial results.	Significantly reduced reimbursement rates to dental providers for Medicaid adult dental care coupled with reduced reimbursement rates for the Alliance adult dental care program. New adult dental fee structure was reduced by approximately 26% of the rates previously paid during the 2009 contract period which began May 1, 2009. Reduction in provider reimbursements continued in 2010 with

Overview of Conditions Leading to DC Chartered's Current Financial Position		
Issue	**Impact on Chartered**	**Chartered's Response**
		savings of approximately $0.5 million and remains in effect. Developed a revised provider fee schedule.
Prescription drug costs increased by $6.1 million resulting from higher utilization and cost of brand name and generic drugs. ER costs increased by $11.21 million an increase of 52.9% from prior year due to higher utilization.	The significant increase in medical costs reduced 2009 statutory net income by $9.7M (230.5%) compared to 2008, which in turn eliminated an additional $6.0M or nearly 30% accumulated statutory surplus.	Increased medical management services; added additional medical management staff, implemented additional medical management software to provide monitoring and analytical assistance to the management staff. As a result, inpatient admits decreased. Consequently, medical costs were lowered due to the increase in cost containment expenses.
Administrative expenses increased due to dental and ER claims adjudication expense and $1.1M mandated payment to District's Department of Health's Immunization Program and other not-for-profit organizations.	Higher adjudication costs from increased claims and external administrative expenses offset reduction in operating costs.	Chartered continued to reduce administrative costs as a percentage of premium income from 13.3% to 10.9% which accounted for $5.5M in savings.
District's AG asked for increase in reimbursement rates paid to UMC to support the District's efforts to save facility. Subsequent to first request, District AG asked Chartered to make loan to assist UMC in making it payroll.	Negotiated contract that paid UMC highest rate for each level of care and type of service that any hospital in the network received. Rates paid to UMC disadvantageous in significantly higher rates and paying other facility for providing essentially same services already having paid to UMC.	Made loan and recouped loan principal from UMC's claims over 18 month period.
2010		

Overview of Conditions Leading to DC Chartered's Current Financial Position		
Issue	**Impact on Chartered**	**Chartered's Response**
Enrollment increase attributable to insolvency of Health Right, Inc. causing a redistribution of Medicaid and Alliance members.	Increase in ACL and H2 due to continued enrollment growth.	Inpatient PMPM costs decreased from $69 PMPM to $63 PMPM as a result of the District reassigning catastrophic members from DCCHP to the District's fee for service program. Reassignment part of initiative began in 2009 by Company in managing claims that are otherwise eligible for payments under either the SSI or the Medicaid Fee for Service programs.
District imposes 2% premium tax on Medicaid and Alliance premiums.	This increased Chartered's underwriting results by 2% and correspondingly decreased its net income.	Argued that tax was not applicable to "Medicaid HMOs" in the District and consequently was exempt from the premium tax. However based on discussions with DISB, subsequent to the Company's 2010 Annual Statement filing, it was determined that the 2% premium tax was applicable to all District HMOs, including Medicaid HMOs
DHCF began moving eligible Alliance enrollees to Medicaid Managed Care absent budget authority to pay actuarially sound capitation rates.		Signed annual contract renewal with DHCF for the period August 1, 2011 through April 30, 2012. New rates added approximately $9 PMPM.
DHCF advised that most of the Alliance members ("774 group") would be transitioned to Medicaid in July reducing Alliance expenditures and losses; however, fewer members were transferred to Medicaid than expected.	Suffered loss on the Alliance line of business of over $4.0M August 1, 2010 through July 30, 2011 period.	Chartered raised these significant medical cost escalations with the District early in 2011 and DHCF declined to take actions to resolve these issues. Chartered advised DHCF staff that it needed to be concerned about the prospective cost of this program change and asked for any pharmacy data that would shed light on what the potential cost of the augmented program might be. DHCF staff responded that no such data existed.
DHCF transferred a second group of Alliance members ("775 group") to the Medicaid program on December 1, 2010.	Incurred losses increases for 774 and 775 groups with pharmacy costs increasing from $23.84 PMPM to $39.10 PMPM. A 16% increase in pharmacy costs in 17 months outpacing Medicaid plans around the nation by $14.00	

Overview of Conditions Leading to DC Chartered's Current Financial Position		
Issue	**Impact on Chartered**	**Chartered's Response**
	PMPM.	
2011		
At the start of the 2011-2012 contract year rate negotiation, Mercer, DHCF's contract actuary, stated that the Alliance rates for the 2010-2011 contract year were not actuarially sound.	In August of 2010, the second month after the start of the Alliance transition to Medicaid, Chartered spent $23.84 PMPM for pharmacy costs overall. By August of 2011, that cost had increased to $36.73 and by December 2011, it had reached $39.10 PMPM. This represents a 16% increase in pharmacy costs in only 17 months, and outpaces Medicaid plans around the nation by $14.00 PM	In November 2011, Chartered filed a claim with DHCF's contracting officer for more than $25.8M excluding the administrative fee component.

Since 2007, Chartered's RBC Ratio has steadily declined as noted in Table 1 below. Prior to 2009, Chartered had consistently maintained its RBC Ratio above any RBC action level. However, Chartered's 2009 operating results saw both a significant loss in TAC and an increase in its ACL amount which led to a 52% decline in Chartered's ACL level from 314% at year-end 2008 to 152% at year-end 2009. At year-end 2010, Chartered's TAC rebounded slightly to $17.4M from $13.8M at year-end 2009 representing a $3.6M or 26% increase. The increase in TAC came primarily as a result of Chartered aggressively pursuing recoupment of claim overpayments to providers. During 2011, however, Chartered experienced a significant increase in pharmacy and other medical costs which drove Chartered's medical loss ratio (MLR) from 90% at year-end 2010 to 96% in 2011, representing an increase of approximately $21M in additional medical costs. As Chartered's medical costs increased, the H2 – Underwriting Risk factor also increased significantly, effectively doubling Chartered's costs. The conditions which caused Chartered's TAC to fall below its MCL that began in 2007, and continued through 2011, are discussed in detail below.

DC Chartered Health Plan, Inc Net Income and Risk Based Capital Results Table 1										
	12/31/11	12/31/10	12/31/09	12/31/08	12/31/07	12/31/06	12/31/05	12/31/04	12/31/03	12/31/02
Statutory Net Income	$ (14,963)	$ 1,208	$(5,470)	$ 4,193	$ 5,464	$ 6,005	$ 3,634	$ 2,351	$ 2,581	$ 917
Total Adjusted Capital	1,442	17,445	13,760	19,724	21,620	20,277	15,365	11,369	9,257	6,610
Authorized Control Level RBC	13,950	10,895	9,053	6,280	5,545	4,378	3,212	2,923	2,572	2,015
RBC Ratio	10.3%	160.1%	152.0%	314.1%	389.9%	463.2%	478.3%	388.9%	359.9%	328.0%

2008 CONDITIONS

Chartered began experiencing certain fiscal challenges in 2008 when Chartered was attempting to meet the requirements of the Salazar Court Order with regard to dental services. The Medical Assistance Administration (MAA) had imposed a dental fee schedule on Chartered in December of 2005. This fee schedule mandated that Chartered pay dentists at a rate that was significantly higher than other Medicaid and many commercial plans in the region. The goal of the increased rates was to encourage new dentists to enter the Medicaid market, and thus increase access for members.

While the MAA included an initial increase in Chartered's capitation payments, it failed to account for the increase in utilization that the new rates were designed to engender. The provider rate increase worked as intended, and many new dentists and dental companies entered the market, thereby rapidly escalating Chartered's dental medical costs. Nonetheless, the MAA and after it, the DHCF, failed to increase Chartered's capitation rates to keep pace with the ever-increasing dental costs. After numerous requests for resolution of this matter, Chartered filed a claim with the Contract Appeals Board in 2011, and the matter was settled in September 2011 for $7.5M.

Also during 2008, Chartered's membership increased by 28% from 63,309 members at the end of 2007 to 80,923 members. This increase was attributable to the new contract with DHCF and the exit of AmeriGroup from the DC market, which resulted in a significant number of AmeriGroup enrollees moving to Chartered. With the exit of AmeriGroup from

the market, Chartered's enrollment increased significantly. These two major conditions had the following impact to Chartered's 2008 financial and RBC results:

1. A significant increase in medical costs that reduced Chartered's 2008 statutory net income by $1.3M (23.3%) compared to 2007, which in turn eliminated $1.9M or nearly 9% of Chartered's accumulated statutory surplus.
2. Chartered was able to offset these various medical costs by various administrative cost savings which allowed Chartered to lower its administrative expenses from 14.0% to 13.3% of premium income.
3. Chartered's TAC decreased from $21.6M to $19.7M, a decrease of $1.9M or 8.8%.
4. Chartered's ACL increased from $5.5M to $6.3M, a 13.3% increase. The increase in the ACL was primarily due to the increase in the H2 – Underwriting Risk which increased from $10.8M to $12.4M, a 13.9% increase. Since the H2 factor accounts for 98% of Chartered's ACL, this was the primary driver. The increase in the H2 factor was due to:
   a. Increase of $15.9M in premiums; and
   b. Increase in the medical loss ratio from 82.3% to 83.9% due primarily to an increase in hospital costs. This represented an increase in Chartered's medical costs of $15.9M which offset completely the $15.9M increase in premiums.

DC Chartered Health Plan, Inc						
Table 2						
					2008 Event Change	
	12/31/08		12/31/07		$ Chg	% Chg
Members	80,923		63,309		17,614	27.8%
Summary Operating Results 000's Omitted						
Net Premiums	180,992	100.0%	165,104	100.0%	15,888	9.6%
Revenue PMPM	$ 213.76		$ 222.02		$ (8.26)	-3.7%
Medical and Hospital Expenses	151,768	83.9%	135,903	82.3%	15,865	11.7%
Cost of Care PMPM	$ 179.24		$ 182.75		$ (3.51)	-1.9%
Administrative Expenses	23,999	13.3%	23,187	14.0%	812	3.5%
Net Underwriting Gain/(Loss)	5,226	2.9%	6,014	3.6%	(789)	-13.1%
Statutory Net Income	4,193	XXX	5,464	XXX	(1,271)	-23.3%
Total Adjusted Capital	19,724	XXX	21,620	XXX	(1,895)	-8.8%
Risk-Based Capital Results 000's Omitted						
	RBC Requirement	%	RBC Requirement	%	2008 Event Change	
	12/31/08		12/31/2007		$ Chg	% Chg
H0 - Asset Risk - Affiliates	157	1.1%	23	0.2%	134	595.4%
H1 - Asset Risk - Other	119	0.8%	1,917	13.5%	(1,798)	-93.8%
H2 - Underwriting Risk	12,352	87.9%	10,842	76.3%	1,509	13.9%
H3 - Credit Risk	371	2.6%	396	2.8%	(25)	-6.2%
H0 - Business Risk	1,056	7.5%	1,040	7.3%	16	1.6%
Total RBC	14,054	100.0%	14,217	100.0%	(163)	-1.1%
RBC After Covariance	12,560	89.4%	11,089	78.0%	1,471	13.3%
Authorized Control Level RBC	6,280	XXX	5,545	XXX	736	13.3%
Total Adjusted Capital	19,724	XXX	21,620	XXX	(1,895)	-8.8%
RBC Percentage	314.1%	XXX	389.9%	XXX	(75.8)	-19.5%

2009 CONDITIONS – COMPANY ACTION LEVEL (CAL) EVENT

Chartered filed its 2009 Health Annual Statement and RBC Report with the DISB on March 1, 2010. For the first time since the adoption of the District's Health RBC Act, Chartered's RBC Ratio fell below the RBC Company Action Level. Chartered reported a TAC of $13.8M

and an ACL of $9.1M, yielding a RBC Ratio of 152% or "Company Action Level" event for the 2009 reporting period. The dramatic drop from 314% at year-end 2008 to 152% at year-end 2009 was caused by a significant loss in TAC ($6.0M/30%) and a concurrent increase in the ACL ($2.8M/44%) led to a 52% decline in Chartered's RBC Ratio.

Total adjusted capital in 2009 declined primarily as a result of Chartered's net loss of $5.5M emanating from increased medical costs. Chartered's medical cost ratio increased from 83.9% in 2008 to 93.5% in 2009 as medical costs increased by $62.8M. As medical costs increased, the H2 – Underwriting Risk factor rose and with the increase in members/premiums, the excessive growth factor was triggered and Chartered's ACL increased substantially.

The unprecedented decline in both Chartered's TAC and RBC was a continuation, and in some respects a culmination, of events which occurred prior to 2009, but affected Chartered's overall surplus position. Consequently during 2009, Chartered continued to experience additional fall-out from AmeriGroup leaving the market and the new rate structure imposed by DHCF. Chartered's membership continued to grow, and at year-end 2009, membership had increased to 88,407 from 80,923 at year-end 2008. This increase was primarily from new enrollees being added to the District's Medicaid population, the open enrollment process, and member attrition related to the departure of AmeriGroup. The membership increase and the increasing underwriting ratio ultimately had a negative effect on Chartered's H-2 Underwriting Risk.

