

RECTOR & ASSOCIATES, INC.

**REPORT TO THE D.C. DEPARTMENT OF INSURANCE, SECURITIES
AND BANKING**

GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC.

Effective September 1, 2009, Rector & Associates, Inc. (“R&A”) was retained by the D.C. Department of Insurance, Securities and Banking (“DISB”) in accordance with D.C. Statutes §§ 31-1402 and 31-3506(h) to examine Group Hospitalization and Medical Services, Inc. (“GHMSI”) and to assist with the DISB’s determination as to what portion of the surplus of GHMSI is attributable to the District of Columbia (“District”) and whether such surplus is excessive.

The scope of our examination, as requested by the DISB, consisted of the following:

1. A review of the various actuarial modeling methods used by different consulting firms to calculate the amount of surplus needed by GHMSI to support its future obligations. Our review primarily focused on the surplus analysis performed by Milliman, Inc. on behalf of GHMSI, as documented in a report from Milliman entitled “Need for Statutory Surplus and Development of Optimal Surplus Target Range” (“Milliman Report”). We also reviewed the following reports:
 - A report from the Lewin Group analyzing the Milliman Report, as prepared prior to the DISB’s public hearing;
 - A second report from the Lewin Group regarding an “appropriate” level of RBC for GHMSI, as prepared after the DISB’s public hearing;
 - A report from Actuarial Risk Management (“ARM”) regarding GHMSI’s surplus position, as prepared prior to the DISB’s public hearing;
 - A second report from ARM regarding an “appropriate” level of RBC, as prepared after the DISB’s public hearing; and
 - A report from Invotex Group analyzing an “appropriate” surplus range for GHMSI;
2. A peer review analysis for GHMSI;
3. A review of GHMSI’s financial projections, as contained in GHMSI’s long-range strategic plan, and GHMSI’s actual financial results;
4. An analysis of GHMSI’s 2008 and 2009 community health reinvestment expenditures; and
5. An analysis of factors that the Commissioner might wish to consider when determining the surplus attributable to the District.

The following constitutes our findings and report regarding each scope item.

I. ANALYSIS OF ACTUARIAL MODELING METHODS

Summary Findings.

We reviewed the surplus analyses performed by Milliman, the Lewin Group, ARM, and the Invotex Group, as documented in their reports. We understand that the Lewin Group and the Invotex Group had access to detailed financial and actuarial information that was employed by Milliman in its surplus analysis, including detailed information regarding its methodology. Our understanding is that ARM did not have access to that information.

As part of our analysis, we considered ARM's analysis and the conclusions it reached in its report. However, because ARM did not have access to the same information as the Lewin Group and the Invotex Group, we did not believe it was appropriate to compare ARM's analysis to Milliman's analysis in the same manner that we compared Milliman's analysis to the analysis performed by the Lewin Group and Invotex Group. Accordingly, our references within this report to the analysis performed by other consultants is limited to the analysis performed by the Lewin Group and the Invotex Group.

We noticed various anomalies and simplifications in Milliman's methodologies that may materially impact Milliman's resulting surplus estimates. Despite these limitations, however, the Milliman methodology is helpful in analyzing the amount of surplus GHMSI could need for future operations. Accordingly, we assumed the basic validity of the Milliman methodology and then reviewed the assumptions used by Milliman. We accepted some of the Milliman assumptions, adjusted others, and added certain other assumptions, as described below and in Exhibit 1 of this Report.

The actuarial analysis performed by all of the consultants focused primarily on GHMSI's financial statements and data as of December 31, 2008 and earlier. After the date of those statements and data, there have been very significant changes in the District and US regulatory frameworks, as described below. Those changes will have a significant impact on GHMSI's future operations and results. The analysis performed by all of the consultants, including R&A, did not attempt to incorporate the effect of such changes on GHMSI's surplus.

Consistent with the work performed by Milliman and the other consulting firms, we calculated various data points as of December 31, 2008, including: (1) the amount of surplus GHMSI needs to ensure it will remain above a 200% RBC target level and (2) the amount of surplus GHMSI needs to ensure that it will remain above a 375% RBC target level. The following chart summarizes the lower and higher RBC numbers that various consultants calculated as of December 31, 2008.

Consultant	Lower Number	Higher Number
Milliman	750% (98% confidence @ 200% RBC, 2 year trend miss) ¹	1,050% (95% confidence @ 375% RBC, 2½ year trend miss)
Lewin Group	750% (Assumptions and methodology not provided)	1,000% (Assumptions and methodology not provided)
Invotex	700% (Assumptions not provided)	950% (Assumptions not provided)
R&A	600% (99% confidence @200% RBC, 2½ year trend miss)	850%² (95% confidence @375% RBC, 2½ year trend miss)

We note that Milliman’s numbers have sometimes been described as providing a “range” of necessary or optimal surplus. In its report, for example, Milliman described its numbers of 750% RBC and 1,050% RBC as an “optimal target surplus range.” It is important to keep in mind, however, that the numbers leading to what is described as a “range” are merely data points based on calculations regarding the amount of surplus needed for GHMSI to remain above various RBC target threshold levels. In other words, Milliman’s 750% RBC number is the amount of surplus Milliman calculates GHMSI needs as of December 31, 2008 to remain above a 200% RBC threshold based on certain assumptions. Milliman’s 1,050% RBC number is the amount of surplus Milliman calculates GHMSI needs to remain above a 375% RBC threshold based on different assumptions.

