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CareFirst BlueCross BlueShield

June 1, 2012

Commissioner William White
D.C. Department of Insurance, Securities and Banking
Health Reform Implementation Committee - Insurance Subcommittee
810 First Street, NE, Suite 700
Washington, DC 20002

Dear Commissioner White:

Enclosed please find the report that is due today, June 1, as required of GHMSI pursuant to DCMR 4601.1.

Sincerely,

Chet Burrell
President and CEO
CareFirst BlueCross BlueShield

Enclosures

Report on GHMSI Surplus
June 1, 2012

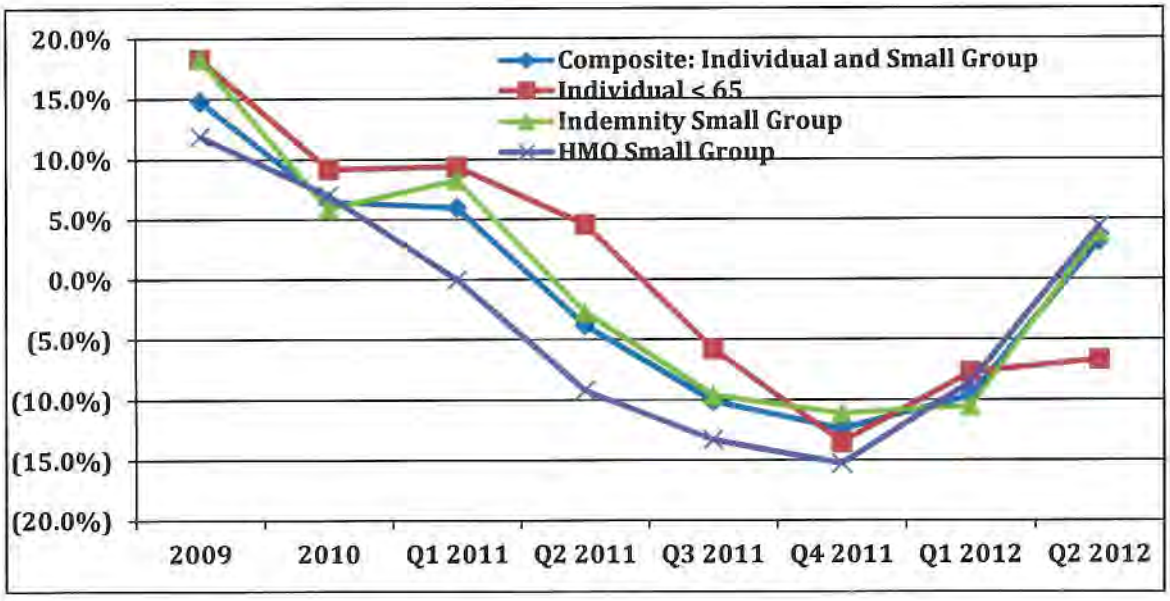
Group Hospitalization and Medical Services, Inc. ("GHMSI" or Company") submits this annual report regarding its surplus to the Commissioner of the Department of Insurance, Securities and Banking ("DISB") pursuant to DCMR 4601.1. As will be discussed more fully below, GHMSI's 2011 surplus fell from 2010, and was below the levels set by the Company's Board, under its established policy and pursuant to independent actuarial advice.

The Current Level of GHMSI Surplus

At Year-End 2011, GHMSI's surplus stood at 998 percent Risk-Based Capital-Authorized Control Level ("RBC-ACL"). This was 100 points lower than its 2010 Year-End RBC-ACL surplus of 1098 percent. This reduction is largely due to the implementation of the Company's Board-approved policy that calls for reducing or moderating premium rates when the Company's surplus rises above the mid-point in its optimal range. Such a rise occurred in 2010 when GHMSI's target surplus range was 750-1050 percent RBC-ACL and health care cost increases had temporarily moderated to their lowest rate of increase in many years.

In 2011 and early 2012, the Company reduced premium rates substantially – by more than 10 percent for some coverage plans – and held rate increases on others to very low levels. This policy of rate reduction/moderation continued through 2011 into the beginning of 2012, when increases in rates became necessary again due to rising health care cost trends. This is shown in the **Chart 1** below.

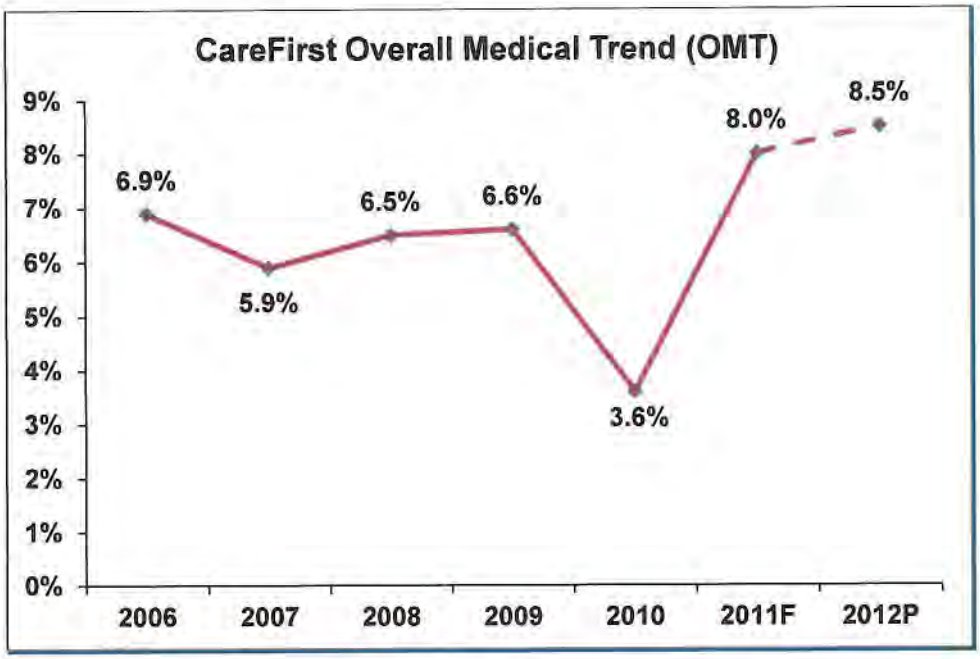
Chart 1
Average Renewal Rate Increases (Decreases)
Individual and Small Group, District of Columbia



Since mid-2011, overall health care cost trends have increased substantially, returning to above their previous levels. This increased trend is also affected by a reduction in the "buying down" of benefits – which refers to efforts by an individual or group to reduce insurance costs by choosing

a plan with increased cost sharing or fewer benefits. Such "buying down" moderated overall trends in the 2007-2010 period, but has since leveled off. In addition, the early impacts of Federal Health Care Reform ("FHCR") have begun to be felt and add to the trend. In **Chart 2** below, Overall Medical Trend ("OMT") represents the total change in allowed costs for all benefits and customer segments of CareFirst, Inc. (risk, FEP, and non-risk).[1]

Chart 2



The Company's surplus at Year-End 2011 stood just below the bottom of the current optimal range of 1000 – 1300 percent RBC-ACL that was established by the CareFirst, Inc. ("CareFirst") and GHMSI Boards in mid-2011 following independent reviews of the surplus requirements of GHMSI and CareFirst of Maryland, Inc. ("CFMI") by two leading actuarial firms that took into account an updated understanding of the impacts of FHCR.

CFMI's surplus also stands below – well below – the updated optimal range that has been approved by the CareFirst and CFMI Boards based on two similar reviews undertaken in 2011. Taken as a whole, CareFirst's surplus, inclusive of both GHMSI and CFMI, stood at 859 percent RBC-ACL at Year-End 2011, placing it 21st out of 37 Blue Cross and Blue Shield Plans around the country in the level of RBC it holds.

Determining the "Right" Level of GHMSI Surplus

1) The Challenge of Calculating Surplus and GHMSI's Current Surplus Level

The calculation and determination of the amount of surplus that GHMSI should appropriately hold is a complex undertaking. As a health care insurance company, the holding of surplus is the

[1] OMT varies from pricing trends embedded in rate filing submissions due to actuarial factors, including shifts in demographics and benefit mix which apply to individuals and small groups, and vary by legal entity and jurisdiction.

means by which the Company fulfills its essential promise of protection to those who purchase its insurance policies.

Consumers must believe that the Company will remain sound and financially able to cover all claims expenses, in order to provide the protection that they seek. In a health care market in which health care costs have reached astronomical levels and the rise in these costs has been steep and inexorable, the purchase of such protection becomes ever more important to the buyer while becoming ever more troublesome and difficult for the insurer.

The central question for the Company (and regulators) is how much surplus is the right amount of surplus to hold – being neither too high nor too low. This question is not answered by the *minimum* surplus levels required by the National Association of Insurance Commissioners ("NAIC"), the Blue Cross Blue Shield Association ("BCBSA"), or various regulators. Such minimums are used to trigger increased scrutiny of or even action against an ailing company that has inadequate reserves. They do not determine the appropriate surplus level for a company that seeks to remain in fiscal health.

For a company such as GHMSI, the "right" level of surplus must be determined in light of the Company's own business risks and must be based upon sound actuarial opinion.