During 2009, Chartered's medical costs also continued to increase significantly. By year-end 2009, Chartered's MLR increased to 93.5% from 83.9% in 2008. The increase in medical costs is more apparent on a per member per month (PMPM) basis as the aggregate cost of care rose from $179.24 PMPM in 2008 to $209.31 PMPM in 2009, an increase of 16.8%. The increase in medical costs in 2009 resulted from a number of significant, and increasingly, recurring systemic events:

1. Dental medical costs continued to increase as noted for 2008; however, in 2009, Chartered began to incur the costs of "adult" dental claims for the first time. In prior years, Chartered incurred claims only for children's dental claims. Consequently, while the total dental claims accounted for approximately 9% of other professional services in 2008, this increased to 17% in 2009 with the addition of adult dental claims.

   The addition of adult dental claims was imposed as part of the new contract with DHCF which began May 1, 2009. The new contract extended dental benefits to cover adults, but the rate was not changed to compensate Chartered's for the increase in benefits. Whereas the DHCF actuarially set rates at $8.60 PMPM, Chartered actually experienced costs of $10.00 PMPM in 2008, which increased to $22.25 PMPM in 2009. Because of the dental program funding deficit, estimated in the range of $10M to $13M in 2008 and 2009, Chartered financial results were significantly impacted.

2. Prescription drug costs for Chartered increased by $6.1M during 2009, an increase of 43.3% from the prior year. Higher utilization and cost of brand name and generic drugs were the primary drivers behind the increase in prescription drug costs.

3. Emergency Room (ER) costs for Chartered increased by $11.2M during 2009, an increase of 52.9% from the prior year. The primary reason for this increase was an unanticipated increase in utilization for ER services.

Chartered's administrative expenses (including cost containment and claim adjustment expenses) also increased marginally in 2009 by 4.0%. This increase was in part due to:

a. Adjudication expense related to dental and ER claims.
b. $1.1M mandated payment to the District Department of Health's Immunization Program and several other not-for-profit organizations, including the District's Public Education Fund.

Another key financial event occurred in the Spring of 2009 when Chartered was approached by the District's Attorney General who asked Chartered to increase the reimbursement rates paid to what is now the United Medical Center (UMC) to support the District's efforts

to save that facility. After considerable discussion and at the urging of the District government, Chartered negotiated a contract that paid UMC the highest rate for each level of care and type of service that any hospital in the network received. Subsequent to this concession to UMC, the District also asked Chartered to make a loan to UMC so that it could pay its employees. Chartered made the loan and recouped the loan principal from UMC's claims over the next eighteen (18) months. The rates paid to UMC were not advantageous to Chartered because, as it turned out, UMC lacked a number of important routine specialty services, and frequently transferred patients to other facilities for care. As a result Chartered was required to pay UMC (at its significantly higher rates) and then pay another facility for providing essentially the same services when under normal circumstances, Chartered would have only paid one facility.

The culmination of the conditions occurring in 2009 and prior became evident when Chartered reported a 52% decline in its RBC Ratio (a decline of 162 basis points). Prior to 2009, as evidenced in Table 1, Chartered had consistently maintained its RBC Ratio above any RBC action level.

These conditions had the following impact on Chartered's 2009 financial and RBC results as summarized in Table 2:

1. An increase in Chartered's MLR from 83.9% to 93.5%.
2. The significant increase in medical costs reduced Chartered's 2009 statutory net income by $9.7M (230.5%) compared to 2008, which in turn eliminated an additional $6.0M or nearly 30% of Chartered's accumulated statutory surplus.
3. Chartered continued to reduce administrative costs as a percentage of premium income from 13.3% to 10.9% which accounted for $5.5M in savings.
4. Chartered's TAC decreased from $19.7M to $13.8M, a decrease of $5.9M or 29.9%.
5. Chartered's ACL increased from $6.2M to $9.0M, a $44.2% increase. The increase in the ACL was due primarily to the following items:

a. H2 – Underwriting Risk (98.6% of RBC) increased from $12.4M to $17.9M, a 44.6% increase. The increase in the H2 factor was due to:

   i. A significant increase of $48.M in premiums; and
   ii. Continued increase in medical loss ratio from 83.9% to 93.5%.

b. H4 – Business Risk (8.6% of RBC) increased from $1.6M to $1.1M, a 47.2% increase. The increase in the H4 factor was due to the significant increase in premium revenue causing Chartered to incur an "excessive growth" charge. The risk charge for excessive growth is set as a function of both growth in underwriting risk revenue and in underwriting risk RBC. A "safe harbor" level of growth is established as the growth rate in premiums plus 10%. Therefore, if the reporting entity had an increase in underwriting risk revenue volume of 30%, its underwriting risk RBC could grow up to 40% before an additional growth risk RBC is generated. Consequently, an entity that doubles its volume without more than doubling its RBC is not subject to the excessive growth RBC charge. However, an entity that doubles its RBC without doubling its underwriting risk revenue volume will trigger the excessive growth charge.

   Chartered's safe harbor for 2009 was $16.9M, but its growth was $17.9M, an excess of $1.0M which triggered an additional RBC amount of $0.5M.

DC Chartered Health Plan, Inc								
Table 3								
					2009 Event Change			
	12/31/09		12/31/08		$ Chg	% Chg	12/31/07	
Members	88,407		80,923		7,484	9.2%	63,309	
Summary Operating Results 000's Omitted								
Net Premiums	229,536	100.0%	180,992	100.0%	48,544	26.8%	165,104	100.0%
Revenue PMPM	$ 223.91		$ 213.76		$ 10.15	4.7%	$ 222.02	
Medical and Hospital Expenses	214,573	93.5%	151,768	83.9%	62,806	41.4%	135,903	82.3%
Cost of Care PMPM	$ 209.31		$ 179.24		$ 30.07	16.8%	$ 182.75	
Administrative Expenses	24,951	10.9%	23,999	13.3%	952	4.0%	23,187	14.0%
Net Underwriting Gain/(Loss)	(9,988)	-4.4%	5,226	2.9%	(15,213)	-291.1%	6,014	3.6%
Statutory Net Income	$ (5,470)	XXX	4,193	XXX	(9,663)	-230.5%	5,464	XXX
Total Adjusted Capital	13,760	XXX	19,724	XXX	(5,965)	-30.2%	21,620	XXX
Risk-Based Capital Results 000's Omitted								
			RBC Requirement	%	2009 Event Change		RBC Requirement	%
	12/31/09		12/31/08		$ Chg	% Chg	12/31/2007	
H0 - Asset Risk - Affiliates	165	0.8%	157	1.1%	8	5.2%	23	0.2%
H1 - Asset Risk - Other	97	0.5%	119	0.8%	(22)	-18.8%	1,917	13.5%
H2 - Underwriting Risk	17,862	87.9%	12,352	87.9%	5,510	44.6%	10,842	76.3%
H3 - Credit Risk	653	3.2%	371	2.6%	282	76.0%	396	2.8%
H0 - Business Risk	1,554	7.6%	1,056	7.5%	498	47.2%	1,040	7.3%
Total RBC	20,330	100.0%	14,054	100.0%	6,276	44.7%	14,217	100.0%
RBC After Covariance	18,106	89.1%	12,560	89.4%	5,546	44.2%	11,089	78.0%
Authorized Control Level RBC	9,053	XXX	6,280	XXX	2,773	44.2%	5,545	XXX
Total Adjusted Capital	13,760	XXX	19,724	XXX	(5,965)	-30.2%	21,620	XXX
RBC Percentage	152.0%	XXX	314.1%	XXX	(162.1)	-51.6%	389.9%	XXX

2010 CONDITIONS – COMPANY ACTION LEVEL

During 2010, Chartered returned to marginal profitability with its TAC increasing from $13.8M to $17.4M. However, Chartered's ACL continued to increase for the fourth consecutive year moving from $9.0M to $10.9M, a 20.3% increase. The increase in the ACL was due primarily to another increase in the H2 – Underwriting Risk (99.1% of RBC) from $17.9M to $21.6M, a 20.9% increase. The increase in the H2 factor resulted from the continued enrollment growth which increased premiums by $67.2M. The increase in

enrollment was primarily attributable to the insolvency of Health Right, Inc. which caused a redistribution of the Medicaid and Alliance members of that entity. The increase to the ACL was offset somewhat by a decrease in the claims ratio from 93.5% to 89.6%. The net effect was only a marginal increase in Chartered's RBC Ratio from 152.0% to 160.1%, a 5% increase.

Despite the appearance of a return to profitability in 2010, two key events occurred, which further eroded Chartered's accumulated surplus in the following periods.

1. In May 2010, the District imposed a 2% premium tax on Medicaid and Alliance premiums. While the DHCF promised that the District's two Managed Care Organizations (MCOs) would have their capitation rates increased by 2% to cover the cost of the premium tax, that increase did not become effective. This increased Chartered's underwriting results by 2% and correspondingly decreased its net income.
2. Also in May of 2010, DHCF began moving eligible Alliance enrollees to Medicaid Managed Care without the budget authority to pay actuarially sound capitation rates for Alliance enrollees. To address this problem, DHCF had promised that additional funds would be added to the adult rates cells to help defer the cost of the unsound Alliance rates. The additional funds were to be provided by raising these cells to the higher end of the actuarial range. However, this did not happen. To the contrary, it appears that some of the rate cells were actually reduced.

Furthermore, DHCF advised Chartered that most of the Alliance members (referred to as the "774 group" or "774 population") would be transitioned to Medicaid on July 1, 2010 and therefore, the Alliance enrollment would be greatly diminished. This transition would reduce the Alliance expenditures and the losses being experienced by Medicaid MCOs relative to this program. However, fewer members were transferred to Medicaid than expected on July 1, 2010. Chartered therefore suffered a loss on the Alliance line of business of over $4.0M during the August 1, 2010 through July 30, 2011 period.

DHCF then transferred a second group of Alliance members (referred to as the "775 group" or "775 population") to the Medicaid program on December 1, 2010. The increased losses Chartered incurred in the 774 and 775 populations manifested themselves rather early. In August 2010, the second month after the start of the Alliance transition to Medicaid, Chartered spent $23.84 PMPM for pharmacy costs overall. By August of 2011, however, that cost had increased to $36.73 and by December 2011, it had reached $39.10 PMPM. This represented a 16% increase in pharmacy costs in only 17 months, and outpaces Medicaid plans around the nation by $14.00 PMPM.

These conditions had the following impact on Chartered's 2010 financial and RBC results as summarized in Table 4:

1. A decrease in Chartered's MLR from 93.5% to 89.6%.
2. An increase in Chartered's statutory net income of $6.7M.
3. Chartered's TAC increased from $13.8M to $17.4M, an increase of $3.7M or 26.8%. Beginning TAC of $13.8M was impacted by the following major items:
   a. Increase of $1.2M from Net Income after Taxes;
   b. Increase from a change in Deferred Tax Assets of $1.3M;
   c. Increase of $0.80M from a decrease in inventory of non admitted assets; and
   d. Increase of $0.4M from audit adjustments.
4. An increase in ACL by $1.9M or 20.3%. The ACL increased from $9.0M to $10.9M and was due primarily to another increase in the H2 – Underwriting Risk (91.2% of RBC) from $17.9M to $21.6M, a 20.9% increase. The increase in the H2 factor was due primarily to the significant increase in premiums of $67.2M. This was offset somewhat by a decrease in the claims ratio from 93.5% to 89.6%.
5. A marginal increase in RBC Ratio from 152.0 to 160.1 of 8 basis points. However the increase did not affect Chartered's RBC status of being in the CAL.

DC Chartered Health Plan, Inc										
Table 4										
					2010 Event Change					
	12/31/10		12/31/09		$ Chg	% Chg	12/31/08		12/31/07	
Members	110,184		88,407		21,777	24.6%	80,923		63,309	
Summary Operating Results 000's Omitted										
Net Premiums	296,733	100.0%	229,536	100.0%	67,197	29.3%	180,992	100.0%	165,104	100.0%
Revenue PMPM	$ 243.93		$ 223.91		$ 20.01	8.9%	$ 213.76		$ 222.02	
Medical and Hospital Expenses	265,859	89.6%	214,573	93.5%	51,286	23.9%	151,768	83.9%	135,903	82.3%
Cost of Care PMPM	$ 218.55		$ 209.31		$ 9.23	4.4%	$ 179.24		$ 182.75	
Administrative Expenses	29,472	9.9%	24,951	10.9%	4,521	18.1%	23,999	13.3%	23,187	14.0%
Net Underwriting Gain/(Loss)	1,402	0.5%	(9,988)	-4.4%	11,390	-114.0%	5,226	2.9%	6,014	3.6%
Statutory Net Income	$ 1,208	XXX	$ (5,470)	XXX	6,678	-122.1%	4,193	XXX	5,464	XXX
Total Adjusted Capital	17,445	XXX	13,760	XXX	3,685	26.8%	19,724	XXX	21,620	XXX
Risk-Based Capital Results										
					2010 Event Change		RBC Requirement	%	RBC Requirement	%
	12/31/10		12/31/09		$ Chg	% Chg	12/31/08		12/31/2007	
H0 - Asset Risk - Affiliates	150	0.6%	165	0.8%	(15)	-9.2%	157	1.1%	23	0.2%
H1 - Asset Risk - Other	130	0.6%	97	0.5%	34	35.0%	119	0.8%	1,917	13.5%
H2 - Underwriting Risk	21,596	91.2%	17,862	87.9%	3,734	20.9%	12,352	87.9%	10,842	76.3%
H3 - Credit Risk	533	2.3%	653	3.2%	(120)	-18.4%	371	2.6%	396	2.8%
H0 - Business Risk	1,267	5.4%	1,554	7.6%	(287)	-18.4%	1,056	7.5%	1,040	7.3%
Total RBC	23,676	100.0%	20,330	100.0%	3,346	16.5%	14,054	100.0%	14,217	100.0%
RBC After Covariance	21,789	92.0%	18,106	89.1%	3,683	20.3%	12,560	89.4%	11,089	78.0%
Authorized Control Level RBC	10,895	XXX	9,053	XXX	1,842	20.3%	6,280	XXX	5,545	XXX
Total Adjusted Capital	17,445	XXX	13,760	XXX	3,685	26.8%	19,724	XXX	21,620	XXX
RBC Percentage	160.1%	XXX	152.0%	XXX	8	5.4%	314.1%	XXX	389.9%	XXX

2011 CONDITIONS CONTRIBUTING TO MANDATORY CONTROL LEVEL (MCL)

SUMMARY

The series of systemic events discussed previously that began in 2008 had a dramatic impact on Chartered's overall financial position by 2011. With the filing of the 2011 Health Annual Statement and RBC Report on April 13, 2012, Chartered reported underwriting losses of $23.1M and a statutory net loss of $15.0M as provided in Table 5. The net loss was the contributing factor in reducing Chartered's TAC from $17.4M to S1.4M. In addition, Chartered's ACL continued to rise for the fifth consecutive year and was reported at $14.0M, a $3.1M increase from 2010. Again the driving factor for the ACL was the increase

to the H2 RBC Risk being influenced by the increase in members from 110,184 members at the end of 2010 to 110,550 members as of year-end 2011, a modest increase of 0.3%. Premium revenue, however, increased from $296.7M to $355.5M, which in tandem with the increase in Chartered's underwriting ratio, caused the ACL amount to increase.