How these numbers relate to what amount of surplus is “necessary,” “optimal,” “appropriate,” “excessive,” or any other such qualitative word depends in significant part on the importance one places on the RBC thresholds that are being protected against. For example, if one believes that it is “necessary” for GHMSI to stay above the 200% RBC threshold level, then GHMSI’s “necessary surplus” as of December 31, 2008 would be 750% RBC based on Milliman’s calculations (or 600% RBC based on our calculations). If one believes that it is “optimal” (but not “necessary”) for GHMSI to stay above the 375% RBC threshold level, then GHMSI’s “optimal (but not necessary) surplus” as of December 31, 2008 would be 1,050% RBC based on Milliman’s calculations (or 850% RBC based on our calculations). Similarly, if one believes that GHMSI’s surplus is “excessive” to the extent that it exceeds what is needed to remain above a 200% RBC target threshold, then GHMSI would have “excessive surplus” to the extent that its surplus as of December 31, 2008 is greater than 750% RBC based on Milliman’s calculations (or 600% RBC based on our calculations). In contrast, if one believes that GHMSI’s surplus is not excessive unless it exceeds what is needed to remain above a 375% RBC target threshold level, then GHMSI would not have “excessive surplus” unless its surplus as of December 31, 2008

¹ Milliman also provided to us calculations showing that a starting/initial 750% RBC number would result in a 90% degree of confidence that GHMSI would remain above a 375% RBC target threshold assuming a 2 year trend miss.

² We also calculated RBC numbers for GHMSI as of December 31, 2008 at a 90% confidence level and at a 99% confidence level based on a 2½ year miss. Based on our calculations, GHMSI would need a starting/initial 800% RBC number to stay above 375% RBC at a 90% confidence level and a starting/initial 900% RBC number to stay above 375% RBC at a 99% confidence level.

exceeds 1,050% RBC based on Milliman's calculations (or 850% RBC based on our calculations).

For these reasons, it is important to pay particular attention to the underlying threshold targets—and not just to the numbers in the “range”—to reach conclusions regarding how GHMSI's surplus compares to the thresholds described in DC law and regulation.

Appropriateness of Milliman Methodology.

The Milliman methodology takes into account a specific set of scenario assumptions regarding GHMSI's future financial and operational results. Once the amount of surplus is determined for various scenarios, those results are translated into a target RBC number that GHMSI should maintain to ensure GHMSI will remain above the selected RBC thresholds with a high degree of confidence.

Based on our review of the Milliman methodology, we noticed various anomalies and simplifications in Milliman's methodologies that may materially impact Milliman's resulting surplus estimates. For example, the Milliman methodology does not validate GHMSI historical results over the last 13 years. Based on a statistical analysis of the Milliman loss curve, it seems highly improbable that GHMSI's actual results could have been generated using the Milliman approach, a critical test for the validity of any modeling approach. As another example, the Milliman loss curve assumes that liability and asset risks are independent of each other and the yield curve. Rather than projecting periodic cash flows with dynamic interactions between assets and liabilities, all the risk assumptions are smoothed and blended into a loss ratio representing an entire underwriting cycle. The theoretical basis for such an approach is outdated. For the last 20 years, industry practice for surplus analysis has incorporated dynamic asset/liability matching in the form of Cash Flow Testing, Dynamic Financial Analysis, and, more recently, Enterprise Risk Management tools.

Despite these limitations, the Milliman methodology is helpful in analyzing the amount of surplus GHMSI would need for future operations. Accordingly, we assumed the basic validity of the Milliman methodology and then focused on whether we agreed or disagreed with Milliman's assumptions.

Assumptions Used By Milliman.

As noted above, the Milliman methodology incorporates numerous assumptions. The reasonableness of Milliman's calculations is directly dependent on the reasonableness of the assumptions used to generate such calculations.

Milliman used one set of assumptions to generate a loss curve. Milliman then incorporated that loss curve into financial projections that were based on a second set of assumptions. We reviewed the assumptions underlying both the loss curve and the financial projections, as described below. We accepted some of the Milliman assumptions without change, adjusted others, and added certain other assumptions, as described below and in Exhibit 1 of this Report.

Loss Curve Assumptions.

Milliman Assumptions. As part of its methodology, Milliman used seven major categories of risk and contingency categories for purposes of constructing the loss curves. Each of these assumptions is identified below, as well as the results of our analysis of each assumption.

- Rating Adequacy and Fluctuation
Based on our review, we did not make any adjustment to Milliman's assumption for this risk category is needed.
- Unpaid Claims Liabilities
Based on our review, we did not make any adjustment to Milliman's assumption for this risk category is needed.
- Interest Rate and Asset Values
In order to develop interest rate assumptions, Milliman estimated a range of deviations of projected asset values and interest rates from a 4% base earned rate assumption. Based on our review of the assumed interest rate changes, we made downward adjustments to the loss curve of between 0.75% and 1.75%, depending on the level of confidence chosen in the modeling.
- Overhead Expense Recovery
Based on our review, we did not make any adjustment to Milliman's assumption for this risk category.
- Other Business Risk, Including ASC Defaults
Based on our review, we did not make any adjustment to Milliman's assumption for this risk category.
- Catastrophic Events
Catastrophic events are infrequent, severe, and unpredictable events. Examples range from natural catastrophes (pandemics, earthquakes, or hurricanes) to human activity (terrorism, nuclear power accidents, or major litigation).

Milliman's catastrophic event assumption results in a charge of 2.5% of non-FEP premiums in each underwriting cycle -- a \$75 million regular expense, or \$25 million per year. As a practical matter, a recurring expenditure of this nature would be provided for in the company's operating budget and a separate provision in surplus for this amount would not be needed.

