EXHIBIT 13

Milliman

Group Hospitalization and Medical Services, Inc.

Review and Consideration of Optimal Surplus Target Range

June 28, 2013

Prepared by:

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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, LLC, (CFH) and to quantify an optimal surplus target range within which the company should strive to operate, under normal circumstances.

In May, 2012 Milliman was asked by GHMSI to (among other things) carry out a brief, limited review of GHMSI's then-current circumstances, in order to consider what, if any, subsequent developments had occurred that we would expect to materially affect the surplus target range produced in our 2011 study. Our report, titled "*CareFirst, Inc. Group Hospitalization and Medical Services, Inc.; Review and Consideration of Optimal Surplus Target Range" was issued on May 30, 2012.*

We have once again been asked to consider circumstances and developments affecting GHMSI subsequent to our 2011 study, and whether any of these would be expected to materially affect the company's surplus target range. This report presents our response.

It should be noted that, while we expect to perform an update of our 2011 target surplus analysis for GHMSI at some point later this year, the modeling and analytical framework required to carry out such an update is beyond the scope of this current assignment. If and when we do complete such an update, it is possible that our conclusions will differ from those presented in this report, due to the differences in the nature of the assignment and the scope of the accompanying analysis.

For the purpose of this report, GHMSI is understood to mean the combination of 100% of the business of GHMSI itself and 50% of the business of CFH, the vast majority of which consists of CareFirst BlueChoice (CFBC). For consistency with our 2011 report, we will refer to CFBC rather than CFH when discussing the GHMSI ownership share of those companies.

Based on our limited review and the observations presented in this report, 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 will not differ when we do update our analysis, or that the overall results will not change. However, in the absence of having completed such an update, at this time we would not expect materially differing results.

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 Affordable Care Act (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.*

[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.

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. While a number of the law's provisions are now in effect, some of the most significant have yet to occur, with many of them scheduled to take effect in 2014. Regulations implementing those provisions are complex, and their effects cannot be fully anticipated at this time. In particular, the impact on individual health plans will depend on not only the specific provisions of the applicable regulations, but also the manner in which they are enforced, and, more importantly, the actions of other health plans and of employers and health plan participants.

Recognizing this complexity and uncertainty, it was impossible at the time of our 2011 study to fully anticipate or reflect in our analysis the impact of health care reform on GHMSI's surplus requirements, and we did not attempt to do so. As noted above, however, we did 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 2011 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 (1050% to 1300% of RBC-ACL) 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, GHMSI has asked us to carry out a limited review of GHMSI's current circumstances in order to consider what, if any, developments have occurred subsequent to the development of our 2011 study that we would expect to materially affect the surplus target range produced in that 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 Based on Recent GHMSI Financial Information – Following are some of our observations regarding recent GHMSI financial experience compared to the assumptions underlying our 2011 surplus analysis modeling:

- **Pricing Margins** – As noted above, in our 2011 modeling we assumed an average pricing margin of 2.8% on non-FEP underwritten business. The reported underwriting margins for 2011 and 2012, measured on a comparable basis[4], were 1.3% and (1.6)%, respectively. We understand that the significant reduction in margin experienced in 2012 occurred in part due to a decision to limit the level of premium increases in the individual product lines. The incorporation of a lower assumed pricing margin in our 2011 analysis would lead to a higher surplus target, in the absence of other changes in values or assumptions.

  GHMSI (along with CFBC) has filed proposed 2014 premium rates for its individual and small group product lines in each of the jurisdictions within which it operates – i.e., the District of Columbia, Maryland, and Virginia. It is our understanding that in some cases the regulating authorities have approved rates that are lower than those originally filed, and in other cases final approvals may still be pending.

  Based on information provided by GHMSI and CareFirst staff, the overall average pricing margin for 2014 non-FEP underwritten business premiums is estimated to be 2.8%, if the originally filed rates were approved. After reflecting the lower approved rates, however, the implied average overall pricing margin is estimated to be 1.8%. This 1.8% estimate does not reflect the potential impact of the risk corridor programs which will become effective in 2014, and which could be expected to increase the effective margin.

[4] The estimated premium margins presented in this report apply to the total non-FEP underwritten business of GHMSI plus its ownership share of CFBC, consistent with the values from our 2011 report.

While we understand that current expectations for pricing margins in subsequent years are closer to the 2.8% assumption in our analysis, there is obviously a great deal of uncertainty regarding pricing and experience levels over the next several years. We will consider these factors as part of our update of our GHMSI surplus analysis later this year.

- **Annual Premium Growth** – GHMSI's reported annual premium growth, at 4.6% in 2012, was slightly higher than in previous years (2.2% in 2010 and 3.8% in 2011, considering GHMSI plus its ownership share of CFBC). Based on the company's projections, premium growth is expected to increase in future years, reflecting the anticipated impact of health care reform. We believe it is prudent to assume such future increases, given the potential for membership increases.