Many Risks and Combinations of Risks are Inherent in Company Operations

The difficulty of establishing the right level of surplus can be best understood when one considers the Company's many different business risks, such as:

1. Rating adequacy, fluctuation and uncertainty risks
2. Unpaid claims liabilities and estimation uncertainty risks
3. Interest rate and portfolio asset value fluctuation risks
4. Catastrophic event risks
5. Business development and growth risks
6. Cost of capital and credit risks
7. Operational performance risks
8. Payment and credit risks of customers
9. Product design and market assessment risks
10. Regulatory risks

All of these risks can occur in different degrees, at different times and in different combinations under nearly innumerable scenarios. The Company must ensure that, regardless of what combinations of risks may materialize in any degree, it can still meet its promises to its policyholders.

This is a bit like determining the stress on a suspension bridge in various conditions of wind, traffic load, temperature, weather and earthquake risk – only more difficult. Special expertise is required in reaching a sound judgment about the level of surplus that is necessary, but one can never reach perfect certainty that a particular level is sufficient. Hence, obtaining independent actuarial expert opinion is necessary for both the Company – and regulators – to come to a sound judgment about an appropriate surplus level, just as engineers would be required to determine the degree of safety on a suspension bridge under varying conditions.

Given that uncertainties cannot be eliminated and that no precise prediction of the future combinations of risks can be made, the experts recommend ranges of surplus within which the

Company can have a certain "confidence level" that it will not experience a situation in which it will fall below minimum levels that are established by the NAIC or the early warning levels established by the BCBSA, thereby violating its licensure standards.

Such a "confidence level" ranges between 95–98 percent certainty that the Company would not fall below the 200 percent RBC-ACL level adopted by the NAIC (and now embodied in DC law) and between 90-95 percent certainty that it would not fall below the 375 percent RBC-ACL that BCBSA holds as an early-warning threshold. These thresholds are important warning signals for insurers; an insurer that falls below 200 percent RBC-ACL is deemed to be a significant failure risk and is subject to corrective regulatory action, while an insurer that drops below the BCBSA early-warning threshold is subject to intensive monitoring, other sanctions, and likely loss of consumer confidence. The confidence levels are designed to ensure that, in 90 to 98 percent of possible scenarios, the Company's RBC-ACL will remain above those "red flag" warning levels. One wonders whether drivers would be comfortable going over a bridge at such confidence levels, but this is what applies in judging GHMSI's ability to fulfill its promises to its subscribers.

One Product, One Region, Non-Profit Company Profile Poses Greater Risks

The challenge in determining an appropriate surplus level for GHMSI is further underscored by the fact that GHMSI is a not-for-profit company selling only one product in one region. It has no geographical diversity, no alternate ways to generate revenue and is subject to forces within its own region from which it cannot escape or offset with other lines of business or geographic results. Should a combination of regional forces turn adverse all at once or appear in an unexpected combination – particularly over an extended period of time – the Company's financial soundness could be severely compromised.

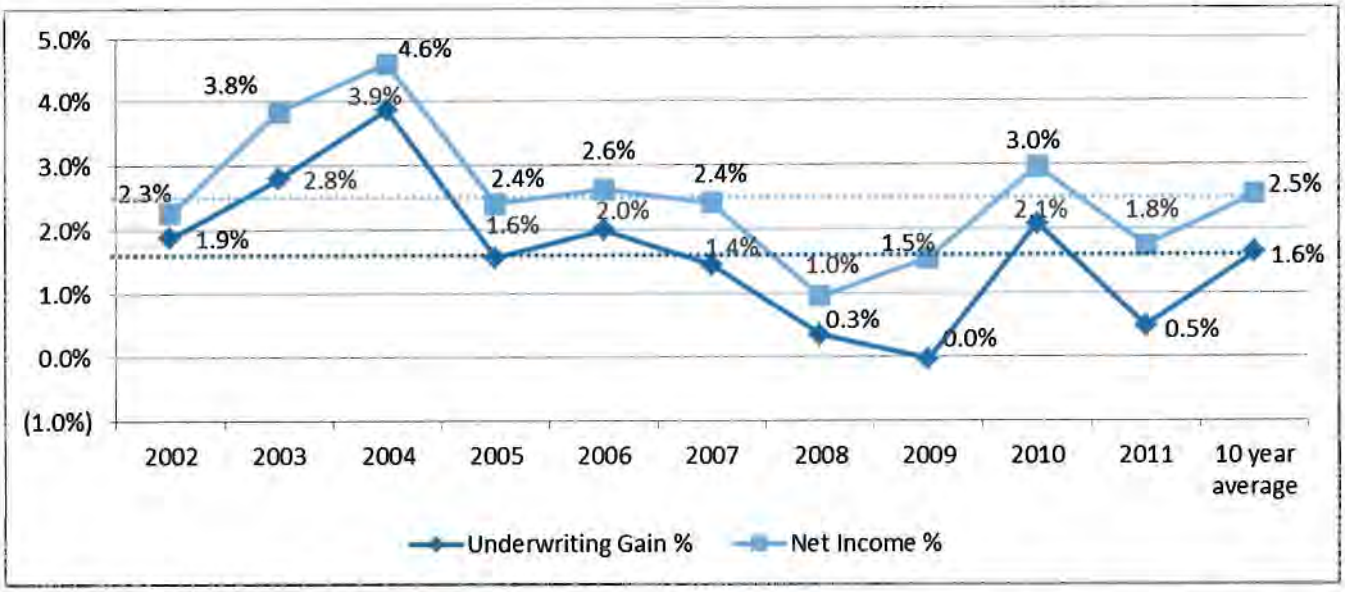
Further, as a not-for-profit, the Company has no access to capital markets and limited borrowing capacity in order to deal with its solvency needs. And, it is subject to statutory accounting standards – causing, in a nutshell, much of its investment in its information systems/ infrastructure required to maintain competitiveness and compliance with State and Federal mandates not to be counted toward surplus as they would under generally accepted accounting principles.

Simply put, the Company sells products whose costs it cannot directly control or precisely predict with great accuracy. Approximately 85 percent of the Company's insured product cost is beyond its direct control. Yet, the Company takes full risk on its insured product prices.

When one considers this in light of the extremely small operating margins which the Company generates through its underwriting/risk taking activities, one can see how inherently risky the business is. With many billions of dollars collected in premium over the past 10 years, the Company's average underwriting margin (gain) has approximated 1.6 percent, with periods in which the underwriting gain has been both lower and higher. See **Chart 3** below.

Chart 3

GHMSI's Underwriting Gain and Net Income



The current year is a good example of how underwriting results can quickly diminish. Through April 2012, the Company has experienced virtually no gain though its underwriting activities following a loss in 2011 – due to a significant rise in health care cost trends observed in this period. Given the scale of Company operations, even small errors in future premium calculations regarding health care cost increases or changes in the composition of risk pools can produce very injurious results with regard to Company surplus.

The Company's surplus is generated in only two ways: through the accumulation of small underwriting gains over the years and through investment income that is derived from the Company's investment of its surplus in the financial markets. Even this latter source is risky. Despite the fact that the Company invests extremely conservatively and with strict discipline, it is exposed to risks inherent in the capital markets which have become volatile and exposed to worldwide events and trends.

Hence, even as the Company enters an era of far greater uncertainty due to the impacts of FHCR, it also faces highly volatile times with regard to financial markets that are likely to continue in a prolonged period of turmoil.

Reduced to its essence, GHMSI and CFMI operate by seeking to manage billions of dollars associated with their subscribers' risks – risks they can neither fully predict nor control – while seeking to do so with deliberately tiny margins in order to keep premiums as affordable as possible for subscribers – all in an attempt to fulfill their promise to subscribers to "be there" in their hour of need.

Federal Health Care Reform Creates Enormous New Uncertainties

In addition to the usual risks attendant to the Company's health insurance business, FHCR poses new, massive uncertainties because it so profoundly changes the way health insurance products are designed, sold, rated and presented to buyers. In effect, FHCR represents a grand social experiment with no precedent, no pilot experience and no trial "break-in" period. It will change

the risks the Company is exposed to and the rules governing those risks while placing major new constraints on how the Company is able to cope with the effects of these new rules.

For example, a portion of the gains GHMSI experiences due to lower-than-planned medical loss ratio, such as has recently occurred, must be returned to subscribers in the form of rebates while losses due to higher-than-expected health care cost trends are potentially exacerbated because new "unreasonable rate" review rules make it more difficult for the Company to raise premiums to keep up with the higher costs of care. For GHMSI and other health insurers, this poses asymmetric risk – that is, it is far easier to lose than to win and far harder to recover from losses when they occur.

These and many other elements of FHCR create new uncertainties as the Company moves forward. Yet, the only source of protection for the Company and its policyholders remains the Company's surplus – now subject to these new uncertainties. Indeed, the one and only thing that appears certain in the era that is dawning is that no government at any level would step in to rescue GHMSI if it faced a financial shortfall due to the effects of FHCR. The fiscal restraints governments at all levels face, and will face far into the far future, are simply too daunting.

One can readily understand the nature of the new risks now coming into view: GHMSI will extend expanded coverage through a public Exchange to a new pool of potential subscribers with unknown creditworthiness, little commercial carrier history and anticipated higher illness burdens. The mechanisms to cope with these added risks that are provided for in Federal law – such as the "three R's" of risk adjustment, reinsurance, and risk corridors – have never before been tried in the commercial health insurance marketplace.