Although we question whether it is appropriate to include catastrophic event assumptions in the manner used by Milliman, we chose to include a charge for catastrophic events. However, based on our review of possible catastrophic risk charges and loss curve sensitivities provided by Milliman, we made downward adjustments to the loss curve of between 1.50% and 2.00%, depending on the level of confidence chosen in the modeling.

- Growth and Development Charges

Growth and development charges are extraordinary expenditures resulting from unanticipated growth, including technology and infrastructure investments. These charges are in addition to increases in ACL-RBC that flow from premium growth.

Milliman's growth and development assumption results in a charge of 2% of non-FEP premiums in each underwriting cycle -- a \$60 million regular expense, or \$20 million per year. As a practical matter, this base line expenditure would be provided for in the company's operating budget and a separate provision in surplus for this amount would not be needed.

Although we question whether it is appropriate to include an assumption for growth and development charges in the manner used by Milliman, we chose to include a growth and development charge. However, based on our review of possible growth and development charges and loss curve sensitivities provided by Milliman, we made downward adjustments to the loss curve of between 1.25% and 1.75%, depending on the level of confidence chosen in the modeling.

Additional Assumptions. In addition to Milliman's assumptions, we identified several additional assumptions regarding which we made adjustments to Milliman's loss curve.

- Pension Plan Charges

Milliman staff indicated that they did not consider pension plan risks in developing their loss curve. We believe such risks should be considered, so we developed assumptions relating to such risks. Our assumptions are based on frequency and severity distributions that are similar to assumptions relating to bond interest rate changes.

Based on our review of possible pension plan risk charges, we made upward adjustments to the loss curve of between 1.00% and 1.75%, depending on the level of confidence chosen in the modeling.

- Management Intervention Actions

Milliman staff has indicated that they did not consider the effect that management intervention might have on GHMSI's operations. We acknowledge that management is not in control of all events affecting an insurer. However, management can take action to mitigate the challenges of underwriting cycles and catastrophic events, including decreasing reserve margins, increasing pricing margins, implementing more stringent underwriting standards, and delaying investments in infrastructure.

- Reserve Margins. Based on our review of GHMSI's financial information, GHMSI targets redundant reserves of approximately 10%. The estimated redundancy for 2008 was \$49 million. It is reasonable to expect that if management were concerned about crossing a particular RBC threshold, management would react by reducing reserve margins and releasing redundant reserves into surplus.

Accordingly, we made downward adjustments to the loss curve of between 0.5% and 1.5%, depending on the level of confidence chosen in the modeling.

- Pricing Margins and Underwriting Standards. The Milliman model assumes a pricing margin on its non-FEP insured business. It is reasonable to expect that if management were concerned about crossing a particular RBC threshold, management would react by increasing pricing margins and/or implementing more stringent underwriting standards. For purposes of developing assumptions for these actions, we assumed that management would identify and respond to a deteriorating situation in year two and implement changes that affect pricing margins and underwriting standards in year three.

Accordingly, we made downward adjustments to the loss curve of 1.50% at all confidence levels.

- Infrastructure Investments. Historical information provided by GHMSI indicates that GHMSI incurred baseline capital expenditures of approximately \$45 million per year during the past decade. It is reasonable to expect that if management were concerned about crossing a particular RBC threshold, management would react by delaying or canceling at least some infrastructure investments.

Accordingly, we made downward adjustments to the loss curve of between 0.0% and 1.0%, depending on the level of confidence chosen in the modeling.

Financial Projection Assumptions.

- Tax Impact. The Milliman projections do not include the value of deferred tax credits that would result from GHMSI's projected losses. Because such tax credits would have value if GHMSI remains a going concern, it appears appropriate to recognize such credits in the financial projections.

For purposes of assumptions used in the financial projections, we assumed that GHMSI would be subject to a 20% tax rate on an ongoing basis.

- Premium Growth. Milliman assumed a 12% to 14% range for premium growth. While this range is not unreasonable, we believe a wider range would better capture the potential risk associated with policyholders' purchasing decisions and management's response to those decisions.

As a result, we assumed a 10% to 16% range for premium growth.

- Selected RBC Thresholds. In connection with its calculations, Milliman used two different RBC ratio thresholds: 200% RBC and 375% RBC.

At the 200% RBC level, the BlueCross BlueShield Association (BCBSA) would terminate GHMSI's license to use the Blue brands and GHMSI would be subject to

stringent regulatory oversight by the DISB. At the 375% RBC level, GHMSI would be subject to intensified monitoring by the BCBSA (the BCBSA Early Warning Level). We agreed that these are thresholds as to which data points should be calculated.

- Selected Confidence Levels. To arrive at its “range” of 750% to 1,050% RBC, Milliman used a 98% confidence level to maintain a 200% RBC level and 90% to 95% confidence level to maintain a 375% RBC level.

The consequences to GHMSI of falling below the 200% RBC level are so severe that we believe it would be appropriate to be even more conservative than Milliman regarding that threshold. So we selected a 99% confidence level (rather than Milliman’s 98% level) as to the 200% RBC level. The consequences to GHMSI of falling below the 375% RBC level have negative implications to GHMSI, but would not itself trigger regulatory action. Consequently, we selected a 95% confidence level as to the 375% RBC level.

- Length of Underwriting Cycle. For purposes of establishing its RBC range, Milliman tested underwriting cycles of both a three-year and a four-year duration. Because the four-year underwriting cycle generates an additional year of underwriting gains, using a four-year cycle reduces the amount of surplus required to achieve certain RBC levels. To be conservative, we assumed a three year underwriting cycle in our financial projection assumptions.
- Trend Miss Durations. In its analysis, Milliman anticipated that GHMSI would miss its anticipated trend assumption for two different time periods: a two-year period and a 2½ year period. To be conservative, we assumed a 2½ year trend miss in our financial projections.