- **Other Modeling Assumptions** – In other regards, we found GHMSI's recent reported 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 due to the significant uncertainty involved at that time.

We now have additional information regarding the details of these provisions, primarily in the form of the numerous regulations that have been issued by the federal agencies charged with implementing the provisions of the ACA. Additionally, premium rates for plans to be sold in the health care exchanges in the District of Columbia, Maryland and Virginia, as filed by health plans operating in those jurisdictions, have been made public. We have not had an opportunity to examine that premium rate information, but expect to do so as part of our future update.

Though numerous regulations have been issued regarding the implementation of various provisions of the ACA, a great deal of uncertainty remains. The new programs in 2014 include the health care exchanges, the insurance reforms and three new risk mitigation programs. These risk mitigation programs are designed to mitigate the impact of potential adverse selection and stabilize premiums in the individual and small group markets as insurance reforms and the exchanges are implemented.

The manner in which employers and plan participants will react to these changes could significantly alter the composition of GHMSI's membership and risk profile. Because these changes cannot be fully anticipated, they cannot be fully reflected in premium rates.

This continued uncertainty entails 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 minimum loss ratio standards 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, at this time 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. LIMITATIONS AND CAVEATS

Milliman has prepared this report for the specific purpose of providing a brief, limited review 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 GHMSI. 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 GHMSI, at the time of our 2011 analysis we constructed several projection models. Differences between these 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 GHMSI. 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.

EXHIBIT 14

MARYLAND INSURANCE ADMINISTRATION

IN RE:	*	
TARGETED SURPLUS RANGES FOR:	*	
CAREFIRST OF MARYLAND, INC. **NAIC #47058** **10455 MILL RUN CIRCLE** **OWINGS MILLS, MARYLAND 21117**	*	**CASE NO. MIA-2011-05-040**
AND	*	
GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC. **NAIC #53007** **840 FIRST STREET NE** **WASHINGTON, DC 20065**	*	

* * * * * * * * * * * * * * *

CONSENT ORDER

This Consent Order is entered into by the Maryland Insurance Commissioner and CareFirst of Maryland, Inc. ("CFMI") and Group Hospitalization and Medical Services, Inc. ("GHMSI") (CFMI and GHMSI being sometimes referred to individually as a "Company" and collectively as the "Companies"). The Consent Order memorializes discussions and a mutual voluntary agreement among the parties regarding the review of surplus held by both CFMI and GHMSI following the issuance of the Maryland Insurance Administration's (MIA's) Report in January 2010, as referred to in paragraph 6 below. The facts supporting this Consent Order are as follows:

1. CFMI is a nonprofit health service plan under Maryland law, which is chartered and domiciled in Maryland.

2. GHMSI, a Congressionally chartered entity, also is licensed in Maryland as a nonprofit health service plan.

3. CFMI and GHMSI are under the common control of CareFirst, Inc., a nonprofit health service plan under Maryland law, which is chartered and domiciled in Maryland ("CFI").

4. Pursuant to § 14-117 of the Insurance Article, nonprofit health service plans such as CFMI and GHMSI must maintain surplus that is at least equal to the greater of $75,000 or 8% of the total earned premium received by the corporation in the immediately preceding calendar year. *See* Md. Code, Ins. § 14-117(b). If after a hearing the Commissioner determines that a larger surplus is necessary for the protection of subscribers, the Commissioner may require a nonprofit health service plan to maintain a surplus in an amount greater than the amount required by § 14-117(b).

5. The surplus of a nonprofit health service plan may be considered excessive only if (i) the surplus is greater than the appropriate risk based capital requirements as determined by the Commissioner for the immediately preceding calendar year and (ii) after a hearing, the Commissioner determines that the surplus is unreasonably large. *See id.* § 14-117(e)(1). If the surplus is determined to be excessive, the Commissioner may order the nonprofit health service plan to submit a plan for distribution of the excess in a fair and equitable manner, or if the nonprofit health service plan fails to submit a plan of distribution within 60 days, may compile a plan and order the nonprofit health service plan to implement it. *See id.* § 14-117(e)(2). Such a distribution may be made only to subscribers who are covered by the nonprofit health service plan at the time the distribution is made. *See id.* § 14-117(e)(3).

6. In 2009, the MIA initiated a review of the surplus held by GHMSI and CFMI as of December 31, 2008. To assist with such review, the MIA engaged an outside firm (Invotex Group) to perform an independent analysis and recommend a targeted surplus range. Following a hearing, the MIA issued a Report in January 2010 entitled: Report on CareFirst Premiums and Surplus (herein the "Report"), which found that the respective surpluses for CFMI and GHMSI were neither unreasonably large nor excessive.