DC Chartered Health Plan, Inc

Table 5

	12/31/11		12/31/10		2011 Event Change $ Chg	2011 Event Change % Chg	12/31/09		12/31/08		12/31/07	
Members	110,550		110,184		366	0.3%	88,407		80,923		63,309	
Summary Operating Results 000's Omitted												
Net Premiums	355,499	100.0%	296,733	100.0%	58,766	19.8%	229,536	100.0%	180,992	100.0%	165,104	100.0%
Revenue PMPM	$ 268.25		$ 243.93		24	10.0%	$ 223.91		$ 213.76		$ 222.02	
Medical and Hospital Expenses	340,676	95.8%	265,859	89.6%	74,817	28.1%	214,573	93.5%	151,768	83.9%	135,903	82.3%
Cost of Care PMPM	$ 257.07		$ 218.55		39	17.6%	$ 209.31		$ 179.24		$ 182.75	
Administrative Expenses	37,966	10.7%	29,472	9.9%	8,494	28.8%	24,951	10.9%	23,999	13.3%	23,187	14.0%
Net Underwriting Gain/(Loss)	(23,144)	-6.5%	1,402	0.5%	(24,546)	-1750.8%	(9,988)	-4.4%	5,226	2.9%	6,014	3.6%
Statutory Net Income	$ (14,963)	XXX	$ 1,208	XXX	XXX	XXX	$ (5,470)	XXX	4,193	XXX	5,464	XXX
Total Adjusted Capital	1,442	XXX	17,445	XXX	XXX	XXX	13,760	XXX	19,724	XXX	21,620	XXX
Risk-Based Capital Results												
	RBC Requirement	%	RBC Requirement	%	2011 Event Change $ Chg	2011 Event Change % Chg	RBC Requirement	%	RBC Requirement	%	RBC Requirement	%
	12/31/11		12/31/10				12/31/09		12/31/08		12/31/2007	
H0 - Asset Risk - Affiliates	143	0.5%	150	0.6%	(7)	-4.7%	165	0.8%	157	1.1%	23	0.2%
H1 - Asset Risk - Other	235	0.8%	130	0.6%	104	79.9%	97	0.5%	119	0.8%	1,917	13.5%
H2 - Underwriting Risk	27,724	93.0%	21,596	91.2%	6,128	28.4%	17,862	87.9%	12,352	87.9%	10,842	76.3%
H3 - Credit Risk	430	1.4%	533	2.3%	(103)	-19.4%	653	3.2%	371	2.6%	396	2.8%
H0 - Business Risk	1,294	4.3%	1,267	5.4%	26	2.1%	1,554	7.6%	1,056	7.5%	1,040	7.3%
Total RBC	29,824	100.0%	23,676	100.0%	6,148	26.0%	20,330	100.0%	14,054	100.0%	14,217	100.0%
RBC After Covariance	27,901	93.6%	21,789	92.0%	6,112	28.1%	18,106	89.1%	12,560	89.4%	11,089	78.0%
Authorized Control Level RBC	13,951	XXX	10,895	XXX	3,056	28.1%	9,053	XXX	6,280	XXX	5,545	XXX
Total Adjusted Capital	1,442	XXX	17,445	XXX	(16,003)	-91.7%	13,760	XXX	19,724	XXX	21,620	XXX
RBC Percentage	10.3%	XXX	160.1%	XXX	(149.8)	-93.5%	152.0%	XXX	314.1%	XXX	389.9%	XXX

CHANGES TO TOTAL ADJUSTED CAPITAL

The conditions contributing to the decrease in Chartered's TAC from $17.4M to $1.4M as of year-end 2011 were driven primarily by the net loss of $15.0M. Chartered reported a net loss at year-end 2011 in the amount of $15.0M compared to net income of $1.2M at year-end 2010. In addition to the net loss, Chartered eliminated its gross adjusted deferred tax asset (DTA) in the amount of $3.3M which directly impacted TAC. The net loss and elimination of the net DTA was offset by a decrease in the inventory of non admitted assets of $2.3M.

Chartered began 2011 with $17.4M of Capital and Surplus as reported in its 2010 Amended Filing filed September 2011. While the drain on surplus began prior to 2011, the monetary disparity between the rates paid to Chartered by DHCF and the costs of mandated benefits provided to enrollees (*e.g.*, dental and pharmacy benefits paid by Chartered), continued into 2011 another medical care issue arose involving emergency room out-of-area claims in addition to the dental and pharmacy issues already in existence.

During 2011 $355.5M of premium income from the District was absorbed by $341.4M in benefits paid for services to the District's residents, and another $7.2M paid back to the District in the form of a premium tax, which left Chartered with $6.9M for operational purposes (see Table 6). This left to Chartered with administrative operating budget of less than 2%. Consequently, in order to continue to: (i) provide benefits under the District's contract; (ii) pay for the District's premium tax; (iii) provide quality customer care and service to providers and Medicaid recipients; and (iv) operate as a viable insurance entity, Chartered continued to utilize its accumulated earnings to subsidize the District and maintain operations, as it had done since 2008. These factors combined with Chartered's operating costs of $30.8M, led to a net loss in 2011 of $15.0M. This net loss, along with other direct statutory charges to surplus, reduced Chartered's surplus from $17.4M to $1.4M in 2011.

Comparative Results of Operations (000 Omitted)
Net of Reinsurance
Table 6

	12/31/11	%	$ Chg	12/31/10	%	$ Change	% Change
Net Premium Income	$ 355,499	100.0%	58.77	$ 296,733	100.0%	$ 58,766	19.8%
Revenue PMPM	$ 268.25		0.02	$ 243.93		$ 24	10.0%
Total Medical and Hospital Costs	$ 340,676	95.8%	74.01	$ 266,665	89.9%	$ 74,011	27.8%
Cost of Care PMPM	$ 257.64		0.04	$ 219.21		$ 38	17.5%
Total Administrative Expenses	$ 37,966	10.7%	8.49	$ 29,472	9.9%	$ 8,494	28.8%
Net Underwriting Gain or (Loss)	$ (23,144)	-6.5%	(24.55)	$ 1,402	0.5%	$ (24,546)	-1750.8%
Net Investment Income	$ 432		(0.33)	$ 767		$ (334)	-43.6%
Other Income/(Losses)	$ 6,788			$ -		$ 6,788	
Provision for Federal Income Tax	$ (961)		(1.92)	$ 961		$ (1,921)	-200.0%
Net Income/(Loss)	$ (14,963)	-4.2%	(16.17)	$ 1,208	0.4%	$ (16,171)	-1338.5%
Capital and Surplus (TAC)	$ 1,442			$ 17,445		$ (16,003)	-91.7%

During 2011, Chartered suffered significant adverse medical underwriting results which stemmed primarily from the significant disparity between revenues generated by the managed care rates set by DHCF and the contractual benefits paid by Chartered on behalf of its members. While revenue PMPM increased from $243.93 in 2010 to $268.25 in 2011 medical costs vastly exceeded those amounts: in fact PMPM costs increased from $219.21 in 2010 to $257.64 in 2011. The disparity in Chartered's revenue and medical costs ultimately led to a $23.1M underwriting loss during 2011. Medical costs as compared to revenue increased across all categories and in total as reported in the Statement of Revenue and Expenses, except for "other professional services."

A number of issues can be linked to the negative underwriting results which occurred over the past five years but one consistent cause was the indisputable disparity between the MCO rates set by the DHCF and the contractual healthcare benefits Chartered is obligated to provide under its contract with the District. While this issue started as a result of the new contract signed with DHCF in 2008, the impact to Chartered's financial position did not begin to fully emerge until 2009 and later. In particular, key issues began to manifest themselves, including:

1. Based upon information provided to Chartered personnel by Mercer and Associates, DHCF actuaries, during subsequent capitation rate negotiations, the process for setting the 2010-2011 capitation rates was as follows:

   – The actuaries looked at the MCO "historical" (actual) financial experience with its Medicaid population;

   – The actuaries, then, looked at "Encounter Data", the claims information submitted to DHCF each month;

   – The actuaries determined that the historical financial experience was 7% higher than the Encounter Data;

   – Instead of meeting with the MCOs to resolve the discrepancy, DHCF decided to average the actual MCO financial experience with the Encounter Data to determine the medical cost component of the 2010-2011 capitation rate. This resulted in a medical cost component that was 3.5% below the prior actual financial experience;

   – DHCF decided to reduce the administrative portion of the rates from 10.5% to 9.5%; and

   – DHCF added 2% for the new Premium Tax imposed in May of 2010.

As a result of these factors, the District's two MCOs received a rate that was 2.5% ([3.5% less (10.5%- 9.5%) plus 2.0%) below what was required to meet their actual costs.

2. In addition to the rate discrepancy described above, there are examples of specific benefit issues that were addressed by Chartered with DHCF during 2010 and 2011, including:

   a. During 2010 Chartered initiated administrative proceedings with the District's Office of Contracting and Procurement regarding an overpayment of Salazar court-mandated dental benefits costs to members above the dental capitation rate paid under the DHCF's Contract. These contractual administrative proceedings were ultimately settled in September 2011 when the District, with the approval of the Centers for Medicare & Medicaid Services, refunded Chartered $7.5M.

b. During 2011, Chartered initiated a similar appeals process with the District regarding certain pharmacy benefits owed Chartered under its contract with the District. Chartered requested that the District review the contract's pharmacy rates and has asserted that DHCF should provide Chartered a rate adjustment for the 2010-2011 Contract year in the amount of $25.8M for losses Chartered incurred from October 31, 2011 through April 30, 2012.

   Both appeals by Chartered demonstrate a pattern of DHCF rates that appear to be actuarially unsound related to the contractual benefits required to be provided by Chartered.

3. Another example of the circumstances impacting Chartered's 2011 underwriting results was DHCF's decision to transition 20,000 Alliance members to Medicaid during the 3rd and 4th Quarters in 2010. The medical costs associated with the transitioned Alliance members' averaged between $120 and $300 PMPM, greater than the Temporary Cash Assistance for Needy Families (TANF) population (Medicaid benefits). The medical costs associated with this membership transition did not fully impact Chartered's financial statements until 2011, when members began to fully utilize the additional Medicaid benefits.

   In addition, DHCF stated during the discussion of the proposed 2012 managed care rates that:

   > "in establishing the previous year's rates, the decision was made to set the rates for the Alliance program below the level determined to be actuarially sound. To offset the anticipated losses from this decision, the Medicaid rates were established at higher levels. For a number of reasons, however, the expected gains on the Medicaid program did not materialize and the Alliance losses were not effectively offset. Accordingly, this model should not be replicated for FY 2012 and the plan for flat rates was abandoned in favor of a strategy to set actuarially sound rates for both programs."

4. Other items that impacted Chartered's 2011 underwriting results include:

a. Unexpectedly high pharmacy utilization with the transition of adults from the Alliance program into the Medicaid program effective July 1, 2010. This increase impacted pharmacy PMPM from the expected $23.78 to $39.10 for calendar year 2011. The high utilization of HIV medications was the major contributor to this increase in expenses and contributed $13.3M to the underwriting deficit. It is the intent of DHCF to carve out HIV medications in the 2012 contract to address this unfavorable trend.

b. Increase in ER utilization and the PMPM expense by 26.9% compared to 2010;

c. Increase in ambulance expenses based on District mandated rates impacting the PMPM by 25.6% compared to 2010;

d. Increase in hospital inpatient costs impacting the PMPM expense by 12.3% compared to 2010; and

e. Increase in hospital outpatient costs impacting the PMPM expense by 20.2% compared to 2010.