Changes in District and US Regulatory Frameworks.

As noted above, the analyses performed by all of the consultants, including R&A, sought to measure GHMSI's surplus needs as of December 31, 2008. However, there have been very significant changes in the District and US regulatory frameworks since that time that will have a significant impact on GHMSI's future operations and results. The analysis performed by all of the consultants, including R&A, did not attempt to incorporate or measure the effect of such changes on GHMSI's surplus.

District Rating Regulation. On March 2, 2010, the District of Columbia Council ("Council") enacted the Reasonable Health Insurance Premium Increase Emergency Act of 2010 ("Act"). The Act provides (among other things) that a hospital and medical services corporation ("Service Corporation"), such as GHMSI, cannot increase its rates in any given year by more than 10% of the preceding year's rates, except that the District Mayor may in his or her discretion grant a Service Corporation an exemption to permit a rate increase of up to 15% of the preceding year's rates. In May 2010, the Council proposed permanent legislation to reform the rate approval process to, among other things, mandate a minimum medical loss ratio.

In addition, the DISB issued the following four Orders that apply to recent GHMSI rate increases: Case No. IB-RF-01-10 dated March 3, 2010; Case No. IB-RF-02-10 dated March 12, 2010; Case No. IB-RF-03-10 dated March 12, 2010; and Case No. IB-RF-04-10 dated April 13, 2010. For reasons set forth in the Orders, the Orders rescinded previously approved GHMSI rate increases that were effective January 1, 2010. The rate increases for GHMSI's various products that were rescinded ranged from 17.3% to 35%. The Orders instead allowed for rate increases for 2010 of 12% of the 2009 premium rates for certain GHMSI products.

It is clear that these reductions in, and caps on, GHMSI's allowable rate increases will impact GHMSI's future financial position. Such reductions and caps were not factored into the actuarial analysis work performed and reviewed in connection with our Report. Accordingly, the actuarial analysis work performed by all of the consulting firms involved, including the work performed by Milliman and R&A, would need to be adjusted to reflect the fact that these limits now exist.

Federal Health Care Reform. Further, the Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Act of 2010 (collectively, "Health Care Reform Bill") was recently enacted. The Health Care Reform Bill provides for a wide range of health care and insurance changes and reforms, including such things as expanded federal oversight of health care plan premium rate increases, restrictions regarding the use of pre-existing condition limitations, and limitations on health care plan designs.

It is not yet clear how many of the changes and reforms will ultimately operate. In many instances, rules and other implementing guidance and procedures still need to be adopted. Further, a number of the changes and reforms have effective dates that are phased in over the next four years. Accordingly, it is expected that there will be significant evolution over time in how the health care industry will react to the changes and reforms and how such changes and reforms will impact all health insurers, including GHMSI.

II. PEER REVIEW ANALYSIS

Summary Findings.

The following chart summarizes our peer review analysis findings:

	RBC Ratio Range	RBC Ratio Average
Invotex Findings	336% — 917%	678%
Appleseed/ARM Findings	384% — 891%	572%
Stock For-Profit Insurer Findings – Publicly Traded	341% — 1,648%	470% ³
Stock For-Profit Insurer Findings – Not Publicly Traded	718% — 721%	700% ³

GHMSI's RBC ratio as of December 31, 2008 was 845%.

Invotex Analysis.

As part of Invotex' analysis on behalf of the Maryland Insurance Administration (MIA), Invotex performed a peer review analysis of insurance companies that Invotex considered to be similar to GHMSI.⁴

Invotex considered GHMSI's peer insurers to consist of mid-sized nonprofit Blue Cross/Blue Shield plans that operate in competitive markets and that write significant amounts of group business, as well as individual business. As a result of its analysis, Invotex selected nine peer insurers. The following chart lists the nine peer insurers that Invotex chose, as well as the insurers' RBC ratios.

	2008 RBC Ratio
BC&BS of MN	489%
BC&BS of RI	738%
BC&BS of TN	891%
Capital Blue Cross	851%
Independence Blue Cross	336%
Premera Blue Cross	662%
Regence BC&BS of OR	563%
Regence BC&BS of UT	655%
Regence BlueShield	917%
2008 Average RBC Ratio	678%

³ We calculated RBC ratio weighted averages for the publicly traded and not publicly traded insurance holding company systems by dividing the sum of the total adjusted capital amounts for all selected insurers within a system by the sum of the authorized control level surplus amounts for all selected insurers within that system.

⁴ See pages 37 – 45 of Invotex' October 30, 2009 report to the MIA.

Actuarial Risk Management(ARM)/DC Appleseed Analysis.

DC Appleseed Center for Law and Justice, Inc. (“DC Appleseed”) provided several reports to the DISB in connection with the DISB’s public hearing. DC Appleseed’s August 31, 2009 pre-hearing report included peer review analysis performed by Actuarial Risk Management (“ARM”).

ARM indicated in its report that it considered GHMSI’s product profile when it identified seven peer insurance companies. All of the seven peer insurers selected by ARM are nonprofit insurers (except for BC&BS of GA, a for-profit insurer).

The following chart lists the peer insurers chosen by ARM, as well as their RBC ratios and AM Best ratings.

	2008 RBC Ratio
BC&BS of GA	551%
BC&BS of MN*	489%
BC&BS of TN*	891%
Horizon Healthcare of NJ	384%
Premera Blue Cross*	662%
QCC Insurance Company	469%
Regence BlueCross Blue Shield*	563%
2008 Average RBC Ratio	572%

*Indicates peer insurers that were chosen by both ARM and Invotex.