7. The Report identified the need for CFMI, GHMSI and the Commissioner to establish a "new working relationship" relating to the surpluses, that the parties work to maintain the surpluses within the targeted surplus ranges and that the Companies and the MIA use these targeted surplus ranges during rate reviews.

8. This Consent Order is meant to establish a framework for this new working relationship and to establish a means by which the parties will review the targeted surplus ranges of the Companies on an ongoing basis.

9. The Companies recognize and agree that they will maintain up-to-date targeted surplus ranges that meet their solvency and other needs, and that these ranges will be disclosed to the MIA together with the underlying methodology, data, and assumptions and any expert, independent evaluation that may have been relied upon by the Board of Directors of CFMI and the Board of Trustees of GHMSI in determining

them. The parties recognize that it is the responsibility of CFI's Board of Directors to oversee the establishment by the respective Boards of CFMI and GHMSI of targeted surplus ranges for CFMI and GHMSI to provide for the financial soundness of the Companies and allow sufficient capital for the Companies to satisfy the requirements of § 14-102 of the Insurance Article.

10. The Companies further agree that they will undertake a review of their targeted surplus ranges by qualified actuarial experts no less frequently than every three years. The Companies will consider the results of these reviews in establishing anew the targeted surplus ranges for each Company, or in revising these ranges as may be necessary given changing circumstances.

11. In order to determine the appropriateness of the targeted surplus ranges established by the Companies, the Commissioner may periodically undertake an independent analysis such as that undertaken by Invotex in 2009.

12. The Companies recognize the Commissioner's authority to use either the Commissioner's own adopted targeted surplus ranges or the Companies' ranges in determining whether and to what extent contingency margins should be included in rate filings.

ACCORDINGLY, it is hereby mutually agreed between the parties and therefore **ORDERED** by the Commissioner as follows:

A. CFI shall submit to the Commissioner the targeted surplus range for both CFMI and GHMSI for approval by July 1, 2011. The submittal shall include the relevant data, assumptions, and external expert opinions and analyses relied upon by the Boards on which the new targeted surplus ranges are based.

B. If and when the Boards, or either of them, consider it necessary to establish new targeted surplus ranges for CFMI and/or GHMSI, but not less than every three years, CFI shall submit such targeted surplus ranges to the Commissioner for approval within 30 days of their establishment by the respective Boards. These submittals shall contain all of the information listed in paragraph A.

C. The Commissioner shall review the submittal or submittals filed by CFI. When the Commissioner is determining the appropriateness of the targeted surplus ranges by the Companies, the Commissioner shall consider:

1. The risks identified by CFMI and GHMSI;
2. The availability of capital within the group of companies controlled directly or indirectly by CFI, including CFMI and GHMSI and their subsidiaries and affiliates;

3. The distribution of the business of CFMI and GHMSI, including both risk and non-risk business;
4. The missions of CFMI and of GHMSI;
5. Whether the surpluses are adequate for the protection of the subscribers of CFMI and GHMSI; and
6. Any other relevant factors.

D. In reviewing each targeted surplus range for each Company, the Commissioner may procure, at the expense of each Company, appropriate experts to advise the Commissioner on the appropriateness of the targeted surplus range. To facilitate the Commissioner's review, the Companies agree to ensure reasonable access to the relevant data, assumptions, and expert opinions and analyses relied upon by the Boards of the Companies and to the experts providing such opinions and analyses and whatever other materials of the Companies and their affiliates and subsidiaries the Commissioner considers reasonably necessary for her review.

E. Upon completion of the Commissioner's review of each targeted surplus range for each Company, the Commissioner shall inform the Companies whether, based on the Commissioner's independent review, the Commissioner intends to approve the targeted surplus range established by each of the Companies or adopt an alternative targeted surplus range for each of the Companies.

F. In the event the Commissioner intends to adopt an alternative targeted surplus range, the parties shall attempt to resolve their differences. In the event that the Commissioner and the Companies are unable to resolve their differences, the Commissioner will hold a quasi-legislative hearing to consider the appropriate targeted surplus range for either CFMI or GHMSI as the case may be. The hearing will be held in accordance with COMAR 31.02.06, after which the Commissioner may issue an order adopting an alternative targeted surplus range for, or approving the targeted surplus range established by, CFMI or GHMSI, as the case may be.

G. GHMSI and CFMI will seek to maintain their respective surplus within their targeted surplus ranges as approved or adopted by the Commissioner, until and unless such ranges are changed in accordance with the terms of this Order.

H. With their Annual Statements filed with the Commissioner under § 14-121 of the Insurance Article, both GHMSI and CFMI shall specify:

1. Their targeted surplus range applicable to the calendar year for which the Annual Statement is filed; and

2. Their actual surplus as a percent of authorized control level RBC at the close of the calendar year for which the Annual Statement is filed.