Overall, Chartered's underwriting ratio increased from 99.5% at year-end 2010 to $106.5% at year-end 2011. This increase primarily was driven by premium revenue PMPM increasing at a lower rate (10.0%) than medical cost PMPM (17.5%). The increase in medical costs was minimized by Chartered's efforts to hold administrative expenses constant. The net underwriting loss was offset by the following items:

1. A dental recovery settlement from the District in the amount of $7.5M. Chartered filed a claim for $14.9M on April 10, 2010 with the DC Contract Appeals Board (CAB) against the DHCF to obtain an equitable rate adjustment to recover an overpayment of Salazar court-mandated dental benefits costs to members above the dental capitation rate paid to Chartered under the District's Medicaid program. On September 9, 2011 Chartered obtained a signed order of judgment from the CAB to obtain an equitable rate adjustment for the dental program. The total settlement amount of $7.5M was paid in full by the DHCF on September 23, 2011.

2. Investment income of $0.4M and other miscellaneous income of $0.3M which led to Chartered's net loss of $15.0M.

In the end, the net loss of $15.0M contributed to the material loss in Chartered's TAC from $17.4M at year-end 2010 to $1.4M at year-end 2011, before the change in net deferred tax assets and non admitted assets.

CHANGES TO AUTHORIZED CONTROL LEVEL RBC

The H-2 Underwriting Risk ("H-2") component of the RBC Formula (see Table 7) accounts for the most significant aspect of a health entity's RBC requirement. For Chartered, H-2 represents approximately 93.0% of the total RBC requirement before the covariance calculation. Consequently, Chartered's underwriting results, before administrative expenses, drive Chartered's overall RBC requirement. In 2011, Chartered's ACL RBC increased by $3.1M (28.1%) from the 2010 requirement. This increase was due almost solely to the significant decline in Chartered's underwriting results, including premium growth, as discussed above.

Median RBC Ratios By Asset Size, 2006-2010						
RBC Ratio for Year Ending						
Table 7						
Asset Size	**2010**	**2009**	**2008**	**2007**	**2006**	
Less than $10 million	1165%	958%	852%	855%	958%	
$10 million to $25 million	491%	448%	465%	497%	438%	
$25 million to $100 million	497%	429%	425%	451%	431%	
$100 million to $250 million	496%	446%	472%	500%	542%	
More than $250 million	**639%**	**568%**	**543%**	**675%**	**687%**	
All Companies	606%	533%	545%	589%	582%	
DC Chartered	**160%**	**152%**	**314%**	**390%**	**463%**	

Health RBC by Components - 2010 (000s Omitted)						
	Industry		DC Chartered			
	12/31/2010		12/31/2011		12/31/2010	
	RBC Requirement	%	RBC Requirement	%	RBC Requirement	%
H0 - Asset Risk - Affiliates	3,698,173	10.3%	143	0.5%	150	0.6%
H1 - Asset Risk - Other	5,129,376	14.4%	235	0.8%	130	0.6%
H2 - Underwriting Risk	22,014,665	61.6%	27,724	93.0%	21,596	91.2%
H3 - Credit Risk	1,285,839	3.6%	430	1.4%	533	2.3%
H4 - Business Risk	3,615,370	10.1%	1,294	4.3%	1,267	5.4%
Total RBC	35,743,423	100.0%	29,824	100.0%	23,676	100.0%
RBC After Covariance	27,683,864	XXX	27,901	XXX	21,789	XXX
Authorized Control Level	13,841,932		13,951		10,895	
			-			
Total Adjusted Capital	92,284,370	XXX	1,442	XXX	17,445	XXX
RBC Percentage	667%	XXX	10%	XXX	160%	XXX

H-2 UNDERWRITING RISK/H0 ASSET RISK-AFFILIATES/H1 ASSET RISK/H-3 CREDIT RISK/H-4 BUSINESS RISK

As medical costs and enrollment increased, the H2 component increased as well. The other RBC components regarding assets, credit and business risk have remained fairly constant over the past five years, and in total account for approximately 7% of total RBC in 2011. For the years prior to 2011, these risk factors were less than 13% of total RBC.

Chartered's H-2 risk has consistently increased over the past five years as enrollment has grown from 63,000 members in 2007 to 110,000 members in 2011. In addition, during that same time period, Chartered's medical loss ratio has increased from 82.3% in 2007 to 95.8% in 2011. These two factors increased Chartered's H-2 component from $10.8M (76.3% of total RBC) in 2007 to $27.7M (93.0%) in 2011.

H-0 Asset Risk

Affiliate risk encompasses the risk of overvaluing investments in affiliates and for off-balance sheet risks. Chartered's only H-0 risk is solely off-balance sheet risk from:

a. Assets pledged to Cardinal Bank in the amount of $13.9M; and
b. Deposits with the DISB in the amount of $0.3M.

H-1 Asset Risk

Asset risk encompasses the risk of a decline in the market value or default of investments of an insurer's investment portfolio. Chartered's H-1 risk is comprised of its invested assets (CDARs, cash equivalents) and EDP equipment.

H-3 Credit Risk

Credit risk is the credit risk associated with reinsurance and other receivables. Chartered's H-3 risk is comprised of various receivables (reinsurance recoverables, investment income due and accrued, etc). Chartered is also assessed an H-3 risk charge for unsecured capitation payments ($13.5M) and various health care receivables ($3.1M).

H-4 Business Risk

Business risk pertains to insurers' potential obligation for the run-off of administrative expenses; uninsured products; excessive growth; and guaranty fund assessments. Chartered's H-4 risk is comprised of an assessment against its administrative expenses only.

CORRECTIVE ACTION PLAN PROPOSAL

As discussed in the Overview Section Chartered believes that that the conditions leading to the 2011 operating loss, and its decline in TAC and RBC Ratio, were events systemic to the Medicaid managed care business in the District and were largely beyond Chartered's control. However, it is our belief that the proposed initiatives summarized below will return Chartered to a positive operating income position in 2012 and in subsequent years, and increase the Company's RBC Ratio above any RBC Action Level Event. These initiatives include:

- A short-term strategy to increase its TAC above the MCL RBC Level by the 2nd Quarter 2012;
- A long-term strategy to further enhance the Company's operating results and RBC position beyond 2012; and
- A strategic re-design of Chartered's management team and Board of Directors to more effectively address the challenges of providing services to the Medicaid population in the District of Columbia under the District's Medicaid contract.

These strategic initiatives, the assumptions underlying the financial initiatives, and the related financial forecasts are addressed below.

SHORT-TERM STRATEGY TO INCREASE TAC ABOVE MCL

In Chartered's 2011 Statutory Statement, as filed with the DISB on April 13, 2012, the Company's TAC decreased from $17.4M to $1.4M and its RBC Ratio decreased from 162.1% to 10.3%. Pursuant to DC Code § 31-3851.01 *et seq.*, Chartered's TAC balance is below the MCL of $9.8M. Subsequent to the April 13th filing in a letter dated April 19, 2012, the DISB exercised its discretion under DC Code § 31-3851.06(c) to allow Chartered up to 90 days to remediate the MCL Event.

Chartered has implemented a number of short-term strategic initiatives to reestablish its TAC above its current MCL level of $9.8M. These initiatives will be reported as of the 2012

2nd Quarter Statutory Statement filed on or before August 15, 2012 and are discussed in detail below.

1. Chartered reported positive financial results in the 1st Quarter of 2012 with an underwriting gain of $2.8M, compared to $1.1M last year, and net income after taxes of $2.1M, compared to $0.7M last year. TAC also increased during the 4th Quarter but was offset by an increase in the inventory of non-admitted assets.

2. During the 2nd Quarter of 2012 two key financial initiatives will be realized that will directly impact Chartered TAC in addition to positive operating results achieved during the 1st and the 2nd Quarter of 2012:

   a. Chartered's parent company DCHSI is in the process of making a surplus contribution to Chartered of the building located at 1025 15th Street, N.W. Washington DC. Based on the applicable Statement of Statutory Accounting Principles, the building will be contributed as surplus at its fair market value less any outstanding mortgage based on the approval of the DISB. There is a current offer on the building in the amount of $10.7M and the building has a mortgage of approximately $7.0M. In addition, Chartered will also be able to admit $274K in leasehold improvements on the building located at 1025 15th Street. This would provide Chartered with a surplus contribution of approximately $4.0M which will be recognized during the 2nd Quarter 2012.

   b. Chartered is working to issue one or more Surplus Notes with a face value of $5M to $10M with potential investors with the prior approval of the DISB. Potential investors include insurance companies and/or current contractual providers. The approved issuance of one or more Surplus Notes with a minimum value of $5M will increase Chartered's surplus above the $9.8M MCL during the 2nd Quarter 2012.

LONG-TERM STRATEGIES TO ENHANCE CHARTERED'S OPERATING RESULTS AND RBC POSITION BEYOND 2012

Chartered continues to implement various long-term strategic cost initiatives that will impact both medical costs and administrative expenses. The financial impact of these cost saving initiatives are discussed in detail in the "Corrective Action Plan Initiatives" Section of this Report.

CORRECTIVE ACTION PLAN INITIATIVES

Chartered's 2012 financial forecasts project $5.5M in after tax net income compared to an after tax net loss of $15.0M in 2011. The change in 2012 after tax net income is achieved by reducing Chartered's medical loss ratio from 95.8% to 87.7% resulting in decreased medical costs of $20.5M or 6%. The following cost-saving initiatives will drive the reduction in medical costs in 2012 and will contribute to additional medical cost savings in 2013 and 2014. These costs savings are considered long-term strategies in the financial impact to Chartered's operating resulting will occur on and/or after May 2012.

Radiology Cost Savings

Chartered issued an RFP for a radiology benefit manager with an effective date of July 1, 2012. Chartered received and is currently evaluating two vendor proposals from Care to Care and Magellan/NIA and expects to implement a contract in the second quarter of 2012. The projected annual medical cost savings on this initiative is approximately $1M with $0.5M occurring in 2012 and the remainder in 2013. These savings will directly impact Chartered's "Hospital/Medical and Benefits" as reported in the Statutory Financial Statement.

Transportation Capitation Costs

Transportation capitation costs were $2.62 PMPM for January through July 2011. The capitation rate was changed with the current provider Logisticare effective August 1, 2011 to $1.97 PMPM which reduced medical costs by $0.3M in 2011. The projected annual

medical cost savings resulting from this change in transportation capitation rate is approximately $0.8M in 2012; however, Chartered has contracted with Battle Transportation in mid-2012 to provide transportation services which will add approximately $0.10 PMPM to transportation costs and effectively reduce the projected annual cost savings to $0.7M. This savings relates only to the Medicaid program, as the Alliance Program does not have a transportation benefit.

Subrogation/COB Recoveries

Chartered terminated its subrogation contract with The First Recovery Group effective May 31, 2012 and entered into a new contract for both subrogation and coordination of benefits (COB) with Discovery Health Partners. The new contractor uses more innovative and sophisticated methods for subrogation recoveries. Historically, Chartered managed its COB recoveries internally, but the new contract will combine both services and therefore Chartered expects to realize annual COB recoveries of approximately $1.0M beginning in 2012 with projected annual medical cost savings of $0.5M in 2012. Chartered has not historically recognized a reduction of its Incurred But Not Reported claim liability for COB recoveries within its Statutory Statement.

Emergency Room Cost

Chartered has identified emergency rooms utilization as a primary driver of excessive costs.

Emergency Room Costs		
Medical Cost Type	**Cost PMPM in 2011**	**Percent of Medical Costs**
Inpatient	66.38	26%
Physician Outpatient	29.01	11%
ER	41.58	16%
Physician ER	6.84	3%
Hospital Outpatient	31.82	12%
Ambulance	5.49	2%
Durable Medical	1.57	1%
Home Health	1.28	1%
Other	0.58	0%
Dental	15.46	6%
Mental Health	5.97	2%
Pharmacy	34.47	14%
Vision	0.76	0%
PCP Capitation	6.33	2%
Non-PCP Capitation	7.40	3%
Subrogation	(0.52)	0%
Reinsurance (Net)	0.70	0%
Total PMPM Costs	**255.12**	**100%**

In 2011, Chartered implemented a targeted cost savings strategy aimed at reducing the number of non-emergent visits to emergency rooms. Primary care practice hours generally do not extend past 6 PM and many providers do not have weekend hours. In addition, prior to mid-2011, the District had no urgent care facilities. The majority of medical emergencies occur during the early evening hours when primary care practices are closed. Without urgent care facilities, Chartered's members are forced to seek emergency medical attention at hospitals.

In 2011, Chartered contracted with a new provider, DC Immediate and Primary Care (DCIPC), which provides expanded service primary and urgent care hours. During 2011, DCIPC opened one office in the District in a strategic location available to Chartered's members with additional offices planned in 2012. Chartered implemented an initiative to inform and encourage its members to take advantage of the services offered instead of hospital emergency rooms. In addition, Chartered contracted with Nurse Response, a 24-hour nurse advice line, to contact members who have used the emergency rooms frequently

in the recent past (but were not admitted for treatment) and to establish a program with each such member to make a nurse available 24 hours a day, and to coordinate the member's emergency needs with their assigned primary care provider.

Thus in 2011, Chartered was able to redirect 57 members who visited the ER more than 11 times in the past year, 395 who visited 6 – 10 times, and 1,792 who visited 3 – 5 times, resulting in a cost avoidance of approximately $2.5M. The projected annual medical cost savings in 2012 is approximately $2M, or $1.75 PMPM.