Stock For-Profit Peer Insurer Analysis.

We noted that Invotex and ARM both selected nonprofit Blue Cross/Blue Shield plans for their peer review analysis. We do not disagree with those selections. However, in order to include additional data points in the peer review analysis, we identified peer companies that comprise for-profit stock insurance holding company systems.

We believe that it is appropriate to consider for-profit insurers as additional data points in the peer review analysis in part because of the provisions of DC law that GHMSI engage in community health reinvestment to the maximum feasible extent consistent with financial soundness and “efficiency”. Because for-profit insurers often are recognized as having efficient operations due to the pressures exerted by the capital markets on for-profit insurers’ profitability goals, considering such companies may provide additional information regarding what level of capital may be consistent with efficient operations.

At the same time, for-profit stock insurers often have access to capital that is not available to nonprofit Blue Cross/Blue Shield plans. In many situations, for-profit stock insurers have ultimate parents that are publicly traded companies that can capitalize their insurers, as needed. Consequently, a for-profit insurer might not need as much surplus as a nonprofit insurer.

So for-profit insurers may not be perfect peers to GHMSI, but we believe that it would be helpful to have RBC information regarding such companies to consider alongside the non-profit Blue Cross/Blue Shield peer companies selected by Invotex and ARM.

Based on our analysis, we chose three for-profit insurance holding company systems. Two of them, Wellpoint and Humana, are publicly traded companies. The third, Wellmark, is not publicly traded. These groups consist of over 20 individual insurers. The chart pertaining to publicly traded companies only includes companies within the groups that have AM Best ratings of A- or higher; i.e., the more highly capitalized companies.

Publicly Traded Companies	2008 Weighted Average RBC Ratio
Wellpoint	471%
Humana	464% ⁵

Non-Publicly Traded Companies	2008 Weighted Average RBC Ratio
Wellmark	700%

The publicly-traded systems include subsidiary insurers that are similar to GHMSI in terms of revenue size, lines of business written (including FEP business), and the number of states in which the insurers operate. Wellmark was chosen as a non-publicly traded peer because the Wellmark insurers have financial results and operations that are similar to results and operations for GHMSI. (For example, the combined net premiums written and admitted assets for the Wellmark insurers as of 12/31/08 are \$2.5 billion and \$1.6 billion, respectively, as compared to GHMSI's net premiums written and admitted assets of \$2.8 billion and \$1.8 billion, respectively.)

⁵ Insurers in the Humana holding company systems were not included in determining the average RBC ratio if their AM Best ratings were lower than A- and if their RBC ratios were not calculated in accordance with the health RBC formula.

III. FINANCIAL ANALYSIS OF GHMSI'S FINANCIAL PROJECTIONS AND ACTUAL FINANCIAL RESULTS

We reviewed the financial projections contained in GHMSI's long-range strategic plan for reasonableness, including, as appropriate, a comparison of the projections to GHMSI's actual financial results. We performed this analysis for three reasons. First, the comparison helps in an evaluation of whether GHMSI's financial projections are reasonable and consistent with GHMSI's historical financial results. Since GHMSI's financial projections, as contained in its long-range strategic plan, serve as the basis for Milliman's analysis, it is important that GHMSI's financial projections be reasonable and consistent with its operating history.

Second, a comparison of actual results to those that were projected allows us to see how GHMSI actually fared in the worst economic recession in recent history. Since the financial projections were made prior to and without knowing of the recession, the comparison of actual to projected provides a view as to how GHMSI's financial position might be affected by future financial and business problems.

Third, we reviewed GHMSI's financial results as of 9/30/09 to assess GHMSI's current financial condition.

Analysis and Findings.

Reasonableness of GHMSI Financial Projections. As part of our review of the surplus analysis performed for GHMSI by Milliman, we evaluated the reasonableness of the financial projections contained in GHMSI's long-range strategic plan. We found that GHMSI's financial projections are reasonable and consistent with GHMSI's historical financial results.

We also reviewed GHMSI's financial operations on a long-term basis to analyze the consistency of its financial results. For the past 10 years, GHMSI has consistently produced positive results from its underwriting operations and its investment holdings. In fact, GHMSI has produced average annual underwriting profits of \$35 million from 1999 through 2008. Additionally, financial and leverage ratios measuring medical losses, administrative expenses, overall underwriting profitability, profit margin, and premium to policyholders' surplus have been consistent from year-to-year, as well as financially conservative. GHMSI's investment portfolio has been moderately conservative, producing average annual net investment gains of \$28 million. Overall, GHMSI has generated consistent net profits since 1999, averaging \$55 million per year.

Analysis of GHMSI's Recent Financial Results. In addition, we analyzed GHMSI's actual 2008 financial results, as compared to its 2008 financial projections, to assess how the worst economic recession in recent history affected GHMSI's financial condition. We also performed a limited comparison of GHMSI's financial results between 2008 and 2007.

With respect to GHMSI's underwriting account, we found that:

- Actual premium and fee revenue were 13.3% lower than projected (\$2.82 billion, as compared to \$3.26 billion); and
- Actual net underwriting gain was 47% lower than projected (\$9.5 million, as compared to \$18 million).

Although premium revenues were lower in 2008 than projected, incurred health care expenses and operating expenses, as a percentage of premium revenues, were fairly consistent with the operating ratios assumed in GHMSI's financial projections. As an example, GHMSI planned for a contribution margin (i.e., incurred health care expenses divided by total premiums) of 12.6% and experienced a contribution margin of 12.2%, despite a lower premium volume. (Net underwriting gain, as a percentage of total revenue, resulted in a margin of 0.3% versus a projected margin of 0.6%.)