In the midst of this, the Company remains a community resource – a safe haven – and a source of coverage when others fail to provide coverage. Its brand is associated with solid coverage. This poses the real danger that the Company may attract more adverse risks than its competitors and must rely on the workings of the new machinery of FHCR – as yet not fully defined, let alone tried and experienced in the commercial health insurance market.

Meanwhile, the Company remains a major contributor to a myriad of community-based organizations that reach a vulnerable and disadvantaged portion of the community and who struggle to gain access to health care services.

It is central to a proper understanding of the Company's Congressional Charter and mission to observe that the greatest service the Company can provide to its community and its policyholders is to provide them with financially sound health care coverage and protection at the most affordable premium levels. The Company's duty to its subscribers to provide the best value for their premiums remains the highest purpose of the Company.

This reinforces the need for the tiny margins that the Company makes, for the administrative efficiency with which it operates, for the conservatism and care with which it invests the funds it holds in surplus, and for the manner in which it seeks to help its subscribers maintain their health and coordinate their care when ill. And, it brings focus to the need for an appropriate surplus level that stands behind and enables all of this.

So, it is within this overall context that the Company seeks to determine what it must appropriately hold in surplus to meet its obligations to its subscribers and to fulfill its mission to them and the larger community it services. This also forms the context for regulatory review of the Company's surplus level.

2) The CareFirst (GHMSI and CFMI) Approach and Policy Regarding Surplus

Given the complexities outlined above and the inherent uncertainties involved, CareFirst and its affiliates have adopted an approach to establishing an appropriate or "optimal" surplus level that carefully relies on considerable outside, independent expertise under watchful governance. CareFirst, GHMSI, and CFMI have followed this approach since 2005.

The essence of the approach is to obtain the best possible independent actuarial advice on surplus needs and to subject this to management and Board review on a periodic basis. Given the changing environment and risk profile in recent years, this has resulted in five Company-initiated full-scale independent studies since 2005.

The two actuarial firms that have been chosen to undertake these studies are among the leading firms in the nation – Milliman, Inc. ("Milliman") and The Lewin Group ("Lewin"). In each case, they have been asked to conduct, in complete independence from each other, full actuarial analyses of each affiliate's "optimal" surplus position using different methodologies. The result is expressed as a recommended range for the level of surplus that GHMSI and CFMI should hold.

The reason for ranges is two fold: first, the range allows for different levels of certainty in avoiding the minimum surplus regulatory/licensure standards, and second, ranges recognize the inherent constant fluctuation that occurs in the Company's underwriting experience and other factors impacting surplus.

The most recent of the five independent actuarial analyses were completed in mid-2011. Based on a review of these analyses, management and the Board adopted surplus ranges for GHMSI and CFMI that are consistent with, but somewhat lower than, those recommended by the experts. The range adopted for each company is intended to be its "optimal" range – neither too high nor too low – given the risks each company faces.

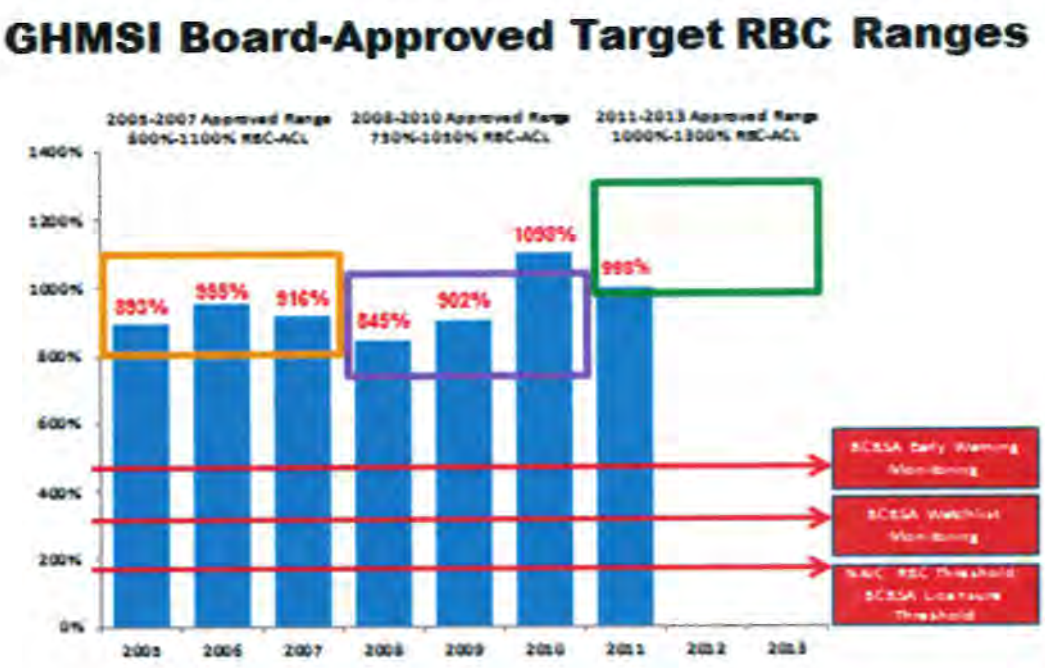
The central objective of Company policy is to seek to maintain an actual surplus level in the middle of the adopted optimal range for each Company. If the underwriting or investment results of one of the Companies were to cause surplus to rise too high in or above the approved range – as occurred with GHMSI, as noted above – the Company would moderate or reduce premium rates to cause the surplus level to drop back toward the middle of the range. If, conversely, one of the companies were to have a surplus too low in the range or be below the range – as is currently the case with CFMI – the policy would call for the addition of a margin to rates so as to gradually build surplus toward the middle of the optimal range for the Company.

Under the oversight of CareFirst's Board, both GHMSI and CFMI update their surplus ranges no less frequently than every three years. But, in an era of rising uncertainty, the Company has conducted this independent analysis more frequently. Indeed, in just the last few months the Company sought updates from Milliman and Lewin – which confirmed the appropriateness of the present surplus ranges that the CFMI and GHMSI Boards have adopted. Letters from the two firms to this effect are attached to this report. All previous reports from the firms have been shared with both the DISB and the Maryland Insurance Administration ("MIA") as they have become available.

The full reviews performed in mid-2011 by Milliman and Lewin resulted in recommendations for a surplus range for GHMSI that were largely overlapping. Milliman recommended a range of 1050 to 1300 percent RBC-ACL while Lewin recommended a range of 1000 to 1550 percent RBC-ACL.

The CareFirst and affiliate Boards, including GHMSI's Board, extensively reviewed and discussed the experts' recommendations and decided to adopt the lower recommended figure for both the top and bottom of the range, thus producing a target range for GHMSI of 1,000 to 1,300 percent RBC-ACL. This is shown in **Chart 4** below.

Chart 4



3) GHMSI's Surplus Levels Have Been the Most Reviewed in the Nation

In addition to the Company's own independently conducted actuarial reviews, both the MIA and the DISB have conducted independent reviews of GHMSI's surplus with assistance from their own consultants.

The MIA has undertaken this twice, once in 2009 through The Invotex Group ("Invotex") and again in 2011 through RSM McGladrey, Inc. ("McGladrey"). The Invotex review resulted in a recommendation to the MIA to approve ranges consistent with those set by the Boards for GHMSI and CFMI. This was upheld by the Commissioner in a January 2010 report and reflected in a subsequent Order, dated May 26, 2011. The McGladrey report awaits final review from the MIA and is expected to be issued soon in concert with an order from the Commissioner.

Similarly, during 2009-2010 the DISB conducted a review of GHMSI's surplus position at Year-End 2008 that resulted in Orders dated August 6, 2010, and October 29, 2010 upholding the appropriateness of GHMSI's surplus. A second review is now underway through the same firm, Rector & Associates.

One of the more remarkable aspects of these studies – whether conducted by the Company's independent experts or the regulators' independent experts -- is the congruity of their opinions. Each study commissioned by DISB, MIA, or CareFirst has upheld the appropriateness of the Company's surplus position at the time the study was conducted.

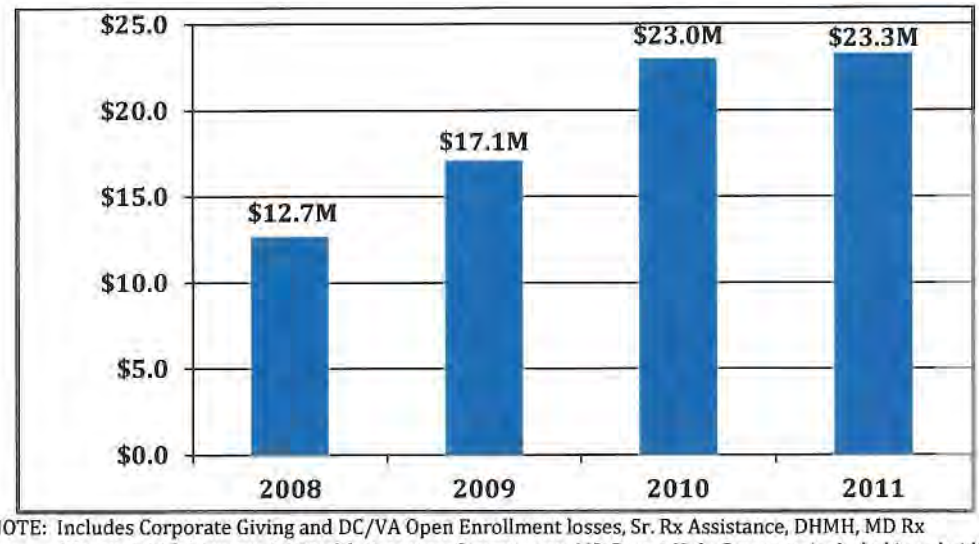
4) GHMSI and CFMI are Generous Givers – No One in the Health Field Invests More in the Community

Over the past four years, CFMI and GHMSI have collectively contributed more than $200 million to a wide variety of community health initiatives dedicated, in one way or another, to affording access to health care to the communities that GHMSI and CFMI serve. Much of this giving has been focused on vulnerable populations who, absent these contributions, would have little or no access to health care services.