Chartered will again utilize Nurse Response in 2012 to target a larger group of members who use emergency rooms frequently without presenting conditions that require admittance for treatment.

Pharmacy Costs

In 2011, DHCF began transitioning most Alliance members (referred to as the "774 group" or "774 groups") to Medicaid, to reduce the Alliance related expenditures. A second group of Alliance members (referred to as the "775 group" or "775 population"), whose income was between 133% and 200% of the FPL, was transferred to the Medicaid program on December 1, 2010.

As a result of DHCF actions, primarily changes in the Medicaid eligibility requirements for the "774" and "775" groups, Chartered's Medicaid pharmacy costs increased from $26.71 PMPM in January 2010 to $46.62 PMPM in March 2012. The result of these changes is that Chartered suffered a loss on the Alliance line of business of over $4,000,000 during the August 1, 2010 through July 30, 2011 period in which the unsound rates were in effect.

Medicaid Pharmacy Costs			
	July 2010 - Dec 2010	Jan 2011 - Dec 2011	Jan 2012 - April 2012
Prescription Cost	$ 5,819,511	$ 21,772,575	$ 24,596,796
Member Months - 774/775 Group	103,383	244,226	253,206
Cost per Script	$ 56.29	$ 89.15	$ 97.14

These groups include a large number of members with advanced diseases and co-morbidities requiring high cost drugs and increased numbers of scripts per member. To address the challenges with these members Chartered has undertaken the following proactive measures:

a. In the 3rd quarter of 2011, Chartered implemented a change in its drug formulary to eliminate certain high cost prescription drugs and replace them with a lower cost generic equivalent. Based upon results provided by Caremark, Chartered's Pharmacy Benefits Manager, these measures combined with other pharmacy initiatives discussed below will yield projected annual pharmacy cost savings of $1.8M in 2012.

   In addition, Chartered has implemented a strategic pharmacy savings initiative program in collaboration with its pharmacy consulting partner, Optimity, and its pharmacist consultant, Tecoya Farrakhan. This initiative has a savings potential of $1.9M to and $4.8M, dependent on the successful implementation and actual impact of each item on the initiatives list.

   These initiatives are tracked on a value scorecard which is updated as new information is provided by Chartered's pharmacy director, and as initiatives are implemented and achievements are realized.

   Chartered plans to begin implementing initiatives from June 2012 through January 1, 2013 with the full impact of savings expected to be realized during calendar year 2013; however, some of the initiatives are scheduled for implementation during the 3rd Quarter of 2012. As an initiative is implemented, the scorecard is updated with the most current savings projection. The 2012 budget has a conservative estimated savings of $0.5M.

b. Chartered also has two Federally Qualified Health Centers that they have committed to implement by January 1, 2013 -- a 340B program for Medicaid eligible participants receiving the covered care. The purpose of this program is to take advantage of the savings that safety net providers are entitled to receive, which is about 20% to 50% of the cost of pharmaceutical costs. This program is expected to provide projected annual

medical cost savings of $0.8M for an annual reduction in pharmacy costs in 2013 and $1.5M by 2014.

c. Chartered has negotiated new pharmacy rates for the contract year 2012/2013 which are more favorable; however, they remain in the lower end of the actuarial soundness range. To alleviate some of the financial pressure, DHCF has created a new rate cell for the 775 population that reimburses a MCO at a higher rate for that group.

Hospital Contract Renegotiation

Chartered Health Plan is finalizing a contract with George Washington University Hospital to modify several areas of expenses. The major contract changes are:

a. Reduced case rates for ER services;

b. Adjusting stop loss thresholds within the percent of billed charges; and

c. Lowering the percent of billed charges paid for hospital outpatient services.

The new contract is anticipated to be in place July 1, 2012 with a projected annual medical cost savings in 2012 of $1.0M.

Utilization Management

Chartered is working on additional medical cost savings strategies that are expected to be implemented by July 2012 and that will effectively manage the challenges of providing services to the Medicaid population in the District of Columbia under the District's Medicaid contract. The following case management initiatives are being implemented:

a. Chartered's Case Management Department is aggressively retooling its processes to reduce readmissions and the underlying associated costs. A new team approach process that coordinates Chartered's case management team and hospital care coordinators will assure that there is 7-day transition planning at discharge. The team will target members with readmissions within 30 days of discharge in the top three diagnostic groups:

   i. Complication of pregnancy;

ii. Diseases of the digestive system; and

iii. Diseases of the circulatory system.

The process is based on 58.4 admits per 1,000 admissions in 2011, and Chartered has set a benchmark for 2012 of 4.1 readmits per 1,000 admissions. Chartered is presently at 4.96 readmits per 1,000 admissions. The projected annual medical cost savings is $0.3M, if Chartered meets 19.5% of the 2011 readmission rate.

b. Chartered is also working towards projected annual medical cost savings of $9.2M based on a reduction in bed days per 1,000 admissions (BD/1,000) and 1-Day Admits. Using industry standards, Chartered's goal is to reduce BD/1,000 from 226 BD/1,000 to 200 BD/1,000 and 1-Day admits from 14 to 9.3. Chartered will use Milliman Guidelines as its new utilization management tool and will begin implementation in July 2012 with full operation by January 2013.

c. Case management teams will also assure that all members meeting the criteria for disenrollment will be referred within 30 days. This has a potential savings of $7M to $9M if the Company successfully identifies 90% of the eligible members.

The 2012 Financial Forecast includes a conservative estimate of $2.0M in savings from these utilization management initiatives.

Other Initiatives Not Included in Financial Forecasts

Chartered is working on a number of other cost-saving and reimbursement initiatives for implementation in 2012 that are also expected to have a favorable impact on its operating results and consequently it's TAC. However, to the extent these initiatives have not been implemented or are contingent upon other events occurring, they have not been included in the Financial Forecasts. In addition, other initiatives previously identified and discussed by Chartered have since been re-evaluated and determined not to any have measurable financial value. Those initiatives have also been excluded from the Financial Forecast.

a. Management is in the process of conducting an in-depth analysis of the medical cost of all other major providers, including Unity Healthcare and its FQHC Health Centers. While Chartered does expect to realize some medical cost savings from this initiative in 2012 and future years, Chartered is not at a point where these potential savings can be specifically measured. The following describes these initiatives:

   i. Develop an additional ER Redirection strategy at United Medical Center (UMC) to triage and transfer low acuity patients to the Primary Care Physicians (PCP) practice on-site;

   ii. Share with providers their ER utilization ranking and develop strategies to move those that are at a visit rate greater than .46 to .37.;

   iii. Introduce a clinically-focused conversation, where appropriate, regarding evidence-based management of care.

b. On April 10, 2012, Chartered filed a claim with the District in the amount $25.8M for the 2010-2011 Contract for pharmacy losses incurred October 31, 2011 through April 30, 2012. Chartered has requested that the District review the Contract's pharmacy rates and make a rate adjustment for the 2010-2011 Contract year. Because this process is contingent upon a resolution with the District, no determination can be made on the timing, funding of a resolution and/or corresponding receivable, and therefore, is not included in the Financial Forecast.

STRATEGIC RE-DESIGN OF CHARTERED'S MANAGEMENT TEAM AND BOARD OF DIRECTORS

In light of the various financial issues facing Chartered a strategic re-design of Chartered's management team and Board of Directors is also underway. This initiative is designed to address more effectively the challenges of providing services to the Medicaid population in the District of Columbia under the District's Medicaid contract. Chartered's believes that in addition to the financial initiatives already underway this initiative will assure that Chartered is a more viable and profitable Medicaid HMO entity in the future. Some of the key managerial and Board changes are identified below:

The Company is currently managed by Mr. Maynard G. McAlpin who assumed the role of President and CEO in 2011 after the 2010 passing of Mr. Gabriel J. Hanna, Chartered's former President, and CEO. Mr. McAlpin has over 17 years of diverse management experience in the health care industry across commercial and government programs such as Medicaid and the Federal Employee Program. He has held numerous executive positions including:

- Managing Director of Enterprise Strategy for Aetna;
- Executive Director of CareFirst BCBS National Capital Area affiliate (Greater Washington DC metro region); and
- Vice President of Strategic Planning for CareFirst where he was responsible for the development and monitoring of CareFirst's Long-Term and Annual Integrated Business Plans,
- Mr. McAlpin also served in a matrixed role in the Operations division as Director of Business Operations Support at CareFirst, supporting all lines of commercial and government segments.

Mr. David D. Wolf is now Chartered's new Board Chairman effective April 13, 2012. Mr. Wolf is a retired health insurance executive who previously served as:

- Interim President and Chief Executive Officer of CareFirst BCBS;
- Executive Vice President, Medical Systems and Corporate Development of CareFirst BCBS;
- Chief Operating Officer of BCBS Maryland (BCBSMD) where he directed overall operations of the company including Managed Care and Indemnity Operations, Information Technology, Finance, Human Resources, Medical Affairs, and Physician Networks;
- Senior Vice President of Managed Care and Chief Financial Officer of BCBSMD; and
- Vice President of Administration and Executive Director for Chesapeake Physicians (CPPA), an independent academic medical group practice of 140 physicians, and chief financial officer of CPPA's professional liability insurance company.

The Company has also added additional management staff and Board members, each with considerable managed-care experience and background:

- Dr. Sharol Lewis, new Medical Director, formerly with Horizon BCBS;
- Mr. Parminder Singh Sethi, new CIO, formerly with CareFirst BCBS; and
- Mr. Livio Broccolino, new Board member, formerly Vice President and Deputy General Counsel for CareFirst BCBS.

FINANCIAL FORECASTS

Overall, with the forecasted 2012 operating results and the successful implementation of the initiatives identified above, Chartered's ACL RBC ratio will improve significantly during 2013. Chartered is providing 2011 current year, and three additional years of statutory forecasts of the Company's:

- Financial Position
- Operating Results
- Capital and Surplus Position
- Cash Flow

- Underlying Assumptions for each Forecast

PRO-FORMA STATEMENT OF REVENUE AND EXPENSES

The Three-Year Statutory Statement of Revenue and Expenses Forecast ("Operating Results Forecast") has a number of key assumptions that are addressed later; however some key assumptions that are inherent in this Forecast include:

Chartered assumes that with the new Medicaid contract being awarded to a new additional MCO, approximately 18,000 of its members will be lost during October 2012.

The Forecast does not include "annual fees" to be assessed against health insurers under Sec. 9010 of the Affordable Care Act (ACA). Chartered believes that CMS intends to compensate government funded plans to cover this additional assessment beginning in 2014.

The Operating Results Forecast posits an underwriting gain of $7.8M, $6.0M and $5.0M, in 2012, 2013, and 2014, respectively. The underwriting gains are driven by a reduction in medical costs in 2012 on a PMPM basis, except for pharmacy, ambulance, dental, and vision costs. As a result of cost-savings measures implemented in medical management and other cost initiatives, the medical cost ratio is expected to decrease from 95.83% to 87.6% in 2011 through 2014.

The primary drivers behind the administrative expenses increases are salaries, consulting fees, and equipment rental. Administrative expenses are forecast to increase from $28.65 PMPM in 2012, to approximately $32.52 PMPM in 2012 through 2014. The increase in administrative expenses on a per member per month basis is from an expected decrease in membership of approximately 18,000 members from 2011 to 2014. Investment income is expected to increase marginally as positive cash flow is translated in additional invested assets from projected net income.

Statutory Financials (Pro-forma P&L)				
('000)	2011 - Actual	2012	2013	2014
Member Months	1,325	1,255	1,105	1,105
Revenues				
Net Premium Income - Medicaid	328,574	343,689	302,072	311,822
Net Premium Income - Alliance Program	26,924	21,058	16,849	17,393
Net Premium Income	**$ 355,499**	**$ 364,747**	**$ 318,921**	**$ 329,215**
Hospital and Medical				
Incurred Clams - Medicaid	317,170	304,872	263,282	273,858
Incurred Clams - Alliance Program	23,506	15,287	13,907	14,447
Total Hospital and Medical	**340,676**	**320,159**	**277,189**	**288,306**
Total Administrative Expenses	**37,966**	**36,808**	**35,728**	**35,921**
Underwriting Gain or (Loss)	**(23,144)**	**7,779**	**6,004**	**4,988**
Net investment income	432	637	714	866
Other Gain or (Loss)	6,788	-	-	-
Net gain before federal income taxes	**(15,923)**	**8,416**	**6,718**	**5,854**
Federal Income Taxes Incurred	**(961)**	**2,946**	**2,351**	**2,049**
Net income	**$ (14,963)**	**$ 5,471**	**$ 4,367**	**$ 3,805**

PRO-FORMA CASH FLOW

Chartered forecasts positive cash flow from 2011 through 2014 resulting primarily from:

- A reduction in medical cost as a percentage of premium revenue; and
- Issuance of a $5M surplus note for cash.

Chartered's investment policy continues to invest in CDARs and thus the Company does not generate realized capital gains or losses from investments.

The Three-Year Statutory Cash Flow Statement forecasts Chartered generating a target premium collected of $365M in 2012, with a net cash inflow from operations of $4.0M. In

addition, Chartered anticipates contributed surplus in the form of a $5M surplus note of in 2012.