GHMSI projected investment interest income of \$41.8 million in 2008 and net investment results of \$42.3 million. Although investment gains and losses were not forecasted, GHMSI reported net realized capital losses of \$18.0 million for 2008. As a result, GHMSI's net investment results were \$24.3 million, which was 42% lower than projected.

Despite the economic recession and tumultuous capital markets during 2008, GHMSI's actual net income was \$26.2 million in 2008 (34.4% lower than its projected net income of \$40 million, but still positive results in a very difficult economic environment). However, this apparent contribution to surplus in the form of net income was offset by the following accounting adjustments, which were primarily driven by the precipitous drop in investment values during 2008:

- Unrealized investment losses of \$10.5 million;
- An increase in the minimum pension liability of \$22.3 million; and
- An increase in prepaid pension assets of \$42 million.

In total, GHMSI's policyholders' surplus declined by \$66.8 million, or 8.9%, to \$687 million for year-end 2008. Despite this decline, GHMSI only missed its targeted RBC ratio of 855% by 10 points.

We also performed a limited comparison of GHMSI's financial results between 2008 and 2007. We noted that GHMSI's net income decreased in 2008 by 61.6% (\$68.4 million to \$26.3 million). As a percentage of premiums, net income dropped from 2.4% in 2007 to 1.0% in 2008.

With respect to GHMSI's underwriting results, net underwriting gain remained positive; however, it decreased by 76.8% between 2008 and 2007 (\$40.9 million to \$9.5 million). As a percentage of premiums, underwriting gain also decreased from 1.5% in 2007 to 0.3% in 2008. The decline in underwriting gain between 2008 and 2007 of \$31.4 million primarily was driven by a 2.5% decrease in premiums, offset by a 1.1% decrease in health and medical expenses, and a 3.8% decrease in operating expenses. Despite these declines, GHMSI's key operating ratios

(i.e. medical loss ratio, administrative expense ratio, and combined ratios) were relatively stable from 2007 to 2008.

Finally, we reviewed GHMSI's financial results, as reported in its Quarterly Statement as of 9/30/09. We found that GHMSI's policyholders' surplus increased by \$38 million to \$725 million, primarily because of improved confidence in the capital markets and the resulting increase in the value of securities. GHMSI's underwriting results appear to be much lower than forecasted because of higher medical and drug costs. At the same time, 2008 claim reserves appear to be redundant by \$26 million as of 9/30/09, a frequent development over the past several years.

IV. COMMUNITY HEALTH REINVESTMENT EXPENDITURES

Summary Findings.

Based on information provided to us by GHMSI and our review of that information, it is our understanding that GHMSI has made or will make the following expenditures (considering those expenditures made **only in the District of Columbia**) that can be considered community health reinvestment expenditures:

2008 Expenditures:	\$13,555,771
2009 Expenditures:	\$16,595,343⁶

These expenditures consist of community giving; open enrollment subsidies; program administration costs; and premium taxes.

Attached as Exhibit 2 is a summary of GHMSI's community health reinvestment expenditures.

Analysis of GHMSI Information.

GHMSI provided several reports to the DISB before and after the DISB's public hearings that included community health reinvestment expenditures information. However, none of this information made clear what expenditures were made in the District of Columbia or were made solely by GHMSI. Accordingly, on November 25 2009, we asked GHMSI to provide the following community health reinvestment expenditures by GHMSI in the District of Columbia, as defined in DC Stat. § 31-3505(1A):

- Expenditures during 2008;
- Actual expenditures to date during 2009; and
- Projected total expenditures during 2009.

In our request, we also indicated that during the September 10-11 hearing, we discussed whether all of the funding listed in the CareFirst Community Giving summaries that CareFirst provided in preparation for the hearing qualified as community health reinvestment expenditures. (As an example, expenditures listed in the Community Giving summaries included funding for the Charter Day Dinner and 140th Anniversary for Howard University Office of the President.) As a result, we asked GHMSI to only include expenditures that qualify as community health reinvestment expenditures, as defined in DC Stat. § 31-3505(1A).

Attached as Exhibit 3 is GHMSI's summary of its expenditures, as provided to us. We noted that GHMSI did remove some expenditures that are listed in the CareFirst Community Giving summaries from the total expenditures it recently provided to us.

⁶ 2009 expenditures are based on actual expenditures through 9/30/09 and projected expenditures for the fourth quarter of 2009.

V. SURPLUS ATTRIBUTION ANALYSIS

Summary Results.

DC Mun. Reg. title 26 § 4699.2 provides for two specific factors to be considered when determining the surplus attributable to the District: the number of policies by jurisdiction and the number of providers by jurisdiction. In addition, the Commissioner may consider “any other factor that the Commissioner deems to be relevant.” In addition to the two factors specified in the regulations, we identified four additional factors that the Commissioner might wish to consider. We also analyzed Milliman’s method of attribution, as set forth in GHMSI’s August 31, 2009 pre-hearing report (“GHMSI Pre-Hearing Report”).

As a result of our analysis, the following summarizes various factors that the Commissioner might wish to consider for purposes of attributing surplus of GHMSI to the District of Columbia.