So ORDERED this 26th day of May, 2011.

Signature on file with Orignal

Beth Sammis
Acting Insurance Commissioner

CONSENT OF CAREFIRST OF MARYLAND, INC. AND GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC.

CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. hereby consent to the entry of this Consent Order, as well as to the terms contained herein. Furthermore, Chet Burrell acknowledges, in his capacity as the President and Chief Executive Officer of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc., that he has the authority to enter into this Consent Order and bind CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. to the terms contained herein.

CAREFIRST OF MARYLAND, INC.
GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC.

Signature on file with Orignal

By:
Name: Chet Burrell
Title: President and Chief Executive Officer

5/24/11
Date

Signature on file with Orignal

Witness

24 May 2011
Date

EXHIBIT 15

EXHIBIT 15

MARYLAND INSURANCE ADMINISTRATION

IN RE:	*	
TARGETED SURPLUS RANGES FOR:	*	
CAREFIRST OF MARYLAND, INC. NAIC #47058 10455 MILL RUN CIRCLE OWINGS MILLS, MARYLAND 21117	*	
	*	Case No. MIA-2012-09-006
AND	*	
GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC. NAIC #53007 840 FIRST STREET NE WASHINGTON, DC 20065	*	
	*	

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CONSENT ORDER

Pursuant to the authority granted in §§ 2-108 and 2-204 of the Insurance Article, Annotated Code of Maryland,[1] the Maryland Insurance Commissioner ("Commissioner"), CareFirst of Maryland, Inc. ("CFMI"), Group Hospitalization and Medical Services, Inc. ("GHMSI"),[2] and CareFirst, Inc. ("CareFirst") (collectively, the "Parties"), enter into this Consent Order (the "Order") to establish the terms and conditions under which the Commissioner hereby approves the targeted surplus ranges adopted by the CareFirst, Inc. Board of Directors, the CFMI Board of Directors and GHMSI Board of Trustees (collectively, the "Boards") on September 22, 2011, as to CFMI and May 25, 2011, as to GHMSI. The Parties enter into the Order pursuant to and in accordance with the terms of a Consent Order dated May 26, 2011, by and between former Acting Commissioner Beth Sammis, CFMI and GHMSI (MIA Case No. MIA-2011-05-040) ("the 2011 Consent Order"), and hereby represent and acknowledge that this Order replaces and supersedes the 2011 Consent Order in its entirety.

The grounds on which this Order is based are as follows:

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[1] All statutory references are to the Insurance Article, Annotated Code of Maryland.

[2] This Order sometimes refers to CFMI and GHMSI individually as a "Company" and collectively as the "Companies."

The Parties

1. CFMI holds a certificate of authority to operate as a nonprofit health service plan in Maryland and is chartered and domiciled in Maryland.

2. GHMSI holds a certificate of authority to operate as a nonprofit health service plan in Maryland and is a congressionally chartered entity domiciled in the District of Columbia.

3. CFMI and GHMSI are under the common control of CareFirst, which holds a certificate of authority to operate as a nonprofit health service plan in Maryland and is chartered and domiciled in Maryland.

4. The Commissioner is responsible for enforcing the Insurance Article.

Applicable Law

5. As nonprofit health service plans, CareFirst, CFMI, and GHMSI are charged with carrying out a three-part statutory mission: (1) to provide affordable and accessible health insurance to the respective plan's insureds and those persons insured or issued health benefit plans by affiliates or subsidiaries of the plan; (2) to assist and support public and private health care initiatives for individuals without health insurance; and (3) to promote the integration of a health care system that meets the health care needs of all the residents of the jurisdictions in which the nonprofit health service plan operates. § 14-102(c), (d).

6. To qualify for a certificate of authority, an insurer, including a nonprofit health service plan, must maintain assets and surplus that are "reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs." § 4-103(c)(1). In determining whether an insurer's assets and surplus are reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs, the following factors, among others, shall be considered:

(i) the size of the insurer as measured by its assets, capital and surplus, reserves, premium writings, insurance in force, and other appropriate criteria;
(ii) the extent to which the insurer's business is diversified among the several lines of insurance;
(iii) the number and size of risks insured in each line of insurance;
(iv) the geographical dispersion of the insurer's insured risks;
(v) the nature and extent of reinsurance of the insurer's risks;
(vi) the quality, diversification, and liquidity of the insurer's investment portfolio;
(vii) the recent past and projected future trends in the size of the insurer's surplus as regards policyholders;
(viii) the surplus as regards policyholders maintained by comparable insurers; and
(ix) the financial position of the insurer, after excluding from assets investments in and other transactions with persons that directly or indirectly, through one or more intermediaries, control, are controlled by, or are under common control with another person.