Cash Flow Statement				
('000)	2011 - Actual	2012	2013	2014
Cash from operations				
Premium	355,160	364,551	319,890	328,997
Investment Income	303	371	716	870
Benefits and related payments	(334,228)	(324,136)	(276,617)	(287,424)
Administrative Expenses	(31,309)	(36,731)	(36,696)	(35,703)
Federal income taxes paid	269	-	-	(3,286)
Net cash from operations	**(9,805)**	**4,054**	**7,294**	**3,454**
Cash from investments				
Proceeds from investments	4,418	-	-	-
Cost of investments acquired	(5,390)	-	-	-
Net cash from investments	**(972)**	-	-	-
Cash from Financing Activities				
Surplus paid-in	-	5,000	-	-
Other cash provided (applied)	927	-	-	-
Net cash from Financing Activities	**927**	**5,000**	-	-
Net cash position				
Opening balance	**28,805**	**18,955**	**28,009**	**35,303**
Change in cash	(9,850)	9,054	7,294	3,454
Closing balance	**$ 18,955**	**$ 28,009**	**$ 35,303**	**$ 38,757**

PRO-FORMA BALANCE SHEET

The Three-Year Pro-forma Balance Sheet forecast presents a conservative balance sheet with invested assets comprising approximately 86.5% of admitted assets by the end of 2014. Invested assets increase each year as Chartered generates positive cash flow. Other admitted assets are estimated based on prior period amounts adjusted for changes in premiums and other income statement amounts. Liabilities are comprised primarily of the unpaid claim and unpaid claim adjustment reserves and premium tax accrual.

The Forecasted Capital and Surplus Position is supported primarily by:

- Net income;
- Contributed surplus in the form of the building located at 1025 15th Street NW; and
- Issuance of a $5M surplus note.

In order to address the immediate capital and surplus needs of the Company, Chartered is in the process of negotiating the issuance of surplus notes in the amount of at least $5M, and receiving the building occupied by Chartered as contributed surplus that would be valued at approximate $4M net of the outstanding mortgage.

The Surplus Notes have the following key provisions which are contingent upon approval by the DISB:

- Receipt of the monies from investor to Chartered within 10 days of execution of Agreement;
- Interest at a rate of 7%;
- Payment of interest is contingent on Chartered having RBC of at least 275%; and
- Repayment of principal is contingent on Chartered having RBC of at least 325%.

Throughout the forecast period Chartered's capital and surplus are expected to increase. In addition, forecasted RBC results and other key financial indicators over the three year forecast period will eventually meet and exceed minimum standards.

Statutory Financials (Pro-forma Balance Sheet)

('000)	2011 - Actual	2012	2013	2014
Assets				
Beginning Cash and Bonds Balance	32,071	32,071	41,126	48,419
Change in Cash and Bonds	-	9,054	7,294	3,454
Ending Cash and Bonds Balance	32,071	41,126	48,419	51,873
Real Estate		4,025	3,978	3,943
Investment Income	284	18	20	24
Uncollected Premiums	7,518	7,713	6,744	6,962
Reinsurance Recoverables	274	257	223	232
Federal Income Tax Recoverable	4,060	1,114		-
EDP Equipment	384	50	100	125
Receivables from PSA	-	4	6	7
Health Care Receivables	3,067	2,454	1,963	1,570
Ending Non-Invested Asset Balance	15,587	15,635	13,033	12,863
Total Admitted Assets	**$ 47,658**	**$ 56,761**	**$ 61,452**	**$ 64,736**
Liabilities				
Claims Unpaid	37,996	31,635	31,635	31,635
Unpaid Claims Adjustment Expense	708	589	589	589
Federal Income Tax Payable			1,237	
Other Liabilities	7,513	7,708	6,740	6,957
Total Liabilities	**46,216**	**39,932**	**40,201**	**39,181**
Capital and Surplus				
Beginning Capital & Surplus	**17,445**	**1,442**	**16,829**	**21,252**
Net income	(14,963)	5,471	4,367	3,805
Change in deferred tax asset	(3,320)	-	-	
Change in non-admitted assets	2,281	863	56	498
Additional Contributed Surplus		4,053		
Change in Surplus Note	-	5,000		
Aggregate Write-ins	(1)	-	-	-
Net change in capital and surplus	**(16,003)**	**15,387**	**4,423**	**4,303**
Closing Capital & Surplus	1,442	16,829	21,252	25,555
Liability & Capital & Surplus	**$ 47,658**	**$ 56,761**	**$ 61,452**	**$ 64,736**

PRO-FORMA RISK-BASED CAPITAL

The Three-Year Pro-forma Risk Based Capital forecast results show Chartered exceeding the CAL by 2014, as TAC increases as a result of positive operating results and infused surplus. Throughout the forecast period, Chartered's TAC increases. Off-balance sheet risk remains constant over the forecast period; and asset risk increases as invested assets increase with additional investments derived from positive cash flows and contributed real estate. Underwriting risk is driven by the change in premium volume and medical costs and business risk remains constant over the forecast period. The main driver of risk based capital requirements is the underwriting risk. Since medical costs are expected to decrease substantially in 2013 from the decrease in membership and the removal of the HIV/AIDS drug costs, Chartered projects a 13% decrease in underwriting risk from 2012 to 2013.

Risk-Based Capital Projections

Risk Category	2011	2012	2013	2014
H0 - Asset Risk - Off-Balance Sheet	142,704	142,704	142,704	142,704
H1 - Asset Risk - Other	234,511	1,314,699	1,324,375	1,311,497
H2 - Underwriting Risk	27,723,571	26,069,434	22,800,499	23,726,026
H3 - Credit Risk	429,556	388,376	325,137	314,364
H4 - Business Risk	1,293,583	1,239,565	1,232,665	1,232,142
RBC Before Covariance	29,823,925	29,154,778	25,825,380	26,726,733
RBC After Covariance	27,900,753	26,277,569	23,017,185	23,938,950
Authorized Control Level RBC	$ 13,950,377	$ 13,138,785	$ 11,508,593	$ 11,969,475
Total Adjusted Capital	$ 1,441,940	$ 16,828,792	$ 21,251,561	$ 25,554,711
RBC Ratio	**10.3%**	**128.1%**	**184.7%**	**213.5%**

FINANCIAL PROJECTION ASSUMPTIONS

The data presented in the financial projections are based upon the best evidence available as of this date and on management's reasonable business judgment. Where cost reductions are expected to be realized, such estimates reflect conservatism. Expected revenues are

based on contracted revenues which Chartered anticipates will continue throughout the projection period.

REVENUE

Chartered's Medicaid membership is expected to decrease by nearly 13,400 members in 2011, primarily as a result of a new contract awarded to a third MCO and the distribution of a portion of Chartered's members to the third MCO. Chartered's Medicaid membership is projected to remain the same in 2013 and in 2014, as it is in year-end 2012.

Chartered's Alliance membership is expected to decrease by about 5,300, as a result of the additional MCO participation in the District's Medicaid program. Membership in 2013 and 2014 is projected to remain steady throughout these years.

The revenue capitation rates beginning May 2012, are based off of the figures in request for proposals DHCF-2012-R-0003, and are expected to increase by 3.7% in May 2013 and May 2014, based on the contract terms.

In addition, Chartered received notice from the District of its intention to obtain approval for a waiver from the Centers for Medicare and Medicaid Services establishing the "Medicaid 1915(b) Distribution and Dispensing of Antiretroviral and HIV related Medications Program." The new waiver will authorize the DHCF to contract with the DC Department of Health's (DOH) HIV/AIDS, Hepatitis, STD and TB Administration to dispense anti-retroviral and other HIV medications. This means that HIV/AIDS drugs, and their associated costs, will be carved out of Medicaid managed care. DHCF is anticipating that the carve out will be implemented on or about January 1, 2013. As a result, the Company has removed the revenue and related expenses of this carve out from its projections beginning January 1, 2013.

The Medicaid capitation rate is projected to average $308.62 PMPM beginning in May 2012. This will decrease from the HIV/AIDS drug carve out to an average of $289.39 PMPM in January 2013. The Medicaid capitation rate is then expected to increase to an average of

$300.10 PMPM in May 2013 and then increase to an average of $309.10 PMPM in May 2014. The Alliance capitation rate is projected to average $193.01 PMPM in May 2012 and increase to an average of $198.72 PMPM in May 2013 and then increase to an average of $204.68 PMPM in May 2014.

MEDICAL COSTS

Medical costs in 2012 are expected to decrease on a PMPM basis compared to 2011, except for pharmacy, ambulance, dental, and vision costs. As a result of cost-savings measures outlined in the initiatives implemented, the medical cost ratio is expected remain relatively constant at 87.78% in 2012 and to 87.1% into 2014.

The average medical inflation within the forecast is anticipated to be 3.7% which mirrors the DC Metro Medical inflation trend over the past four years. In addition the forecast anticipates an 8% medical inflation in prescription drugs every year, and 8% inflation in 2013 for physician claims. The higher anticipated physician claims is due to payments in primary care physician fee schedules moving from the current Medicaid levels to 100% of Medicare beginning in 2013.

GENERAL & ADMINISTRATIVE (G&A) EXPENSES

General Administrative expenses excluding the 2% premium taxes incurred are expected to be at a lean 8% of premium revenue in 2012 and increase slightly to 9.2% of premium revenue in 2013. The increase in the percentage is a result of the anticipated decrease in revenue from the drop in membership and removal of the HIV/AIDS drug carve out. The administrative expenses will remain flat through 2014.

IDENTIFY THE QUALITY OF AND PROBLEMS ASSOCIATED WITH DC CHARTERED'S BUSINESS

DC CHARTERED'S BUSINESS MODEL

Chartered is a 25 year old, locally owned, and operated HMO employing 172 people, 25% of whom are residents of the District of Columbia. The majority of our employees are single mothers of African-American descent.

Chartered generates operating revenues solely from its contract with the DHCF under which Chartered provides health insurance services to the District's Medicaid and Alliance Program members. Premium rates for these services are established actuarially through the DHCF on a prepaid, contractual basis. The contract with DHCF has a five-year term with annual rate adjustments.

Chartered has contracts with providers on a capitated and contractual fee basis to provide medical care to its members. Consequently, unexpected medical costs, as well as adverse administrative expense trends, ultimately affect Chartered's underwriting results, its surplus base, and RBC Ratio. To offset adverse medical and administrative expense trends that negatively impact these core principles, Chartered seeks to build it surplus base with liquid and diverse investments, as well as maintain adequate reserves for unpaid claims and other administrative expenses.

Despite its operating results in recent years, Chartered believes it business model remains viable and that Chartered's core business practices will enable the Company to both recover loss surplus and reestablish an appropriate RBC Ratio.

ASSET BASE

Chartered's total admitted assets decreased from $59.7M to $47.6M during 2011, including a decrease in invested assets from $40.9M to $32.1M (see table below). Chartered's asset base decreased across all asset lines, with invested assets representing the most significant

decrease. Further, Chartered took a complete valuation allowance against its net deferred tax assets. Other asset balances remained constant for the most part during the year.

Asset Base				
	2011	**2010**	**$ Chg**	**% Chg**
Long-Term Invested Assets	13,116,327	12,144,079	972,248	8.0%
Cash and Other Short-Term Invested Ass	18,955,149	28,805,282	(9,850,133)	-34.2%
Ending Invested Asset Balance	32,071,476	40,949,361	(8,877,885)	-21.7%
Investment Income	284,351	155,428	128,923	82.9%
Uncollected Premiums	7,517,582	7,859,616	(342,034)	-4.4%
Reinsurance Recoverables	273,685	157,939	115,746	73.3%
Federal Income Tax Recoverables	4,059,917	4,329,303	(269,386)	-6.2%
Deferred tax asset	-	2,601,280	(2,601,280)	-100.0%
EDP Equipment	384,261	75,401	308,860	409.6%
Receivables from PSA	-	3,059	(3,059)	-100.0%
Health Care Receivables	3,066,962	3,365,781	(298,819)	-8.9%
Aggregate Write-Ins	-	158,516	(158,516)	-100.0%
Ending Non-Invested Asset Balance	15,586,758	18,706,323	(3,119,565)	-16.7%
Total Admitted Assets	**$ 47,658,234**	**$ 59,655,684**	$(11,997,450)	-20.1%

Chartered's investment strategy is to provide "taxable cash management" which is derived to provide the following key objectives:

1. Maximize investment income, maintain adequate cash flow, and provide financial stability, subject to a limited risk tolerance.
2. Obtain favorable risk adjusted investment returns to achieve long-term growth of policyholder surplus to enhance the Company's position.
3. Match the cash flow/maturity of investments to the Company's anticipated liability stream.
4. Preserve capital. If the Company's financial strength deteriorates to the point that the Chartered could not withstand even a small loss on the portfolio, then the investment

objective becomes capital preservation. A capital preservation objective will be considered an interim measure until the Company's financial strength returns.

Chartered's investment strategy is designed to conform to D.C. Regulation Title 26, Chapter 31, Investment Guidelines for Health Maintenance Organizations. The strategy for the management of Chartered's investments includes guidelines and controls that are designed to conform to the District's insurance regulatory requirements and to provide a means to evaluate the individual investment transactions for their effectiveness within the plan.

However, this investment strategy, along with the overall decline in investment returns on all securities, has contributed to a decrease in Chartered's overall return on investment income (see Table 8). Currently, the majority of Chartered's investment portfolio consists of CDARs (Certificates of Deposits Registry Service) which are reported as either long-term bonds (CDs with a maturity greater than one-year) or cash (CDs with a maturity date less than one-year). CDARS facilitates the placement of deposits with various insured financial institutions, and deposits are insured up to $250,000 with the Federal Deposit Insurance Corporation. Chartered utilizes CDARs to meet limitations on investments in a single bank or issuer as prescribed by the District's investment statutes for HMOs. Based on a directive from the Board of Directors to diversify and comply with the District's investment statutes for HMOs, Chartered began this initiative in 2007.