SURPLUS ATTRIBUTION FACTORS			
Attribution Methods Set Forth In DC Regulations	Jurisdiction		
	DC	MD	VA
Number of Policies By Jurisdiction	31.20%	35.85%	32.95%
Number of Providers By Jurisdiction	12.5%	Not provided ⁷	Not provided ⁷
Additional Attribution Methods			
Premiums By Jurisdiction	68.92%	17.59%	13.49%
Number of Certificateholders By Jurisdiction	10%	44%	22%
Claim Expenses By Jurisdiction of the Policyholder	69.18%	18%	12.82%
Paid Claim Expenses by Jurisdiction	12%	42%	23%
Milliman’s Attribution Method	11.6%	Not provided ⁸	Not provided ⁸

Data Limitations.

The most accurate determination of surplus attributable to the District would require a review of GHMSI’s operations for the entire period of its existence. However, this level of review is not feasible given limitations on the availability and quality of GHMSI’s data. Accordingly, we limited the time periods for which data was considered, as described in our analysis of each of the factors, below.

⁷ This information was not provided by GHMSI.

⁸ This information was not provided by Milliman.

Analysis of Identified Factors.

Number of Policies by Jurisdiction

Number Of Policies By Geographic Area As Of 12/31/2008				
Type Of Contract	Jurisdiction			
	DC	MD	VA	TOTAL
Individual Policies	12,905	9,816	14,031	36,752
Group Policies	3,712	9,263	3,535	16,510
ASO Contracts	25	43	9	77
Total Policies/Contracts	16,642 ⁹	19,122	17,575	53,339
Percentage of Total Policies/Contracts	31.20%	35.85%	32.95%	100%

This approach attributes surplus to a jurisdiction based on the location of the policyholder or contractholder and has been referred to as the “situs” approach. Policies or contracts are attributed to a jurisdiction in the following manner:

- Individual health insurance policies — the jurisdiction in which the policy was issued;
- Group health insurance policies — the jurisdiction in which the master group policy was issued; and
- Self-insured ASO business — the jurisdiction in which the ASO contract was issued.

For purposes of determining the situs of GHMSI’s policies or contracts, we relied on the information provided by GHMSI in Attachment 4 to its November 2, 2009 responses to questions posed during the public hearing (“GHMSI Post-Hearing Responses”), which set forth the information summarized above.

We note that it does not appear that GHMSI provided any information regarding the location of the FEP contract. It is our understanding that the national Blue Cross/Blue Shield Association enters into one contract with the appropriate federal agency to provide coverage to FEHP enrollees and then assigns enrollees to particular Blue Cross/Blue Shield plans, including GHMSI. Because the FEP coverage does not arise from a particular GHMSI policy or contract, we do not believe excluding the FEP contract from this attribution approach affects the percentage of policies or contracts assigned to each jurisdiction.

⁹It does not appear that GHMSI provided any information regarding the location of the FEP contract. It is our understanding that the national Blue Cross/Blue Shield Association enters into one contract with the appropriate federal agency to provide coverage to FEHP enrollees and then assigns enrollees to particular Blue Cross/Blue Shield plans, including GHMSI. Since inclusion of the FEP contract would add, at most, one extra contract to the existing DC total of 16,462, excluding the FEP contract from this attribution approach does not affect the percentage of policies or contracts assigned to each jurisdiction.

Number of Health Care Providers by Jurisdiction

Number Of Providers By Geographic Area As Of 12/31/08			
	DC	Other Jurisdictions	Total
Number of GHMSI Providers	4,423	30,900	35,323
% of Total Providers	12.5%	87.5%	100%

This approach attributes surplus to a jurisdiction based on the location of the health care providers under contract with GHMSI. For purposes of determining the location of health care providers, we relied on the information provided by GHMSI in Attachment 4 to the GHMSI Post-Hearing Responses, which set forth the information summarized above.

We note that GHMSI indicated that its data is based on individual practitioners rather than provider groups. For example, if a physician provider group consists of 10 physicians, GHMSI included 10 physicians in its data count but did not include the physician group as a provider in its data count.

In addition, if a practitioner is affiliated with multiple provider groups or office locations in multiple jurisdictions, the practitioner is counted one time in each jurisdiction where the practitioner has an office location. If the practitioner has multiple office locations in the same jurisdiction, only one location was included in the number of providers in a particular location.

Number of Certificate Holders by Jurisdiction

Number Of Certificate Holders By Geographic Area					
	DC	MD	VA	Outside Of Area	Total
% of Certificate Holders	10%	44%	22%	24%	100%

This approach attributes surplus to a jurisdiction based on the location of the individual certificate holders under the policies and contracts and has been referred to as the “residency” approach. It is our understanding that certificate holders are attributed to a jurisdiction in the following manner:

- Individual health insurance policies — the jurisdiction in which the policyholder resides;
- Group health insurance policies — the jurisdiction in which the certificate holder resides;
- Self-insured ASO business — the jurisdiction in which the enrollee resides; and
- FEP business – the jurisdiction in which the enrollee resides.

For purposes of determining the residency of GHMSI certificate holders, we relied on the information provided by GHMSI in Attachment B to the GHMSI Pre-Hearing Report, which sets forth the information summarized, above.

We note that GHMSI did not indicate the date for which its information was provided. Because we anticipate that the information was provided either as of December 31, 2008 or at a later date, we believe the information is timely for our purposes.