Chart 5 below shows the level of community giving by GHMSI since 2008. The Company's generosity has been well recognized throughout the community. Indeed, GHMSI has been recognized in the *Washington Business Journal* as the third most generous corporate contributor in the District of Columbia. As can be seen, the level of community giving by GHMSI has risen steadily in recent years, totaling just over $76 million for the years 2008-11.

Chart 5

GHMSI Community Giving 2008-2011
$ millions



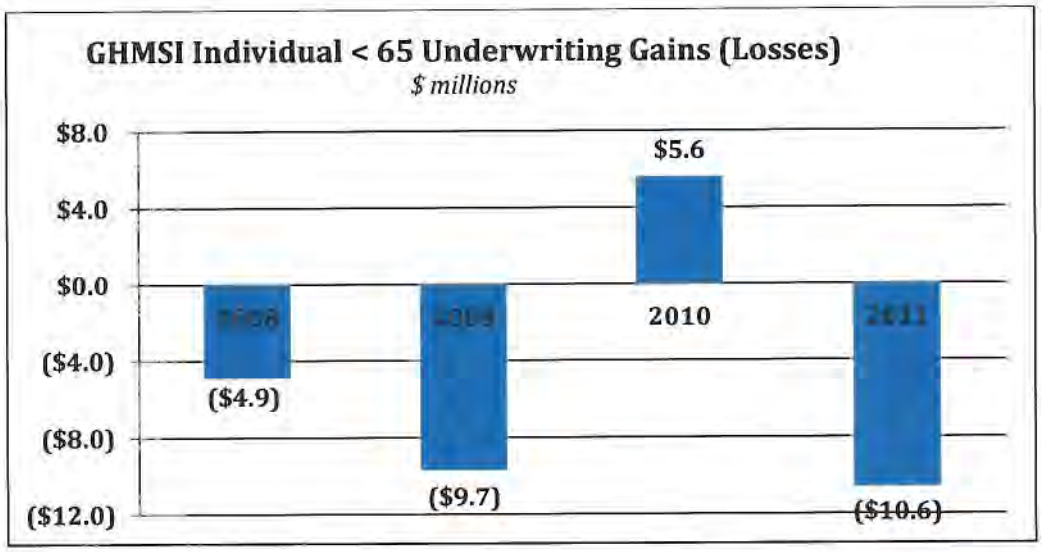
NOTE: Includes Corporate Giving and DC/VA Open Enrollment losses, Sr. Rx Assistance, DHMH, MD Rx Discount, Md. Community Health Resource Commission, MD Donut Hole Coverage included in subsidies effective Jan. 2009, contribution to Healthy DC Fund effective Jan. 2010.

GHMSI's Congressional Charter clearly establishes that the Company was created for the benefit of its subscribers. Consistent with that purpose, it is the Company's view that, notwithstanding its generosity toward the community it serves, its most fundamental obligation is to provide the best value possible to its subscribers in the form of the lowest possible premium rates. This is essential in making health care affordable and accessible to as many people as possible and to fulfilling the Company's obligations under the Medical Insurance Empowerment Amendment Act ("MIEAA"). That statute provides a framework for the Company's "community health

reinvestment" in the District and specifically provides that the Company may meet its community health reinvestment obligation through rate moderation to its subscribers.

To this end, and in addition to the giving it provides to its community, GHMSI has commonly held premium rates to individual subscribers below cost in order to maximize affordability and it has done so over many years. This is a direct way to meet the community health reinvestment obligations of the Company. In addition, GHMSI has offered individual "open enrollment" products that do not require medical underwriting, causing the Company to serve in the role of "insurer of last resort" for the community. **Chart 6** below shows GHMSI's underwriting results in the individual subscriber market.

Chart 6



A careful balance must be struck between the affordability of premiums to those who pay premiums and avoidance of excessive burdens on these premium payers in order to give to others. No premium payer expects that the hard-earned money he or she pays in premiums would be given away and not applied to the cost of his or her own coverage. For this reason, the Company is as careful as it is generous in who it gives to and for what purpose. The Company's community giving is overseen by a Board committee specifically dedicated to this purpose. Simply put, the Company can never forget that its principal obligation is to those who pay its premiums. This, we believe, was established from the outset in the Company's Congressional Charter.

5) Observations about the Approach to Surplus Setting

It is the Company's belief that the duty to establish an appropriate surplus level lies first with the management and the Boards of both GHMSI and CFMI (under the oversight of the CareFirst Board). This places accountability where it most appropriately belongs. This is reflected in the formal policy that the Boards of CareFirst, CFMI and GHMSI adopted in 2008 with regard to the calculation and maintenance of the companies' surplus, a copy of which is attached to this report.

In May 2011, CFMI and GHMSI entered into a Consent Order with the MIA that provides for periodic and independent reviews of the companies' surplus positions by the MIA. This Consent Order outlines an orderly process for the companies to establish their surplus target ranges and

for MIA review of the conclusions that come out of this process. The Companies believe this forms a model for the future and would welcome a similar process in the District of Columbia.

Further, GHMSI urges the DISB and the MIA to coordinate their reviews – as required under MIEAA – so that the prospect of inconsistent orders can be avoided.

Conclusion:

Through repeated, independent, and professional reviews by highly qualified experts of the surplus positions held by GHMSI and CFMI, the companies have sought to hold only that degree of surplus that is appropriate given their risk exposures. The policy of the Companies is to abide by these ranges and to seek an actual surplus level in the middle of each Company's optimal range. GHMSI has followed this policy faithfully and has acted quickly to adjust rates when needed – as evidenced by its recent self-initiated premium rate reductions/moderations.

The Companies now enter an era of profound change, uncertainty and risk associated with FHCR. GHMSI remains a single product, single region, not-for-profit health insurer and, as such, remains highly vulnerable to adverse trends.

The record of regulatory oversight of the companies' surplus-setting process, including the facts, the analyses and the conclusions developed and reached by these reviews over the past four years, has been among the most extensive in the country. Remarkably, there has been, up to the present time, a great congruity in the conclusions reached.

The fact that GHMSI holds a surplus within or, as is presently the case, slightly below its optimal range – as tested and reviewed by multiple independent experts – provides assurance that the surplus is not "unreasonably large" and therefore not "excessive." Indeed, to be within or below these ranges essentially means that the surplus must be both reasonable and not excessive.

The emerging 2012 trends show a diminution in GHMSI's underwriting margins, as the early effects of FHCR are felt and overall health care costs return to historical rates of increase. All of these changes occur in the context of a continuing weak economy and worldwide turmoil, leaving the Company exposed to additional risk associated with the world financial markets, with no source of rescue should it run into trouble.

In sum, we believe the surplus level held today by GHMSI meets the MIEAA's test and that the surplus range adopted by the Board does as well. Ongoing vigilance will be necessary to assure both the range and the actual level of surplus held by GHMSI continue to meet this test. The Company is committed to this. GHMSI believes the record of the past four years gives confidence in this regard, as does the policy the Company follows in establishing its surplus level under regulatory oversight in both the District of Columbia and the State of Maryland.

Milliman

CareFirst, Inc.
Group Hospitalization and Medical Services, Inc.

Review and Consideration of Optimal Surplus Target Range

May 30, 2012

Prepared by:

Phyllis A. Doran, FSA, MAAA
Robert H. Dobson, FSA, MAAA
James A. Dunlap, FSA, MAAA

A. INTRODUCTION

In May of 2011 Milliman issued a report titled "*CareFirst, Inc. Group Hospitalization and Medical Services, Inc.; Development of Optimal Surplus Target Range*". The purpose of the report and its underlying analysis was to address the need for statutory surplus for GHMSI, including its ownership share of CareFirst Holdings, Inc., and to quantify an optimal surplus target range within which the company should strive to operate, under normal circumstances.

CareFirst has requested that Milliman carry out a brief, limited review of GHMSI's current circumstances, in order to consider what, if any, developments have occurred in the past twelve months that we would expect to materially affect the surplus target range produced in our 2011 study. In addition, we have been asked to consider alternative potential scenarios regarding the future of the Affordable Care Act (ACA). Specifically, we have been asked to address the following three questions, in light of the legal challenge to the ACA currently under consideration by the US Supreme Court:

(1) If there are no changes in the ACA as a result of the Supreme Court ruling, and considering any new developments since our previous study was completed, what conclusions might we draw regarding the continued applicability of our previous surplus target range?

(2) If all provisions of the ACA related to commercial health insurance were to be deemed unconstitutional and overturned by the Supreme Court, how would we expect the GHMSI surplus target range to be affected?

(3) If the individual mandate, guaranteed issue and community rating provisions of the ACA are ruled unconstitutional, and all other provisions remain in place, what impact would we expect on the surplus target range?