However, the investment yield on CDARs is much lower than other investment vehicles. Consequently, as Chartered moves to diversify its portfolio in accordance with the District's investment statutes for HMOs, this strategy, along with fewer invested assets, has contributed to a decrease in Chartered's overall return on invested assets.

Investment Gain Table 8						
Year	**2011**	**2010**	**2009**	**2008**	**2007**	**2006**
Investment Gain	$ 432,338	$ 766,821	$ 1,081,313	$ 1,330,369	$ 2,153,488	$ 1,834,191
$ Change	$ (334,483)	$ (314,492)	$ (249,056)	$ (823,119)	$ 319,297	
% Change	-43.6%	-29.1%	-18.7%	-38.2%	17.4%	

This investment strategy is included in Chartered's forecast for 2012 and subsequent years. As noted in the forecast, Chartered expects liquid assets, comprised primarily of invested assets and uncollected premiums from the DHCF, to grow from 67.3% in 2011 to 87.1% in 2012 of total admitted assets due to:

1. An increase in invested assets resulting from operational cash flows approximating $23.5M; and
2. Collection of and consequently, a reduction in federal income tax recoverables, healthcare receivables, and receivables from parent, subsidiaries, and affiliates.

The quality of Chartered's admitted assets is considered sufficient to meet Chartered's current and emerging liabilities, which consist primarily of unpaid claims. As noted in Table 9 below, Chartered expects to increase liquid assets with the collection of other non-liquid receivables. This will increase Chartered's liquidity ratio as also noted below.

Forecasted Asset Distribution

Table 9

	2011 - Actual		2012		2013		2014	
	$ Amount	%	$ Amount	%	$ Amount	%	$ Amount	%
Invested Assets	32,071	67.3%	26,407	59.1%	51,615	85.1%	59,642	87.1%
Investment Income	284	0.6%	392	0.9%	20	0.0%	24	0.0%
Uncollected Premiums	7,518	15.8%	7,444	16.6%	6,713	11.1%	6,915	10.1%
Reinsurance Recoverables	274	0.6%	610	1.4%	222	0.4%	224	0.3%
Federal Income Tax Recoverables	4,060	8.5%	3,166	7.1%	-	0.0%	-	0.0%
Deferred tax asset	-	0.0%	-	0.0%	-	0.0%	-	0.0%
EDP Equipment	384	0.8%	32	0.1%	100	0.2%	125	0.2%
Receivables from PSA	-	0.0%	-	0.0%	6	0.0%	7	0.0%
Health Care Receivables	3,067	6.4%	6,657	14.9%	1,963	3.2%	1,570	2.3%
Aggregate Write-Ins	-	0.0%	-	0.0%	-	0.0%	-	0.0%
Total Admitted Assets	**$47,658**	**100.0%**	**$44,708**	**100.0%**	**$60,639**	100.0%	**$68,507**	100.0%
Total Current Liabilities	**$46,216**	**100.0%**	**$63,009**	**100.0%**	**$39,896**	**100.0%**	**$39,134**	**100%**
Liquidity Ratio	**1.03**		**0.71**		**1.52**		**1.75**	

ANTICIPATED BUSINESS GROWTH AND ASSOCIATED SURPLUS STRAIN

Since 2007, Chartered's membership has grown from 63,309 to 110,550 in 2011 -- a rate of approximately 15% per year (78% from the period 1/1/2007 – 12/31/2010). This rate has grown as a result of more Medicaid members and a loss of other MCOs operating in the District. Going forward, the Three-Year Statutory Forecast assumes a reduction of approximately 18,000 members beginning October 2012. The Forecast assumes that DHCF will award a Medicaid contract to a new MCO in 2012 and members currently enrolled with Chartered will migrate to the new MCO. In addition, Chartered believes that based on its anticipated surplus and RBC positions, its membership should not exceed 60% of the total Medicaid population in the District. Consequently, a key strategic objective will be to maintain membership at a level that is consistent with its Surplus and RBC position. The reduction in membership will provide two primary benefits to Chartered:

1. An anticipated decrease in medical costs resulting from a reduction in members with higher utilization than the average member; and
2. Achieving an optimal membership level consistent with the Company's projected surplus and RBC position.

Enrollment (Actual and Forecasts)

Table 10

	Forecasted			Actual				
Year	**2014**	**2013**	**2012**	**2011**	**2010**	**2009**	**2008**	**2007**
Members	92,042	92,042	104,610	110,550	110,184	88,407	80,923	63,309
% Growth	0.0%	-12.0%	-5.4%	0.3%	24.6%	9.2%	27.8%	XXX

MIX OF BUSINESS

Chartered generates operating insurance revenues solely from its contract with the DHCF. Chartered is currently in the process of responding to the DHCF's new proposal for award of the District's Medicaid contract for the period 2012 through 2017. Chartered expects to

continue as a Medicaid MCO in the District and does not plan to expand into other lines of business.

EXTRAORDINARY EXPOSURE TO RISK

Being a monoline company, lacking the benefit of multi-line insurance diversification, Chartered must generate additional surplus from its net earnings to insure against catastrophic risk. Catastrophic risk for Chartered is primarily manifested from poor underwriting results and inadequate rates. While Chartered seeks to manage its underwriting risk with various provider contracts, it also works aggressively with DHCF to ensure that the actuarially determined rates are based on current levels of utilization and proper medical costs trends, and that these rates are sufficient to pay the medical benefits required under the contract.

To the extent these rates historically have not been actuarially sound, Chartered has initiated two administrative proceedings with the District's Office of Contracting and Procurement. Chartered filed the first action in 2010 regarding an overpayment of Salazar court-mandated dental benefits costs to members above the dental capitation rate paid under the DHCF contract. This proceeding ultimately was settled in September 2011, when the District, with the approval of the Centers for Medicare & Medicaid Services, refunded Chartered $7.5M.

Chartered initiated a similar appeals with the District in 2011 regarding certain pharmacy benefits under the contract, which Charted believes are actuarially unsound. Chartered requested that the District review the Contract's pharmacy rates and make a rate adjustment for the 2010-2011 contract year in the amount of $25.8M for pharmacy benefit losses incurred through October 31, 2011 and projected through April 30, 2012.

Both appeals by Chartered, demonstrate a pattern of DHCF rates that appear to be actuarially unsound related to the contractual benefits required to be provided by Chartered.

REINSURANCE

Chartered maintains an "HMO Specific Excess Loss Reinsurance Agreement" with Zurich American Insurance Company. The Reinsurance Agreement covers:

- Hospital inpatient services – acute care services;
- Skilled nursing facility services at "hospital for sick children" only (Children's National Medical Center); and
- Continuation of coverage in the event of insolvency (maximum aggregate continuation limit of $3M.

The Reinsurance Agreement also provides for an experience refund based on positive experience. The Reinsurance Agreement has the following key provisions:

- Specific Deductible per Covered Person: $300,000
- Maximum Payable per Covered Person: $2,000,000
- Maximum Aggregate Limit Of Company's Liability: Not Applicable

Covered Expenses - Exclude:

Hospital Inpatient Services - Sub-Acute Care Services (extended care services, skilled nursing, rehabilitation), Sub-Acute Care Facility Services/Extended Care Facility Services/Rehabilitation Facility Services/Skilled Nursing Facility Services (except as noted above)/Home Health Care Services, Long Term Acute Care Facility Services, Hospital Outpatient Services, Professional/Physician Services, all organ and tissue transplant related services, retail prescription drugs, capitated arrangements and services that are not eligible under the Membership Services Agreement.

Covered Expenses - Limits:

Hospital Inpatient Services - Acute Care Services: the lesser of the amount Paid or the contracted rate provided to Presidio Excess Insurance Services, Inc. ("Presidio") on behalf of the Company on August 31, 2011.

Skilled Nursing Facility services at "Hospital for Sick Children" only: the lesser of the amount Paid or the contracted rate provided to "Presidio" on behalf of the Company on August 31, 2011 and subject to a maximum stay of 45 days per Covered Person per Agreement Term.

EXHIBIT 5

CHARTERED
HEALTH·PLAN

April 12, 2012

By Email and Hand Delivery

William P. White
Commissioner for Insurance
Government of the District of Columbia
Department of Insurance, Securities and Banking
810 1st Street, N.E.
Washington, DC 20002

RE: David Wolf

Dear Commissioner White:

DC Chartered Health Plan, Inc. is pleased to announce that Mr. David Wolf has joined our Board of Directors and has assumed the role of Chairman after Mr. Jeffrey E. Thompson stepped down from that position last Friday. I have enclosed a copy of Mr. Wolf's resume. From his resume, you will note that Mr. Wolf has extensive experience in the health insurance arena, much of it in the regional market. I hope that I will shortly have the opportunity to introduce Mr. Wolf to you personally.

Sincerely,

Maynard McAlpin

Maynard G. McAlpin,
President and CEO

Enclosure

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Sparrows Pt., MD 21219

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David Wolf

Career Summary

Strategic-oriented health care executive with a record of developing and implementing long range strategic plans through numerous acquisitions and mergers as well as building start-up and turn-around companies into successful enterprises. In addition to managing a variety of numerous operating functions, led several companies through changing environments and highly competitive markets. A proven track record of leading change while achieving fiscal goals by developing strategic relationships and creative financial arrangements. Management style promotes teambuilding while maintaining accountability.

Education

Master of Business Administration-Finance, Loyola College
Sellinger School of Business, 1976

Bachelor of Arts-Accounting, Loyola College, Baltimore Md, 1972
Accounting Medal, 1972

Professional Experience

BUSINESS CONSULTANT — Present

Since retiring in May, 2010, working with several organizations of various sizes to evaluate different business options and opportunities. In addition, working on several personal real estate ventures.

CAREFIRST BLUECROSS BLUESHIELD, Owings Mills, Md. — 1998-2010

Executive Vice President Corporate Development and Medical Affairs.
Reporting to CEO responsible for medical management, network management, HMO subsidiaries, owned medical groups, mergers, acquisitions, affiliations, and long-range strategic planning.

Accomplishments:

-Served as Interim CEO and President from November 2006 until December 2007 with significant membership growth and record levels of profitability.

-Led the developing and execution of long range strategic plan;

-Transitioned managed care philosophy from capitation to fee-for-service model while maintaining enrollment growth and profitability targets in multiple jurisdictions.

Some Initiatives Supporting these outcomes included:

-Negotiation and integration of National Capital Blue Cross with Maryland Blue Cross.
-Negotiation of definitive agreements between Carefirst and Delaware Blue Cross.
-Negotiation of definitive agreements between Carefirst and Wellpoint.
Built medical management organization to support NCQA accredited PPO and HMO programs.
-Led development of disease management and case management programs.
-Repositioned owned medical groups with over 100 physicians from capitated to fee-for-service oriented groups with over $30 million in annual revenue.
-Led contracting effort for Rx and Mental Health vendors resulting in cost savings and service improvements.
-Led selection, development, and implementation of several technology solutions to improve medical information and management efficiency.

BLUECROSS/BLUESHIELD OF MARYLAND, Owings Mills Md. 1994-1998

Chief Operating Officer

Reporting to CEO, responsible for all functional areas except marketing and sales.

Accomplishments:

-Led turnaround of organization from near bankruptcy to financial stability.
-Improved service scores from bottom of Blue Cross plans to top quartile'

Initiatives supporting these outcomes included:

-Sold several underperforming subsidiaries to raise $50 million of capital.
-Developed financial reporting and management system to manage enterprise through growth phase.
-Led cultural change to reward achievement of goals and objectives.
-Led financial turnaround of HMO's through consolidation of operating subsidiaries and provider contracting.

FREESTATE HEALTH PLAN 1991-1993

President and CEO

-Led turnaround of HMO losing $2 million per month to breakeven within 6 months.
Led integration of two health plans into a profitable freestanding subsidiary.
-Led acquisition and integration of 20,000 member plan.

CAREFIRST, INC. 1985-1991

President and CEO

-Grew venture-backed HMO from 3900 members to over 100,000 members including two acquisitions.
-Successfully negotiated sale to Blue Cross Blue Shield of Maryland.

CHESAPEAKE PHYSICIANS, PA 1977-1985

Executive Director

-Led growth of independent academic multi-specialty medical group from 55 to over 100 physicians.
-Expanded fee-for-service and alternative funding service agreements.

COOPERS AND LYBRAND 1972-1977

Audit Manager

-Healthcare and insurance specialist
-Promoted to manager within 4 years.