§ 4-103(c)(2).

7. Further, to safeguard the solvency of the insurance business in the State, an insurer, including a nonprofit health service plan, should maintain an amount of capital in excess of certain minimum risk based capital ("RBC") levels as set forth in Title 4, Subtitle 3 of the Insurance Article. That Subtitle provides that it is "the public policy of the State" that "additional capital is used and useful in the insurance business and helps to secure an insurer against various risks inherent in, or affecting, the insurance business and not accounted for or only partially measured by the [RBC] requirements contained in this subtitle." §4-302(2).

8. As defined in § 14-117(a)(4), a nonprofit health service plan's "surplus" is the amount by which certain defined assets exceed liabilities described in § 5-103. Those liabilities applicable to CareFirst, CFMI and GHMSI are the amounts needed to pay: all reported or unreported losses and claims incurred as of the date of the respective company's annual statement; the expenses of adjustment or settlement of those losses and claims; taxes, expenses, and other obligations due or accrued at the date of the annual statement; the amount of reserves equal to the unearned parts of the gross premiums charged on policies in force; and any additional reserves that the Commissioner reasonably requires. § 5-103.

9. Additionally, the Insurance Article provides that a nonprofit health service plan generally is required to maintain a surplus in an amount equal to the greater of: (1) $75,000; and (2) 8% of the total earned premium received by the corporation in the immediately preceding calendar year. § 14-117(b). The Commissioner may require a nonprofit health service plan to maintain a surplus in a larger amount if the Commissioner determines after a hearing that a larger surplus is necessary for the protection of the plan's subscribers. § 14-117(d).

10. Section 14-117(e) defines when the Commissioner may consider the surplus of a corporation authorized under Title 14 to act as a nonprofit health service plan to be excessive and the procedure by which excessive surplus may be distributed. The surplus of a nonprofit health benefit plan "may be considered excessive only if: (i) the surplus is greater than the appropriate risk based capital requirements as determined by the Commissioner for the immediately preceding calendar year; and (ii) after a hearing, the Commissioner determines that the surplus is unreasonably large." § 14-117(e)(1). After the Commissioner has determined that a corporation's surplus is excessive, the Commissioner may order the corporation to prepare a plan for distribution of the excess surplus. Such a distribution "may be made only to subscribers who are covered by the corporation's nonprofit health service plan at the time the distribution is made." § 14-117(e)(3)

Procedural Background and Expert Reports

11. In 2008, the Companies retained Milliman, Inc. ("Milliman") to analyze the Companies' surplus, and Milliman recommended that the Companies maintain target surplus ranges of 900% to 1200% of authorized control level RBC (ACL-RBC) for CFMI and 750% to 1050% ACL-RBC for GHMSI. These ranges were adopted by the Companies' Boards after receiving Milliman's report. In 2009, then-Commissioner Ralph S. Tyler engaged the Invotex Group ("Invotex") to perform a comprehensive review of Milliman's analysis, as well as the

target surplus ranges recommended by Milliman and adopted by the Companies' Boards. Invotex was engaged to evaluate the reasonableness and appropriateness of the analysis and underlying assumptions. Invotex also conducted an independent analysis of the surplus requirements of the Companies, identified assumptions and risk factors that should be considered in performing such an analysis, and recommended targeted surplus ranges of 825% to 1,075% of authorized control level RBC (ACL-RBC)[3] for CFMI and 700% to 950% of ACL-RBC for GHMSI. While the Invotex review was in progress, the Companies retained The Lewin Group ("Lewin") to conduct an additional independent analysis of GHMSI's surplus, and Lewin recommended a target surplus range for GHMSI of 750% to 1000% ACL-RBC. The Invotex, Milliman, and Lewin reviews reached "similar conclusions" that were expressed as overlapping surplus ranges, as outlined in the Maryland Insurance Administration, Report on CareFirst Premiums and Surplus, at 8 (Jan. 2010) ("2010 MIA Surplus Report").[4] Commissioner Tyler conducted a hearing on the surplus of CFMI and GHMSI in Case No. MIA-2009-11-017, and in January 2010, adopted the targeted surplus ranges recommended by Invotex. *See id.*

12. On May 26, 2011 then-Acting Commissioner Beth Sammis, CFMI and GHMSI entered into the 2011 Consent Order, which was intended "to establish a new working relationship" in which the parties would work to maintain the Companies' surpluses within targeted surplus ranges approved by the Commissioner. Among other things, the 2011 Consent Order provided that the Companies would maintain up-to-date targeted surplus ranges that meet their solvency and other needs, and that those ranges would be disclosed to the Commissioner together with the underlying methodology, data, and assumptions and any expert, independent evaluation upon which the Boards may have relied in determining those targeted surplus ranges. The 2011 Consent Order also recognized that "it is the responsibility of [CareFirst's] Board of Directors to oversee the establishment by the respective Boards of CFMI and GHMSI of targeted surplus ranges for CFMI and GHMSI to provide for the financial soundness of the Companies and allow sufficient capital for the Companies to satisfy the requirements of § 14-102 of the Insurance Article." 2011 Consent Order ¶ 9.