This report presents our response to these two requests.

B. BACKGROUND: RESULTS OF 2011 STUDY

Summary of Surplus Target Range from 2011 Study – Milliman's May 31, 2011 report presented the conclusions of our analysis of surplus requirements for GHMSI, as follows:

(a) ***Optimal Surplus Target Range for GHMSI*** *– Based on our analysis, we conclude that an appropriate target for GHMSI's surplus falls in the range of* ***1050% to 1300% of RBC-ACL***[1]*, taking into account the impact of federal health care reforms currently in effect. These reforms include: (a) the new minimum loss ratio (MLR) standards that became effective in 2011, requiring the payment of rebates if minimum loss ratio levels are not met, (b) the increased regulatory review of premium rate increases, and (c) the new benefit coverage requirements that became effective in 2010 as a result of the passage of the ACA.*

(b) ***Future Adverse Selection and Operation of Exchanges*** *– While we have not directly incorporated in our analysis the potential impact of the health care reform provisions that are scheduled for implementation beginning in 2014 or later, including the new health care exchanges, we have separately considered certain aspects of those provisions. Specifically, we have estimated the impact on the GHMSI surplus target range of potential increases in adverse selection in the individual and small group markets that would not be anticipated in premium rates, and would not be fully offset by the risk mitigation programs that are required by the ACA to be established after the implementation of new rating and underwriting rules in 2014*[2]*.*

Any such estimate is subject to significantly increased uncertainty, due in part to the current lack of regulations prescribing how the exchanges and the risk mitigation programs will operate, but more importantly, a lack of knowledge as to how health plans, plan sponsors, and consumers will respond. We estimate that the surplus target range for GHMSI could be expected to ***increase by 100% to 150%*** *of RBC-ACL, if the potential for such adverse selection were taken into account. We would characterize this as an indication of the directional nature of the impact of the health care exchanges, rather than a precise quantification of their potential financial consequences.*

Treatment of Health Care Reform – The health care reform law has had an impact on many aspects of the operations of health plans, and will ultimately have an even far greater impact if it is not overturned by the Supreme Court when it issues its rulings on the recent legal challenges. While a

[1] RBC-ACL refers to the Risk Based Capital Authorized Control Level, a key reference value for the National Association of Insurance Commissioners (NAIC) risk based capital formula and a commonly accepted measure of surplus levels for insurance organizations.

[2] The ACA calls for the following risk mitigation programs to be implemented effective in 2014 and later: (i) transitional reinsurance program for the individual market; (ii) risk corridors for plans in individual and small group markets; and (iii) risk adjustment in the individual and small group markets.

number of the law's provisions are now in effect, some of the most significant will not occur until 2014 or later. Regulations implementing those provisions are complex, and while a number of them have recently been issued or finalized, they leave many unanswered questions, and in some cases leave significant issues to be determined by the states. The impact on health plans will depend on the specific provisions of such regulations, the manner in which they are enforced, and, most importantly, the actions of health plans and of employers and health plan participants.

Against this background, it was impossible to fully anticipate or reflect in our previous analysis the impact of health care reform on GHMSI's surplus requirements, and we did not attempt to do so. We did, however, incorporate techniques to simulate the effects of the minimum loss ratio standards and rebate requirements as well as the potential restrictions on premium rate increases, and we reflected the impact of the new benefit coverage requirements that became effective in 2010.

Pricing Margins – In our modeling, we assumed an average pricing margin of 2.8% on underwritten business (excluding the Federal Employee Program). The assumed overall average underwriting margin was 1.6%, including FEP business and gains/(losses) from ASC business. Based on our analysis of the financial operations of GHMSI, we estimated that if the company's surplus were at a level equal to 900% of RBC-ACL, an average margin of 2.8% for the non-FEP insured business would be sufficient to maintain that 900% level on an ongoing basis, assuming that premium were to grow at an annual rate of 9% and that experience were to develop as anticipated in pricing. To maintain surplus at the higher levels indicated by our 2011 study would require even greater margins, unless premium growth rates were lower than the 9% assumed.[3]

[3] In this analysis, premium growth is a proxy for growth in claims and expenses, as the two tend to mirror each other to a significant degree. Growth in claims and expenses produces a higher RBC-ACL value, which requires higher surplus in order to maintain a constant percentage.

C. CONSIDERATION OF CURRENT GHMSI CIRCUMSTANCES

As mentioned above, CareFirst has asked us to carry out a limited review of GHMSI's current circumstances in order to consider what, if any, developments have occurred in the past twelve months that we would expect to materially affect the surplus target range produced in our 2011 study. We were not asked to update our previous surplus analysis modeling, and we have not done so. Further, we have not attempted to quantify the specific impact of any given factor on the target surplus range that we previously developed. To do so would require a level of analysis that is beyond the scope of our assignment.

Our approach has consisted of a review of the company's recent financial experience and of the current health care reform environment as it affects GHMSI. Based on this limited review, we would not expect the surplus target range for GHMSI to differ materially from the results of our 2011 study, if we were to update the study based on current information.

Observations from Recent GHMSI Financial Experience – Based on information provided by CareFirst staff, we have observed that the average pricing margins for 2012 non-FEP underwritten business premiums have increased somewhat over those in the 2011 premiums. However, the overall average margin still falls below the 2.8% assumed in our 2011 modeling, and we would not recommend lowering that assumption (a lower assumed margin would produce a higher target surplus range).

We also noted that there was essentially no premium growth in 2011 (considering GHMSI plus its ownership share of CFBC). This reflects recent membership declines and, presumably, the decreases in premium rates for the individual and small group segments that were effective starting in the second quarter of 2011. (Most of the affected product lines have subsequently experienced premium increases.) Despite the recent lack of growth, we believe it is prudent to anticipate future premium growth for purposes of surplus target assessment, given the potential for membership increases under health care reform.

In other regards, we found the recent financial experience, taken as a whole, to be generally consistent with the assumptions underlying our 2011 analysis.

Health Care Reform Environment – As mentioned above, the estimated surplus target range produced by our 2011 study did not incorporate the potential impact of the health care reform provisions that are scheduled for implementation beginning in 2014 or later, including the new health care exchanges, due to the significant uncertainty involved. A year after completing our previous study, much is still unknown regarding the operations of the health care exchanges and the impact of the new rating and underwriting restrictions in the individual and small group markets, both of which will begin in 2014. Because the changes in the marketplace cannot be fully anticipated in premium rates, the potential for significant premium shortfalls will exist.

This uncertainty entails additional financial risk to the company, and therefore tends to indicate the need for higher levels of surplus than would otherwise be considered prudent. In particular, the potential for significant membership growth as the individual mandate takes effect in 2014 would call for conservatism in selecting a surplus target range, given the direct correlation between growth in membership and an increase in the RBC-ACL value: A growth in membership will lead to an increase

in claims and expenses and therefore in the RBC-ACL value, which will in turn lower the surplus when measured as a percentage of RBC-ACL.

Further, the new minimum loss ratio standards and regulatory limitations on premium increases serve to limit the company's ability to achieve a level of underwriting gains that would allow it to generate the income needed to restore surplus funds, if they should be materially depleted due to unfavorable financial experience or inadequate premium rates. It is therefore essential for GHMSI to strive to maintain adequate surplus levels at all times, in order to minimize the need to grow surplus at a rate beyond that which is achievable under the constraints of health care reform.

Conclusions – Based on our limited review and the observations summarized above, we would not expect the GHMSI surplus target range to vary materially from that produced in our 2011 study, if we were to undertake a similar study today. This is not to say that certain factors would not differ if we were to update our analysis, or that the overall results would not change. However, in the absence of completing a new study, we would not expect materially differing results.

D. CONSIDERATION OF ALTERNATIVE FUTURE SCENARIOS

The US Supreme Court will issue its ruling later this year regarding legal challenges to the Affordable Care Act. Among the possible outcomes of that ruling, we have been asked to consider the following three: (1) no changes are made to the ACA; (2) all ACA provisions related to commercial health insurance are deemed unconstitutional and overturned; and (3) the individual mandate, guaranteed issue, and community rating provisions are ruled unconstitutional, while all other provisions remain in place. Specifically, we have been asked to comment on the expected impact of each of these potential outcomes on the required surplus target range for GHMSI.

Scenario 1: If there are no changes in the ACA as a result of the Supreme Court ruling, and considering any new developments since our previous study was completed, what conclusions might we draw regarding the continued applicability of our previous surplus target range?

Based on our limited review and the considerations discussed in the previous section, if there are no changes in the ACA we would expect our previous surplus target range to continue to apply, subject to the caveat that it does not reflect the potential impact of the health care reform provisions that are scheduled for implementation beginning in 2014 or later. The uncertainty associated with those provisions, combined with the limitations on the company's ability to restore lost surplus funds -- due to the minimum loss ratio requirements, regulatory review of premium rate increases, and other ACA provisions -- point to the importance of maintaining adequate surplus levels at all times.

Scenario 2: If all provisions of the ACA related to commercial health insurance were to be deemed unconstitutional and overturned by the Supreme Court, how would we expect the GHMSI surplus target range to be affected?

If the commercial health insurance provisions were to be overturned, it is possible that the regulatory environment would revert to its 2010 status. However, it is also likely that the District and State legislators would attempt to adopt provisions similar to the ACA, resulting in an environment similar to that of Scenario 1, or something in between those two situations.