Board Involvement

Sellinger School of Business, Loyola College
Board of Sponsors, Past Chairman

University of Maryland, School of Nursing, Past Board of Advisors

Licensures

Certified Public Accountant, Maryland 1972

Personal

Baltimore Native Married, 36 years

Exhibit 6

VITA

Daniel L. Watkins
Attorney at Law
901 New Hampshire Ste 200
Lawrence, KS 66044
785-843-0181 (o) 785-749-5652 (fax)
785-979-2518 (cell)

PERSONAL
Born September 2, 1947
Married to Phyllis Meitl Watkins
643 Indiana
Lawrence, KS 66044

EDUCATION

University of Kansas, Juris Doctor, 1975
St. Mary of the Plains College, Bachelor of Arts, Mathematics, 1969

EMPLOYMENT EXPERIENCE

Attorney at Law: Private Practice, Lawrence, Kansas, 1987-Present
Insurance Supervision/Receivership, 1997-Present
Vice President, Foresight Resources Corp., Lawrence, Kansas, 1984-1986

Government Service/Practice

Chief Counsel and Special Assistant to the Secretary of Transportation, State of Kansas, 1980-1984
Chief Administrative Assistant to the Governor of Kansas, 1979-1980
Assistant Attorney General, Criminal Division, State of Kansas, 1975-1978, Division Chief 1977-1978
VISTA Volunteer and VISTA Supervisor (Volunteers in Service to America), Broward County, Florida, 1969- 1972

CIVIC/PROFESSIONAL ACTIVITIES

Member, American, Kansas and Douglas County Bar Associations
Certified Insurance Receiver-Multiple Lines, International Association of Insurance Receivers, 2001-Present; Member, Board of Directors, 2003-2009, Member and Past Chair Accreditation and Ethics Committee
Chair, Kansas Bioscience Authority, 2010-present
Board Member, Mid-America MS Society, 2009-Present
Past Chair, Board Member, Kansas Development Finance Authority, 2003-2010
Treasurer, Kansas Inaugurals, 2003 and 2007
Past Chair, Board of Directors, Bert Nash Community Mental Health Center, 1986-1992
Past Chair, Bert Nash Community Mental Health Center Endowment Board, 1998-2002
Past Chair, Board of Directors, Friends of the Lied Series (Performing Arts), University of Kansas, 1996-1998
Past Chair, Board of Directors, Lawrence Chamber of Commerce, 1990-1996
Trustee, Overland Park Regional Medical Center, Overland Park, Kansas, 1997-1998
Board of Trustees, St. John's School Development/Endowment Fund, Lawrence, Kansas, 1989-1995
Board of Directors, Union Pacific Depot Restoration, Lawrence, Kansas, 1990-1997

CAREER SYNOPSIS

Currently represent regional and national clients in business matters and governmental affairs and have specialized since 1997 in the management of financially troubled insurance companies.

Insurance Company Supervision/Receivership

Served as Special Examiner, Supervisor, Rehabilitator and/or Liquidator for numerous financially troubled insurance companies. Coordinate troubled company activities with Insurance Department Commissioners, Chief Counsels and Chief Financial Examiners and work closely with outside counsel, NOLHGA, State Guaranty Associations and other professionals in managing affairs of financially troubled insurance companies. Designated as a Certified Insurance Receiver-Multiple Lines by the International Association of Insurance Receivers.

Governmental Practice

Served as Chief Counsel and special Assistant to the Kansas Secretary of Transportation from 1980-1984. Managed a staff of attorneys, coordinated activities of outside counsel and served as a key member of the Secretary's executive committee which managed and reorganized the agency of over 3000 employees.

Responsibilities included: tort claims/personal injury actions, eminent domain proceedings, contract preparation and review, construction claims and administrative actions. Represented Kansas at the Interstate Commerce Commission in the Union Pacific/Missouri Pacific Railroad merger; directed the settlement of state and county tax claims and other creditor claims in the Rock Island Railroad Bankruptcy; and assisted U. S. Attorney in investigating and taking administrative and criminal action against Kansas highway contractors involved in bid rigging.

Chief Administrative Assistant to the Governor of Kansas

Served as Governor's Chief Administrative Assistant, working with cabinet officials on the Governor's agenda and serving with the Secretary of Administration, Press Secretary, Policy Director and Legislative Liaison as Executive Committee in coordinating the Governor's management of state government.

Kansas Attorney General's Office

Served as Assistant Attorney General in the Criminal Division. Responsible for research and writing of legal opinions on criminal law and procedure; assisted county and district attorneys as a special prosecutor; reviewed and argued appeals to the Kansas Supreme Court; reviewed extraditions; investigated allegations of official misconduct; represented the Kansas Highway Patrol and advised the Director of the Kansas Bureau of Investigation.

OTHER EMPLOYMENT

Director and Vice President of Foresight Resources Corp.

Helped found Foresight Resources Corp., a software development and marketing company. Responsible for securing venture capital investment in the company. Foresight developed computer aided design software products. **drafix 1** gained a niche in the worldwide microCAD market and was ultimately sold to Autodesk.

VISTA

After receiving a degree in mathematics from St. Mary of the Plains College, served a year as a VISTA (Volunteers in Service to America) Volunteer in Broward County, Florida. Selected by the sponsoring agency as Project Supervisor for 35 VISTA Volunteers in 13 Broward County communities, serving for two years following initial year of VISTA service.

Daniel L. Watkins
Statement of Qualifications and Experience

Special Assignments

HMO

In 2012 appointed Special Examiner of a financially troubled Medicaid HMO with $350 Million in annual premium. Leading a strategic assessment for Commissioner. Additional information not publicly available.

Brooke

In May, 2011, prepared an Expert Report in litigation between Robert D. Orr and Albert A. Reiderer (Special Master of the Brooke Entities' interdependent insurance franchising businesses). In the United States District Court for the District of Kansas at Wichita, Case No. 6:10-CV-01303-CM-JPO, opining on whether Mr. Reiderer's conduct as Special Master met the Standard of care for receivers and/or special masters. This engagement involved the review of voluminous documents including corporate records and minutes; reports of financial professionals, consultants and governmental regulatory agencies; pleadings from an underlying lawsuit of Bank of Mellon v. Aleritas et. al.; and other documents and records.

Security Benefit Life Insurance Company

Appointed Special Examiner for Kansas Insurance Department in 2009 and 2010 to assess the severely deteriorating capital and surplus situation of Security Benefit Life (SBL), analyze strategic alternatives aimed at raising capital and increasing liquidity, and advise the Commissioner on a proposed transaction which led to the acquisition of SBL by a Guggenheim Partners-led team of investors. SBL's capital and surplus declined over 50% in a year with more than 50% of the remaining capital and surplus represented by surplus notes. Increased reserve requirements of AG43 and a large portfolio of mortgage backed CDO's further compounded the company's financial situation. As Special Examiner, led a team of investment bankers, attorneys, actuaries and asset management analysts in evaluating, monitoring and approving the terms of the sales transaction and demutualization of Security Benefit, a retirement/annuity company with over $10 Billion in assets under management. The $400 million transaction stabilized the company, which has recently received an upgraded rating of A-, Outlook Stable from S&P.

National Prearranged Services/Lincoln Memorial Life Insurance Company/Memorial Services Life Insurance Company

Contracted as Acting Manager of National Prearranged Services, Inc. (NPS), Lincoln Memorial Life Insurance Company and Memorial Service Life Insurance Company from March-May 2008 for the Texas Insurance Commissioner. Role was to oversee all aspects of the day-to-day operations of the Companies with full power, authority, and control of the companies while

Texas' approval process of a receiver took place. NPS sold prepaid funeral contracts, with two NPS-owned insurance companies purportedly backing the contracts with life insurance. In this engagement, determined that NPS and the insurance companies were out of cash and that there existed few assets to cover 150,000 contracts totaling over $600 million in funeral coverage claims. Unwound a $12 Million reinsurance transaction in 30 days to provide liquidity for the receivership operations. NPS, LMLIC and MSLIC were put in liquidation in Texas and the U.S. Attorney in Missouri has indicted the principals of the companies for fraud.

In the Matter of the Conversion and Acquisition of Blue Cross Blue Shield of Kansas, Inc., Docket No. 3014-DM

Served as key Hearing Team advisor to KID Commissioner in 2001 and 2002. Assisted in drafting order on proposed affiliation of BC/BS of Kansas with Anthem Insurance Company, with $320 million in consideration proposed for distribution in the transaction. After extensive hearings and analysis of evidence, Commissioner disapproved the demutualization and acquisition, finding the proposed transaction hazardous and prejudicial to the insurance buying public and not in the public interest.

KBK Financial, Inc. v Freeman and Freeman Holdings, LLC, Shawnee County, Kansas District Court, Case No. 03-C-1000

Appointed Receiver by the Court to control and manage the operations of a large MillionAir franchised FBO entity and determine the financial status of the general aviation services company which serviced and fueled civilian and military charters and leased aircraft, among other businesses. Appointment was made on the agreed motion of the parties in a dispute over the proceeds of a sale of a Boeing 707 and the status of other jet aircraft. Reported to the Court on the assets and financial status of the companies.

Insurance Receivership Appointments

Company	**Status**	**Date of Order**
Kansas Health Care Association W/C pool	Rehabilitation	November 3, 2010
Independence Indemnity Insurance	Rehabilitation	June 25, 2002
Kansas Transportation and Industry Self-Insurers Workers Compensation Fund	Rehabilitation	March 4, 2002
Kansas Manufacturers and Commerce Self-Insurers Workers Compensation Fund	Rehabilitation	February 7, 2002
Heartland Health, Inc.	Liquidation	May 10, 1999
Centennial Life Insurance Company	Supervision	November 6, 1997
Centennial Life Insurance Company	Rehabilitation	February 7, 1998
Centennial Life Insurance Company	Liquidation	May 27, 1998
Nations Title	Supervision	May 5, 1997
National Colonial Insurance Company	Liquidation	October 7, 1997
West General Insurance Company	Liquidation	October 7, 1997
Farm and Ranch Life Insurance Company	Liquidation	October 7, 1997

IAIR Certification

The International Association of Insurance Receivers, a 400 member organization of experienced professionals, regulators and guaranty association executives involved with troubled insurance companies, has established standards and a certification program for insurance receivers.

Designations are awarded for work and experience with property and casualty (P&C), life and health (L&H) or multiple lines if qualified for both P&C and L&H designations. In 2001, received the designation of CIR-Multiple Lines (CIR-ML).

The CIR-ML designation is awarded to those who have demonstrated their knowledge and experience in the overall control and management on a day-to-day basis of all facets and parts of both Property and Casualty and Life and Health receivership proceedings for a minimum of three years.

Receivership Descriptions

Initially contracted as SDL for three Kansas estates previously managed by Hugh Alexander and Associates: Farm and Ranch Life Insurance Company (Farm & Ranch), West General Insurance Company (West General) and National Colonial Insurance Company (NCIC).

Also served as SDR and SDL from inception for the other companies listed above. The following is a brief description of the companies and the issues involved in the estates:

The Centennial Life Insurance Company.

The company entered the health insurance market in the late 1980's after its long-term disability business began to wane and the company could not generate sufficient revenue to service its acquisition debt. Assumption of large blocks of marginal business was engineered through letters of credit from reinsurers securing $25 million in surplus notes. High expenses, steadily worsening loss ratios and the cost of the surplus notes combined to cause the company's capital and surplus to plummet. Health claims of approximately $40 million and LTD reserves of approximately $40 million were paid by the estate and 47 state guaranty associations (SGA's).

Marshaled and distributed assets to SGA's totaling 98% of Class 3 claims. Special issues encountered in this liquidation included: backlog of 90,000 health care claims; quality control in claims processing; time-sensitive hardship payment issues for LTD claimants; major litigation with the health block reinsurer; extensive litigation over rescission of health block assumed; reinsurance recoveries through litigation and commutation; premium dispute with fronting company; and claims against management, reinsurance intermediary and independent auditor. Worked closely with NOLHGA from the inception of rehabilitation to address claim processing and other major estate issues.

Heartland Health, Inc. Heartland (Horizon) wrote accident and health coverage in Kansas. It was owned by an HMO sponsored by the Kansas Medical Society. Health claims totaling approximately $5,000,000 could not be paid due to the company's insolvency. Special issues involved in this estate included incomplete premium and reinsurance accounting; Y2K information system challenges at the claim processing TPA; problematic intercompany accounting records and provider network ownership transfer.

Independence Indemnity Insurance Company. Independence was a property/casualty company operating in fourteen states as an excess and surplus lines insurer providing liability insurance including medical malpractice, general liability and targeted environmental coverages, primarily to the health care industry. It was a subsidiary of the PHICO Group, Inc., an insurance holding company which also owned PHICO Insurance Company (PHICO) and Pennsylvania Casualty Company (PCC). PHICO is in liquidation.

Independence primarily wrote professional liability coverage for physicians and physician practices that were higher risk or difficult to place with PHICO. There was no guaranty fund coverage. All claims have been resolved or settled and all reinsurance recoveries were made. Assets of $3 million were returned to the Health Association of Pennsylvania at the end of the Rehabilitation in December 2011.

Kansas Manufacturers and Commerce Self-Insurers Fund and Kansas Transportation and Industry Self-Insureds Fund. Group-funded workers compensation pools. The Funds have been in a run off position in Rehabilitation.

National Colonial Insurance Company. NCIC, engaged in writing non-standard automobile coverages in nine states. A secondary line dealt with extended warranties on automobiles and marine equipment. Class 3 claims paid and reserved totaled approximately $32 million. Asset recoveries of $30 million allowed a Class 3 pro-rata distribution of 94%.

West General Insurance Company. Primary business was non-standard automobile insurance, the majority of it written through contracts with managing general agents. The estate has recovered and distributed assets of $14,000,000 to GA's and non-GA Class 3 creditors.

Farm and Ranch Life Insurance Company. Farm and Ranch wrote health, credit life, accident and disability business in eighteen states. Guaranty associations paid $4,857,000 in Class 3 claims and have received distributions from the estate of 53.5% on those claims.