13. The 2011 Consent Order provided that by July 1, 2011, CFMI and GHMSI would submit to the Commissioner targeted surplus ranges for approval and that, upon completion of her review, the Commissioner "shall inform the Companies whether, based on the Commissioner's independent review, the Commissioner intends to approve the targeted surplus range established by each of the Companies or adopt an alternative targeted surplus range for each of the Companies." Under the terms of the 2011 Consent Order:

> [in] determining the appropriateness of the targeted surplus ranges by the Companies [sic], the Commissioner shall consider:

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[3] Maryland law defines various "action level" and "control level" events in relation to an insurer's risk based capital. When an insurer's total adjusted capital falls below its ACL-RBC, the Commissioner may, among other things, take any action necessary to place the insurer under conservation, rehabilitation, or liquidation, if she considers it in the best interest of the insurer's policyholders, the insurer's creditors, and the public. Clearly, an insurer in sound financial health would have a surplus in excess of the level at which such regulatory intervention would be warranted.

[4] The Report is available at http://www.mdinsurance.state.md.us/sa/documents/CareFirstSurplusReport-final010610.pdf.

1. The risks identified by CFMI and GHMSI
2. The availability of capital within the group of companies controlled directly or indirectly by CFI, including CFMI and GHMSI and their subsidiaries and affiliates;
3. The distribution of the business of CFMI and GHMSI, including both risk and non-risk business;
4. The missions of CFMI and GHMSI;
5. Whether the surpluses are adequate for the protection of the subscribers of CFMI and GHMSI; and
6. Any other relevant factors.

14. The 2011 Consent Order further provided: "In the event the Commissioner intends to adopt an alternative targeted surplus range, the parties shall attempt to resolve their differences. In the event that the Commissioner and the Companies are unable to resolve their differences, the Commissioner will hold a quasi-legislative hearing to consider the appropriate targeted surplus range for either CFMI or GHMSI as the case may be."

15. In accordance with the 2011 Consent Order, on June 30, 2011, CareFirst submitted for the Commissioner's approval targeted surplus ranges for CFMI and GHMSI. In support of those targeted surplus ranges, CareFirst submitted reports by two independent actuarial firms, Milliman and The Lewin Group ("Lewin"), engaged to assist the Companies in establishing proposed targeted surplus ranges. Milliman and Lewin used proprietary models to independently determine recommended targeted surplus ranges for CFMI and GHMSI based upon the firms' analyses of the business risks faced by the Companies. Both firms considered, among other things, potential impacts of Affordable Care Act ("ACA") implementation on the health insurance markets and on the Companies' potential need to draw upon surplus to satisfy their statutory missions. Milliman recommended a targeted surplus range of 1,050% to 1,300% of ACL-RBC for each Company. Lewin recommended targeted surplus ranges of 1,050% to 1,600% of ACL-RBC for CFMI and 1,000% to 1,550% of ACL-RBC for GHMSI.

16. Considering the targeted surplus ranges recommended by Milliman and Lewin, the respective Boards adopted, with one exception, the lower recommended figures for both the bottom and top of each range: 1,050% to 1,350% of ACL-RBC for CFMI and 1,000% to 1,300% of ACL-RBC for GHMSI. With regard to the top of the range for CFMI, management recommended that the Board increase the lower 1,300% recommended figure to 1,350% to maintain "the 300% span from the low to the high end of the range that is consistent with CFMI's past practices." *See* Letter from Chet Burrell to Commissioner Therese Goldsmith (June 30, 2011).[5]

17. In accordance with the 2011 Consent Order, the Commissioner initiated a review of the Companies' Board-approved targeted surplus ranges. To assist with this review, the Maryland Insurance Administration ("MIA") engaged a professional services firm, RSM McGladrey, Inc. ("McGladrey"), to perform an independent analysis of the appropriateness of

[5] In its January 2010 Report on CareFirst Premiums and Surplus, the MIA adopted 250-point targeted surplus ranges.

the Board-approved targeted surplus ranges. McGladrey's engagement included a review and evaluation of information concerning the business risks faced by the Companies and the development of the Board-approved targeted surplus ranges, an evaluation of the models used by Milliman and Lewin in developing their recommended targeted surplus ranges, and consideration of whether alternative targeted surplus ranges would be appropriate. In a report dated May 29, 2012, McGladrey concluded that the Board-approved targeted surplus ranges appear reasonable and supported by the analyses completed by Milliman and Lewin.[6]

18. In addition to McGladrey's conclusions regarding the Board-approved targeted surplus ranges, the McGladrey Report contains a number of observations and recommendations for the Companies related to potential enhancements to their financial projections, surplus management and liquidity.