Based on the analysis underlying our 2011 study, we have developed the estimated target surplus range that would result if none of the ACA provisions were taken into account. In that situation, we would conclude that a range of **850% to 1100% of RBC-ACL** would be appropriate for GHMSI. This range compares to the range of 1050% to 1300% of RBC-ACL from our May 31, 2011 report, and was derived in the same manner. It differs only in the assumption that all of the ACA provisions that were reflected in our 2011 analysis do not apply. These target ranges are based on work done at the time of our May 31, 2011 study, and reflect information available to us at that time.

A range of possible scenarios could result from efforts at the District or State level to institute some or all of the provisions of the ACA. Such efforts could produce an environment that incorporates greater risk and uncertainty to GHMSI than that of the ACA, particularly if no individual mandate is involved. An applicable surplus target range would vary accordingly, and determination of an appropriate range would need to reflect the environment created by any specific legislation or regulations.

Scenario 3: If the individual mandate, guaranteed issue and community rating provisions of the ACA are ruled unconstitutional, and all other provisions remain in place, what impact would we expect on the surplus target range?

It is difficult to envision this scenario, because the remaining ACA provisions that would affect commercial health insurance were designed to operate in an environment where guaranteed issue of coverage is required of all health plans. As in Scenario 2, it is possible that the District and some States would attempt to pass legislation to reproduce the guaranteed issue and community rating provisions, and possibly the individual mandate as well. As compared to scenario 2, this scenario would leave intact the ACA benefit changes, minimum loss ratio requirements, rate increase review, exchanges, subsidies, reinsurance, risk corridors and risk adjustment. This would create a great deal of uncertainty in the market place. The impact on required surplus would be expected to fall between Scenarios 1 and 2 and be subject to the same considerations discussed above

E. LIMITATIONS AND CAVEATS

Milliman has prepared this report for the specific purpose of providing an analysis of GHMSI surplus targets. This report should not be used for any other purpose. This report has been prepared solely for the internal business use of and is only to be relied upon by the management of CareFirst. We understand that GHMSI may wish to share this report with regulators and their professional advisors in the District of Columbia, Maryland and Virginia, or other appropriate regulators. We hereby grant permission, so long as the entire report is provided. We recommend that any party receiving this report have its own actuary or other qualified professional review this report to ensure that the party understands the assumptions and uncertainties inherent in our estimates. Judgments as to the conclusions contained in our report should be made only after studying the report in its entirety. Furthermore, conclusions reached by review of a section or sections on an isolated basis may be incorrect. Milliman does not intend to benefit any third party either through this analysis or by granting permission for this report to be shared with other parties.

In order to provide the information requested by CareFirst, we have constructed several projection models. Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

In performing this analysis, we relied on data and other information provided by CareFirst. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

The authors of this report are Consulting Actuaries for Milliman, are members of the American Academy of Actuaries, and meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinions contained herein.

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May 31, 2012

Mark Chaney, Chief Financial Officer
CareFirst Blue Cross Blue Shield
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Gentlemen:

At your request, The Lewin Group (Lewin), in conjunction with the actuarial practice at OptumInsight was asked to consider the impact of potential rulings by the Supreme Court as they relate to work previously performed considering potential ranges for risk based capital (RBC) requirements for CareFirst, Inc.'s affiliate, Group Hospitalization and Medical Services, Inc. (GHMSI). This would be an assessment of the impact of different Court rulings with regard to PPACA implementation. The surplus ranges would still be based on work we undertook in 2009 through 2011 in which we applied analytical models to generate scenarios which reflect GHMSI long-term surplus needs. In this case, we are not re-running those models, but have been asked to comment upon the impact of potential rulings on the scenario outcomes we previously developed.

As one might imagine, we can provide only a little insight in terms of actually handicapping the rulings we expect to see in June. The questions the Court posed as to the constitutionality of the Individual Mandate offer much room for speculation as to what this might hold for the ACA-based reform environment. However, in discussions with Carefirst we compared our own assessment of potential rulings with those Carefirst had been considering.. This results in three broad categories of outcomes as they might relate to surplus impacts under potential Supreme Court decisions:

1. **No Change to ACA**. If the Individual Mandate were to be deemed constitutional, we would expect to see ACA implemented much as it currently is understood.

2. **Reversal of ACA**. If the Individual Mandate was deemed unconstitutional, and it was not severed the outcome could well be the striking down of all the provisions of the ACA.

3. **Judicial Intervention**. This suggests the Individual Mandate might be deemed unconstitutional, but the Court would allow certain elements of the ACA to continue to be implemented. If deemed severable, there is a great deal more uncertainty as to which provisions might remain. Based on oral arguments, one reasonable working assumption holds that striking down the Individual Mandate would also remove the Guaranteed Issue and Community Rating elements.

In general, however, we might break down intermediate judicial actions based on key considerations in terms of market and underwriting impacts:

a. Health Benefit Exchanges (HBE). Theoretically, HBEs represent purchasing mechanisms which may or may not continue even without mandated participation or subsidies. The issue would be scope, timing, and effectiveness of remaining exchanges.
b. Market Reforms. ACA changes to pricing and anticipated Payer margins is driven by the introduction of Guaranteed Issue, more restrictive rate bands, and ACA "market leveling" provisions such as Risk Adjustment, Reinsurance, and Risk Corridors. The lack of a mandate makes the issues more difficult. However, we feel the mandate, as enacted, did not provide a particularly robust tool for improving the overall risk pool.
c. Subsidies and Penalties. While designed to move uninsured populations, other provisions could be implemented without subsidy or penalty provisions. Additionally, we could consider a situation where those provisions are not funded by Congress. While unlikely to have subsidies without market reform and/or HBEs except in Medicaid, it is conceivable we might see other provisions move forward without subsidies and penalties.
d. Medicaid Expansion. This is in the ACA legislation, but actually represents a change to the overall market for health coverage which theoretically does not require continuation of any of the commercial insurance market changes.

We can consider the potential decision outcomes in terms of the forces driving higher RBC targets. While it would require additional modeling to quantify such new potential ranges, we can certainly provide directional indications as to the impact compared to work we did in 2011. Reviewing the driving forces in our detailed modeling, we can point to certain considerations which have significant impact:

- Mix of Business. Considerations as to whether available contribution to surplus based on product portfolio mix might well change due to introduction of new products and competitors.
- Pricing Uncertainty. Considerations as to whether shifts in products and risk pools compared to historical cost of care experience might increase the likelihood of a pricing error.
- Regulatory Oversight. Considerations as to whether changes in regulation with respect to an acceptable rate increase might impact the implementation of pricing corrections on a timely basis.
- Underwriting Cycle. Fundamental changes seemed likely based on our modeling compared to the "traditional" underwriting cycle upon which RBC targets had historically been based. The typical "down cycle" seemed more likely due to greater uncertainty, and endured greater length due to the ability to understand pricing problems and implement remediation. Since RBC requirements are largely determined by the need to "weather the down cycle", this increases the need for surplus and contribution to surplus.

In our previous analysis, we determined that a range of 1000% to 1550% of RBC might be appropriate based on initial understanding of ACA implications. With the passage of time, we have become more familiar with the ACA implications. Combining our improved understanding of the ACA impact with the Court decision scenarios, we can comment on the impact we believe GHMSI might face.

As a sidebar, but one which impacts our previous modeling, we note the global economic, political and social environment is less stable than it was when we performed our original modeling. Greater exposure to large, material swings in asset performance might now tend to broaden our ranges for surplus by deepening or lengthening recovery from loss cycles. In particular, we would have to examine whether GHMSI is still subject to surplus draws relative to the demands of GHMSI's liability streams on its pension obligations. We previously focused less on asset risk in our modeling because our own economy appeared to have stabilized domestically.

Scenario 1: No change to ACA. Based on our current understanding, we believe we might actually produce a range of RBC scenarios which could run higher than the 1000-1550% range in our initial estimation:

- Mix of Business As Optum continues to work to understand potential shifts in portfolio on the mix of business under ACA, we believe we might well increase our estimates of the possible underwriting losses. Greater understanding of the potential for membership volatility due to the method of determining and applying individual premium subsidies would lead us to model increased surplus needs for this risk. We now believe there to be a greater potential for wholesale market swings and therefore greater potential for significant first year pricing misses for which correction may be difficult, with member reaction to prices creating further churn in the market. These dynamics would add significantly to overall surplus need.

- Pricing Uncertainty.. In addition to uncertainty as to the change in mix of business, we must then consider the ability of ACA risk adjustment mechanisms to compensate for morbidity selection within this new mix, Based on our current understanding of the limitations of ACA proposed risk adjustment mechanisms , increased risk due to guaranteed issue and community rating requirements for the individual market would lead us to model higher surplus needs for this risk than we did in our earlier modeling. This is compounded by delay and uncertainty in obtaining an appropriate understanding of the emerging cost of care for these new pools of business. This uncertainty and potential for inadequate rate adjustments will increase surplus needs.

- Regulatory Oversight. The observed regulatory environment in terms of granting rate adjustments may be more severe than our original modeling. This would therefore potentially lengthen recovery from loss cycles and thereby increase surplus requirements.

- Underwriting Cycle. Subsequent information released regarding the "3-Rs" (Risk Adjustment, Reinsurance, and Risk Corridors), create adjustments to Payer revenue which may be much more impactful than Minimum Loss Ratio refunds in terms of limiting contribution to surplus.

Scenario 2: Reversal of ACA. In our initial work, we suggested that a pre-ACA range for GHMSI RBC targets under a "business as usual" basis, might be in the range of 750%-1000% of RBC. In our view this range is also likely to increase even if ACA were to be repealed or overturned by Court decisions. Issues and activities already underway make it unlikely to see a complete restoration of a pre-ACA environment. In particular:

- Mix of Business. Speculation exists as to whether the market may see a continuation of private exchanges, additional state-run exchanges similar to Massachusetts, cooperatives, or other mechanisms which introduce new competitors and programs into the current markets. The potential for these market shifts could very well change the available margin mix and contribution to surplus for GHMSI, even without the impact of ACA mandates.

  On the other hand, there is a strong feeling that the current HBEs are struggling to organize operations and other pools similar to HBEs and timing of such changes might not start in 2014 even if they were to continue without ACA. Co-ops have already been approved and funded in many jurisdictions and we can reasonably assume that agreements to fund co-ops signed prior to the repeal of ACA would remain in force even if it is repealed.

  The introduction of new competitors and distribution channels will increase market risk, potentially reduce available margins due to increased competition, and potentially require additional investments in infrastructure for GHMSI to remain competitive. All would lead to higher surplus requirements than if this dynamic did not exist.

- Pricing Uncertainty. Since we believe there will be market shifts due to forces at work beyond ACA, the above logic as to increased uncertainty in pricing would still apply. Any mix of business shift and lag in morbidity recognition will increase the need for surplus. In this case, such shifts might not even obtain the risk adjustment relief to the extent we believe such relief might be available from ACA provisions.

- Regulatory Oversight. As above, we believe the regulatory environment and public perception of the need for rate increase and margins for Payers is more adverse than we might have originally modeled. Unraveling of the market reforms and HBEs puts additional public pressure on the industry and the regulators, which would result in limited premium increases for GHMSI when they need to recover from losses.

- Underwriting Cycle. It is unclear, but some pressure for minimum loss ratios – formal, state-based, or even informal – could well be an influence on contribution to surplus outcomes. The potential for lengthening the "loss cycle", even without refunds and transfers under the 3-Rs' could produce more adverse scenarios than our original work.

Scenario 3: Judicial Intervention. As one might imagine, these outcomes are influenced by the blend of the above forces, depending upon which elements might stay or go and their combined impacts. As in the above cases, one would suspect our general sense of the impact would develop a range of surplus targets somewhat higher than the 750-1000% baseline – but even potentially higher than the 1550% under some combinations of events.

If one were to postulate repeal of Individual Mandate would also remove Guaranteed Issue, and Community Rating, the primary elements remaining would be Minimum Loss Ratio and rate review components . We would therefore expect to see similar market changes as we anticipate under total repeal. Coops and other private sector changes might even receive more reform-based boost. Regulatory oversight might be slightly stronger since the MLR and rate review requirements remain law. Impact of regulation and changes in investment income with respect to the underwriting cycle is similar but again more explicit since MLR is still law.

Using our framework above:

- Mix of Business. Assuming a repeal of limited parameters, most of the environmental changes described in Scenario 2 would still be in play and would have a similar effect. In particular, there remains a strong potential that Medicaid availability changes would remain, which would further alter historical mix of business and margins.

- Pricing Uncertainty: As indicated above, we assume that shifts in business are going to occur under most of these scenarios. With any such shifts, the increased likelihood of adverse experience and delay in recognizing emerging experience is going to increase the potential for adverse outcomes and the need for surplus beyond what might have been anticipated before ACA. We believe a partial implementation might well actually create more uncertainty as to underwriting rules and outcomes than either full repeal or full implementation.

- Regulatory Oversight. The effect of these provisions would remain and would be more explicit if those provisions were not repealed. Rather than indirect rate review authority, states and HHS would retain the formal process that was included in ACA. This should logically lead to a nominally greater impact than under Scenario 2.

- Underwriting Cycle. As with regulatory oversight, this is similar other than remaining more explicit. Under this scenario, formal MLR and rebate requirements would remain in place. This

was a significant factor in modeling surplus needs under ACA and would remain a significant factor.

Overall, we might speculate that, while the outcome is between full repeal and full implementation, some provisions remain or are more explicit than in Scenario 2 but something less explicit than full implementation. Directionally we would be closer to the higher end than the low end due to the significance of the MLR and rebate provisions on the previously modeled underwriting cycle.

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As suggested above, the regulatory environment and uncertainty in pricing will contribute to greater pressure on surplus needed to weather a loss cycle, combined with a more difficult environment to obtain needed contributions to surplus.

Scenario	Original Report	Directional Expected Change in RBC from Original Report
1	1000 – 1550%	Incremental increase in required RBC levels due to subsequent insights • Greater shift in mix deemed likely • Greater uncertainty in pricing • Stronger regulatory pressure in pricing review • Impact of "3-Rs" may well be more adverse
2	750-1000%	Incremental increase in required RBC even without ACA • Shift in mix deemed likely to happen to even without ACA • Stronger regulatory pressures still likely to persist • Less ability to adjust rates for mix and emerging experience
3	1000 – 1550%	Mixed outcomes –but all partial repeals will increase required RBC • Mix shifts will occur – markets impacted may vary • Partial repeal may actually create even greater uncertainty • Stronger regulatory pressures still likely to persist • Various mixes of remaining regulations will pressure results

Additional modeling would be needed to add more precision to the directional commentary provided above. Our logical review of forces impacting surplus requirements, however, clearly indicates the ranges provided in our initial examination could be reviewed and very likely increased. In fact, regulation and guidance issued subsequent to our original analysis have influenced our understanding, and would likely change our assessment of the environment even under a full reversal of ACA. These are obviously judgmental inputs. However, the basis for both our modeling and the regulatory RBC model was predicated on historical underwriting outcomes and rating mechanisms. At this stage, we believe those mechanisms have been fundamentally altered under any of these Supreme Court decision scenarios.

We would be happy to further explain our conclusions or attempt to develop a more precise quantification. However, we are hoping that the above explanation as to how we might view the GHMSI surplus needs offers a logical and reasonable conclusion. While not precise, most forces we have examined call for surplus targets certainly as great, and possibly greater, than our initial work on this issue.

John Lloyd
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CareFirst BlueCross BlueShield

Policy on Community Giving in the Context of Role as a Not-for-Profit Health Plan

Policy of CareFirst BlueCross BlueShield

Regarding

Community Giving in the Context of its Role as a Not-for-Profit Health Plan

CareFirst BlueCross BlueShield's core mission and purpose is to serve its policyholders. In fulfilling this mission, CareFirst seeks to offer the lowest possible rates for its subscribers while providing the best overall value in health care benefits, provider access and customer service. To achieve this standard, CareFirst must continually invest in system improvements to support the complex requirements of its many products and services.

Central to this purpose is maintaining financial strength sufficient to meet future claims obligations. To this end, the Company maintains capital reserves for the benefit of its policyholders. After these two purposes are met, CareFirst seeks to serve the broader communities in its service area by facilitating, supporting and funding a range of health-related initiatives.

Consistent with its not-for-profit charter and enabling legislation, CareFirst has no shareholders, incurs no debt and operates only within its defined service area of Maryland, the District of Columbia and Northern Virginia. Earnings on its capital reserves are used to stabilize and moderate premiums for CareFirst's policyholders.

Long-Range Strategic Plan
In fulfilling the purpose and goals of CareFirst's enabling statutes and charters, the CareFirst Board has approved a long-range strategic plan (LRSP) implemented in annual plans in the context of rolling, three-year increments. Among other things, the LRSP creates the framework for the interplay between premiums and fees charged, the amounts held in reserve for the protection of policyholders, and the amounts allocated for giving to the wider community. Management uses this framework as a guide in executing the Company's operating plan on a year-to-year basis. All rate requests and financial filings to regulators are developed in the context of the LRSP and this Policy.

Key Elements of CareFirst Policy on Premiums, Reserves and Community Giving

1. **Setting Reserve Levels:** CareFirst seeks to maintain capital reserves within a target range over a continually rolling three-year period that are prudent, reasonable and appropriate given the risks to which the Company is exposed.

    a. "Prudent" means a range recommended by external professional actuaries that is expressed as a percentage of Risk Based Capital (RBC) in accordance with guidelines established by the National Association of Insurance Commissioners (NAIC) and standard actuarial practice. The Board of Directors adopts this range as its target "optimal" range. Separate optimal ranges are established for the consolidated CareFirst, Inc., and for its two operating affiliates, GHMSI and CFMI.

    b. The Company commissions external reviews at least every three years. Reports of the external actuarial adviser(s) are provided to regulators in each jurisdiction in which the Company operates. For these reviews, the Company seeks the services of an external third party that is nationally recognized as a leader in the actuarial field. The Company also may seek from time to time a second review from a nationally qualified firm to further validate the "optimal" RBC ranges.

c. The Company seeks to meet all applicable minimum requirements for reserves as established by the NAIC and the Blue Cross and Blue Shield Association, as well as any applicable state or local regulatory requirements. CareFirst avoids accumulating reserve levels above the optimal range which are viewed, by definition, to be inconsistent with CareFirst's mission.

d. In turn, this optimal reserves range guides development of annual operating plans and budgets. While some fluctuation in year-to-year performance can be anticipated, every effort is made to moderate premium levels in order to avoid sharp changes, particularly increases.

e. As a further attempt to validate its reserve position, the Company also continually assesses its performance and reserve ranges relative to other not-for-profit Blue Cross and Blue Shield Plans and monitors its performance relative to the ratings of external rating organizations such as Standard and Poor's.