Findings

19. The analysis and conclusions of three independent consultants – two retained by the Companies and one retained by the MIA – support a finding that the targeted surplus ranges adopted by the Companies are appropriate, at present, to provide a high level of confidence that the Companies' surpluses will not fall below levels that could result in corrective regulatory action or jeopardize the Companies' use of the Blue Cross Blue Shield trademark, thereby potentially eroding consumer confidence and undermining the Companies' ability to satisfy their statutory mission and obligations to policyholders and creditors. Risk factors cited by the Companies or the consultants include, but are not limited to, underwriting risk; asset risk; cost of capital and credit risk; operational and business risk; planned capital expenditures; anticipated business plan changes; Company subsidization of the health care markets in some instances; and the statutory mission of nonprofit health service plans. According to the Companies and consultants, there also are additional, potentially substantial risks associated with implementation of the ACA, in the short term at least, such as significant potential shifts in the risk profiles and volumes of blocks of business being insured by the Companies, and new underwriting and rating regulations under the ACA.

20. The details of programs designed to mitigate risks associated with implementation of the ACA, including risk adjustment, reinsurance, and risk corridor programs, have not yet been fully defined, and their potential impact on CareFirst is uncertain at present.

21. As nonprofit health service plans, the Companies are required under § 14-106(d) to offer health care products in the individual and small employer group markets, which are smaller and less lucrative market segments than the large group market. According to an independent report, CareFirst affiliated entities (CFMI, GHMSI and CareFirst BlueChoice, Inc.) have approximately a 70% share of the individual and small group markets in the State. *See* Mercer, *Report of Market Rules and Risk Selection for the State of Maryland for the Maryland Health Benefit Exchange*, (November 9, 2011)

[6] The McGladrey Report and CareFirst's response are included as Attachment 1.

http://dhmh.maryland.gov/exchange/pdf/FinalMDStudyofMarketRules-and-RiskSelectionReport.pdf.

22. The Companies lack access to equity markets, and must rely on accumulated surplus and any future gains from underwriting and investment to fund their obligations.

23. The Companies' business is not diversified among several lines of insurance. Rather, CFMI and GHMSI underwrite only health insurance and cannot offset risk with other lines of business.

24. Unlike many of their competitors, the Companies operate in only one geographic region: Maryland, the District of Columbia, and Northern Virginia. The Companies cannot offset risk in this region with business in other geographic regions.

25. As noted by Invotex in 2009 and McGladrey in 2012, substantial proportions of the Companies' surplus levels are attributable to their 50% joint venture investment in CareFirst Holdings, LLC. ("CF Holdings").[7] This is particularly true for CFMI.

26. CareFirst's surplus, inclusive of both GHMSI and CFMI, was at 859% of ACL-RBC at the end of 2011, placing CareFirst below the median for Blue Cross and Blue Shield Plans around the country.

27. Based upon a review of the factors listed in § 4-103(c)(2) and those listed in the 2011 Consent Order, as well as the expert opinions referenced in paragraphs 15 through 18 above, the Commissioner finds that, at present, targeted surplus ranges of 1,050% to 1,350% of ACL-RBC for CFMI and 1,000% to $1,300% of ACL-RBC for GHMSI are adequate and are neither excessive nor unreasonably large.

ACCORDINGLY, it is hereby mutually agreed among the Parties and therefore **ORDERED** by the Maryland Insurance Commissioner this 14th day of September, 2012, as follows:

A. The approved targeted surplus range for CFMI effective from the date of this Order shall be 1,050% to 1,350% of its authorized control level risk based capital.

B. The approved targeted surplus range for GHMSI effective from the date of this Order shall be 1,000% to 1,300% of its authorized control level risk based capital.

C. The Companies agree to review the appropriateness of the approved ranges annually during the three year period from 2013 through 2015. During this annual review period, the Companies will submit by July 1 of 2013, 2014 and 2015 a report to the Commissioner assessing the continued appropriateness of the ranges approved in this Order, or those subsequently approved by the Commissioner and then in effect. Such submissions shall

[7] The majority of the value of CF Holdings is the carrying value of its investment in the Companies' for-profit affiliate, CareFirst Blue Choice, a health maintenance organization that operates in Maryland, the District of Columbia, and Virginia.

include all relevant supporting facts, analysis, assumptions, and external analyses and opinions relating to the targeted surplus ranges of the Companies, including, but not limited to, how developments in the implementation of the ACA, and any corresponding reduction in risks or uncertainties, have affected the Companies' surplus needs. The parties agree that the Companies may designate information as confidential commercial information, when appropriate and subject to a determination by the Commissioner under the Public Information Act, and that a consultant retained by the MIA may be required to sign a reasonable confidentiality agreement with the Companies before confidential commercial information is provided to the consultant.