2. **Rate Setting:** CareFirst continually analyzes emerging claims experience and updates forecasts of underwriting results at least quarterly. As a matter of Board policy:

   a. The Company seeks to set premiums at the lowest possible level of underwriting gain consistent with maintaining reserves within the optimal target range.

   b. All investment income on reserves is applied toward meeting future reserve requirements, thereby further moderating any pressure on underwriting gains.

3. **Adjusting Premiums when Results Fall Outside Optimal Reserve Range:** Since changes in medical trends and operating expenses occur constantly, the Company continually monitors its results and makes adjustments as needed.

   a. Should reserve levels be projected to fall below the minimum of the target range during any three-year planning cycle, the Company will initiate steps to increase its targeted underwriting gain sufficient to restore reserves to the optimal range.

   b. If reserves are projected to exceed the high end of the target range in a three-year planning cycle, CareFirst will initiate rate actions (typically holding rates steady for longer periods or selectively reducing rates on certain products) designed to bring reserves back within target range. Thus, the Company always strives to achieve levels of reserves that are sufficient without being excessive (e.g., within the optimal range).

4. **Community Giving:** Within the context above, CareFirst seeks to serve the larger community through carefully targeted giving to worthy, primarily health-related community projects and initiatives.

   a. In Maryland, CareFirst contributes an amount equivalent to at least 2 percent of its indemnity premium revenues to health-related initiatives that benefit the community. In effect, through these contributions CareFirst "earns" its exemption from the state's 2 percent premium tax levied on commercial insurers. As financial performance permits, the Company's contributions often exceed the 2 percent standard.

   b. A similar legislative framework does not currently exist in the District of Columbia. Instead, CareFirst pays a premium tax (at 2 percent, beginning in 2009) on commercial indemnity business to the District, most of which is directed into the District's General Fund. The Company also contributes to worthy health-related projects above this 2 percent tax rate. CareFirst favors extending Maryland's premium tax equivalence approach to the District.

5. **Community Giving Focus:** CareFirst employs an evaluative framework to guide its community giving that is focused on certain priorities:

    a. The most intense focus of giving is to expand access to health care coverage by subsidizing health coverage for many of the region's most vulnerable people.

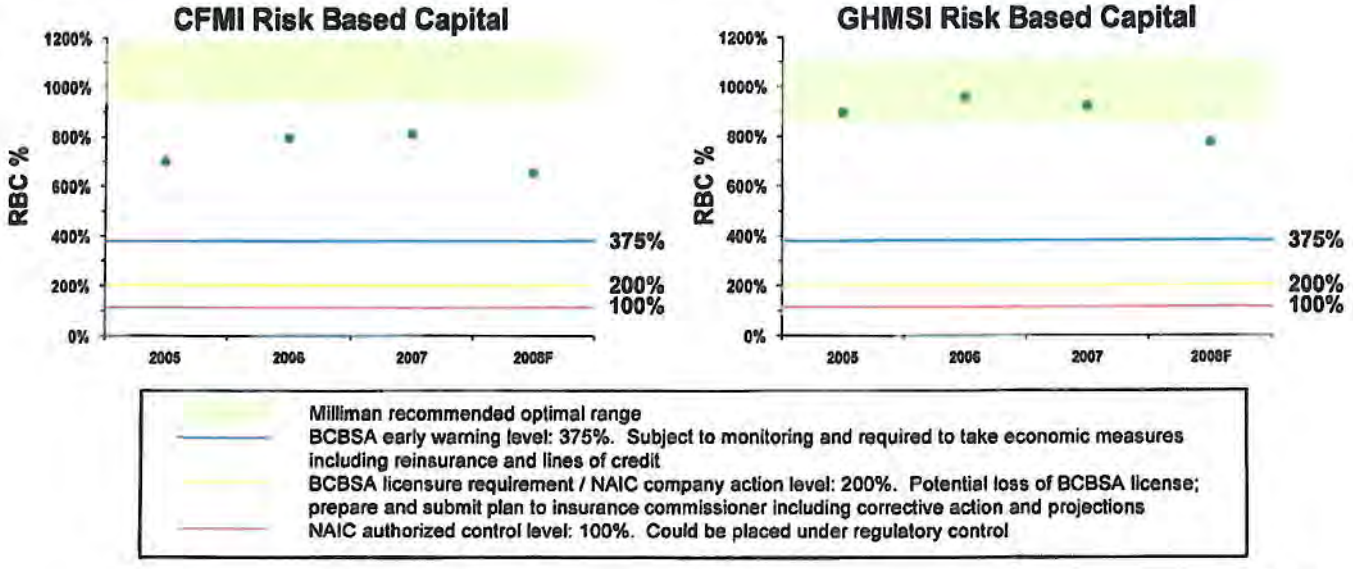
    b. CareFirst also seeks to act as a catalyst in developing systemic improvements in health care delivery in ways that benefit the entire community.

    c. A third area of giving is in targeted programmatic initiatives undertaken by qualified non-profit community organizations that focus on opportunities to address specific health issues, such as reducing childhood obesity and reducing cardiovascular risks in older men.

    d. The entire process is overseen by a special Board committee called the Mission Oversight Committee, which monitors the Company's corporate giving activities. Giving by geography/government jurisdiction generally is proportionate to the insured membership within each jurisdiction.

CareFirst's Performance Under Policy Framework

1. **Setting Reserve Levels:** The CareFirst and affiliate Boards, which underwent an almost total turnover in 2003 and 2004, engaged Milliman USA, an internationally respected actuarial consultant, in 2005 to analyze CareFirst's consolidated and affiliate reserve levels and to advise the Boards on appropriate levels of reserves. CareFirst engaged Milliman again in 2008 to update this analysis. Based on their relative risks, Milliman determined that optimal reserve levels for **CFMI should be in the range of 900% to 1200% RBC** and for **GHMSI should be in the range of 750% to 1050% RBC**. Milliman deemed these levels "reasonable and appropriate." While GHMSI historically has operated within that targeted RBC range, it is projected to fall below this range in 2008. CFMI's RBC historically has been below the optimal level recommended by Milliman (see below) and is projected to continue to be below this range for 2008. CareFirst's consolidated RBC was 869 percent at year-end 2007, which is within 5 percent of the weighted average RBC of not-for-profit Blues Plans generally.



a. Milliman said its recommended RBC ranges "should be wide enough to allow for a reasonable degree of fluctuation in operating results year-to-year, under normal operating circumstances, over a multi-year horizon." Basing its analysis on certain assumptions, at a high level of confidence, Milliman set as minimal goals reserve levels that 1) avoided the BCBSA Early Warning Monitoring threshold; 2) avoided the BCBSA Loss of Trademark threshold; and 3) provided equity capital for development and upgrading CareFirst's infrastructure and systems.

b. It concluded that accumulating reserves in excess of the optimal range "by definition...would not add to the well being of the company." In such circumstances, Milliman recommended "taking actions to ease surplus growth as it nears the upper end of the target range." The 2005 Milliman Reports on CFMI and GHMSI were shared with regulators in MD and DC as well as with selected legislators.

c. Using another benchmark, one respected actuarial consultant, The Lewin Group, suggests a reserve standard in the range of 15 percent to 25 percent of annual premium revenue to protect against undue risks. CareFirst's $1.27 billion in reserves equal about 20 percent of revenues.

d. Besides the Milliman analyses, CareFirst also relies on the annual review and rating of the Company's performance by Standard & Poor's as another monitoring measure of financial viability. In its most recent review, S&P rated the National Capital Area affiliate "A-/Stable", a notch better than the Maryland affiliate's "BBB+/Positive".

e. In a June 2008 Report in which S&P rated 10 large not-for-profit and mutual Blues Plans, it said the capital positions of the Plans was "Strong" but needed to be strong given the marketplace challenges they face and their lack of access to the equity markets for investment capital. Eight of the 10 Plans had ratings better than either of CareFirst's operating affiliates.

f. S&P noted, however, that these plans lacked national scale and business line diversification and are on the defensive competitively against for-profit carriers who increased their enrollment 7.2% versus the 1.4% membership growth reported by the Blues Plans. By comparison, CareFirst's consolidated "BBB-/Stable" rating ranked below these Plans by S&P. (S&P typically rates holding companies lower than their operating units.)

2. **Members and Revenues** – Revenue and membership generated by the business underwritten in the District of Columbia (excluding FEP) approximates 10 percent of CareFirst, Inc.'s total revenue and membership.

3. **Community Giving:** In fulfilling its not-for-profit mission, the Company has dramatically enhanced efforts to increase access and affordability, improve quality and safety, and reduce disparities in health care. From 2005 through 2008 (projected), CareFirst will have provided nearly $131 million in community giving, medical initiatives and subsidies under its CareFirst Commitment initiative (see chart, below). In 2007, CareFirst contributed $34.3 million to benefit the community, which exceeded the 2 percent payment in lieu of Maryland's premium tax by more than $8 million.

2008 Community Benefit Giving