D. Unless otherwise agreed to by the Parties or ordered by the Commissioner, after July 15, 2015, the Companies shall undertake a review of their targeted surplus ranges by qualified actuarial experts no less frequently than every three years and shall submit such targeted surplus ranges to the Commissioner for approval. These submittals shall contain all of the information listed in paragraph C.

E. In reviewing each targeted surplus range for each Company submitted in accordance with paragraphs C and D above, the Commissioner may procure, at the expense of each Company, appropriate experts to advise the Commissioner on the appropriateness of the targeted surplus range. To facilitate the Commissioner's review, the Companies agree to ensure reasonable access to the relevant data, assumptions, and expert opinions and analyses relied upon or in the possession of the Companies and to the experts providing such opinions and analyses and whatever other materials of the Companies and their affiliates and subsidiaries the Commissioner considers reasonably necessary for her review.

F. Pursuant to § 2-210(a)(1), and in accordance with COMAR 31.02.06, the Commissioner may conduct a quasi-legislative hearing before determining whether the revised targeted surplus ranges submitted pursuant to paragraph C and D are appropriate. If the Commissioner determines that the surplus ranges submitted under paragraphs C and D are not appropriate, the Commissioner will set out her findings and conclusions in an Order.

G. The Companies agree to strive to maintain an actual surplus position for each Company at the midpoint of the surplus ranges approved by the Commissioner, and to move surplus to the midpoint in a gradual manner. Consistent with these two principles, in each rate filing submitted to the Commissioner for approval, each Company will provide its actual surplus as of its most recent quarterly filing, expressed in absolute dollar values and as a percentage of the Company's most recently calculated ACL-RBC, as well as the Company's projected surplus over the next 12 months, expressed in those same terms, to include, without limitation, the projected impact to the total surplus resulting from changes in contribution to surplus factor approved in prior rate filings and any pending changes in contribution to surplus factor that have yet to be approved. The Company also will provide in each rate filing an explanation of that portion of the requested rates or change in rates that relates to the Company's contribution to or reduction of its surplus.

H. The Companies agree and recognize that the Commissioner may consider the information provided to the Commissioner as required by paragraph G, in determining whether

to approve, disapprove, or modify the form or table of rates filed by CFMI or GHMSI, along with the other relevant factors.

I. CFMI, GHMSI and CareFirst will provide a joint report reviewed and approved by the applicable Boards to the Commissioner, on or before December 30, 2012, regarding the Companies' plans to address the observations and recommendations contained in the McGladrey Report on the Companies' financial projections, surplus management, and liquidity.

J. In their annual statements filed with the Commissioner under § 14-121, both GHMSI and CFMI shall specify:

1. their targeted surplus range applicable to the calendar year for which the annual statement is filed; and
2. their actual surplus in absolute dollar values and as a percent of authorized control level RBC at the close of the calendar year for which the annual statement is filed.

So ORDERED this 14th day of September, 2012.

Signature on original

Therese M. Goldsmith
Maryland Insurance Commissioner

CONSENT OF CAREFIRST OF MARYLAND, INC., GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC., AND CAREFIRST, INC.

CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc., and CareFirst, Inc. hereby consent to the entry of this Consent Order, as well as to the terms contained herein. Furthermore, Chet Burrell acknowledges, in his capacity as the President and Chief Executive Officer of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc., and CareFirst, Inc. that he has the authority to enter into this Consent Order and bind CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc., and CareFirst, Inc. to the terms contained herein.

CAREFIRST OF MARYLAND, INC.
GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC.
CAREFIRST, INC.

By: Signature on original
Name: Chet Burrell
Title: President and Chief Executive Officer

9/13/12
Date

RIGHT TO REQUEST A HEARING

Pursuant to § 2-210 of the Insurance Article of the Annotated Code of Maryland and COMAR 31.02.01.03, a person aggrieved by this Order may request a hearing. The request must be in writing and be received by the Commissioner within 30 days of the date of this Order.

Pursuant to § 2-212 of the Insurance Article, the Order shall be stayed pending a hearing only if a request for a hearing is received by the Commissioner within ten days of the date of this Order.

The written request for a hearing must be addressed to the Maryland Insurance Administration, 200 St. Paul Place, Suite 2700, Baltimore, Maryland 21202, ATTN: Sharon Kraus, Appeals Clerk. Failure to request a hearing timely or to appear at a scheduled hearing will result in a waiver of the right to contest this Order and the Order shall be made final on its effective date.