Premiums by Jurisdiction

PREMIUMS BY GEOGRAPHIC AREA					
	DC	MD	VA	TOTAL	DC % OF TOTAL
1999	\$908,819,339	\$83,525,180	\$104,742,539	\$1,097,087,058	82.84%
2000	\$1,048,252,425	\$127,803,783	\$144,959,171	\$1,321,015,379	79.36%
2001	\$1,114,933,999	\$193,129,743	\$201,241,879	\$1,509,305,621	73.88%
2002	\$1,226,135,126	\$249,494,130	\$244,309,938	\$1,719,939,194	71.29%
2003	\$1,308,729,168	\$431,661,020	\$266,815,048	\$1,891,205,236	69.20%
2004	\$1,439,510,026	\$313,458,050	\$278,857,013	\$2,031,825,089	70.85%
2005	\$1,543,997,081	\$407,191,415	\$307,183,890	\$2,258,372,386	68.37%
2006	\$1,617,459,439	\$496,440,116	\$342,619,427	\$2,456,518,982	65.84%
2007	\$1,690,875,050	\$631,314,306	\$384,792,857	\$2,706,982,213	62.46%
2008	\$1,966,714,108	\$721,455,267	\$438,659,661	\$3,126,829,036	62.90%
Average	\$1,386,542,576			\$2,011,908,019	68.92%

This approach attributes surplus to a jurisdiction based on the premiums attributable to each jurisdiction and has been referred to as the “Schedule T” approach. Premiums are attributed to a jurisdiction based on the Schedule T information reported by GHMSI in its Annual Statements for the years ending 1999-2008, which set forth the information summarized, above.

We note that because we had access to Schedule T information for the last 10 years, we elected to average the premiums attributable to the District of Columbia for the 10-year period to determine the percentage of premiums attributable to the District. It would also be possible to only use the percentage of premiums attributable to the District for 2008 for this approach.

Claim Expenses by Jurisdiction of the Policyholder

This approach is intended to attribute surplus to a jurisdiction based on claims expense incurred in a particular jurisdiction based on the location of the policyholder giving rise to the claim.

In order to determine the percentage of claims expense incurred by GHMSI in a particular jurisdiction, we analyzed the health care services incurred in each jurisdiction based on the location of the policy/contract. For purposes of determining the health care services incurred in a particular jurisdiction, we relied on the Exhibit of Premiums, Enrollment and Utilization reported

by GHMSI in its Annual Statements for the years ending 2002-2008, which set forth the information summarized below.

INCURRED HEALTH CARE SERVICES BY POLICY/CONTRACT LOCATION					
	DC	MD	VA	TOTAL	DC % OF TOTAL
2002	1,134,926,969	208,919,544	199,109,387	1,542,955,900	73.56%
2003	1,194,389,270	268,205,389	212,199,548	1,674,794,207	71.32%
2004	1,311,236,788	249,256,766	209,586,556	1,770,080,110	74.08%
2005	1,414,619,860	345,190,631	255,188,393	2,014,998,884	70.20%
2006	1,490,308,712	406,547,014	276,534,584	2,173,390,310	68.57%
2007	1,663,437,499	518,531,491	320,314,860	2,502,283,850	66.48%
2008	1,762,885,669	598,101,589	375,175,422	2,736,162,680	64.43%
Average	1,424,543,538	370,678,918	264,015,536	2,059,237,992	69.18%

We note that because we had access to this information for the last seven years, we elected to average the claims expense attributable to the District of Columbia for the seven-year period to determine the percentage of claims expense attributable to the District. It would also be possible to only use the percentage of claims expense attributable to the District for 2008 for this approach.

Paid Claims Expense By Jurisdiction

PAID CLAIMS EXPENSE BY JURISDICTION					
	DC	MD	VA	OUTSIDE OF AREA	TOTAL
Paid Claims Expense	\$316,694,208	\$1,054,505,383	\$570,214,894	\$591,320,458	\$2,532,633,943
% of Paid Claims Expense	12%	42%	23%	23%	100%

This approach attributes surplus to a jurisdiction based on claims expense paid in a particular jurisdiction.

In December 4, 2009 email correspondence to GHMSI, we requested the amount of claims expense incurred in each state as of December 31, 2008. On December 8, 2009 GHMSI responded in email correspondence with the dollar amounts of claims paid in DC, Maryland, Virginia, and in all other jurisdictions for the period July 2008 to June 2009. The percentages set forth above in the chart, above, are based on the total dollar amount of claims paid, as set forth in GHMSI's December 8, 2009 email correspondence.

We note that there are limitations on the information provided by GHMSI. First, GHMSI indicated in its response that the data provided only included medical claims for "FLEXX, NASCO DC and NASCO MD" and excludes "CARE, FEP MD and Facets 4.5". Further, the

title of the chart providing the data states “GHMSI Legal Entity only NASCO DC and Flexx Paid Medical Claims”.

It is our understanding that some of these acronyms might be references to operating systems that allow insurers to track claims data. However, we did not receive information describing why or how the claims data was limited by the use of such systems. In addition, the title of the chart and other data in the chart conflict as to whether NASCO MD data is included in the data.

Second, as noted above, we requested information on claims expense incurred in each state and instead received data on paid claims expense. Because we do not anticipate that the difference between claims incurred and paid claims in each jurisdiction will have a significant impact on the attribution analysis, we chose to employ the paid claims information we received.

Finally, we requested claims data as of December 31, 2008 and instead received claims data for the period July 2008 to June 2009. Because we do not anticipate that data for a different time period than was requested will have a significant impact on the attribution analysis, we chose to employ the paid claims information we received.

Milliman Attribution Method

In Exhibit A to the GHMSI Pre-Hearing Report, Milliman provided an analysis of the surplus to be attributed to the District of Columbia. Based on its analysis, Milliman estimated that 11.6% of GHMSI’s surplus as of December 31, 2008 is attributable to the District.

Milliman indicated that it first attributed each year’s underwriting gain/loss to a jurisdiction in proportion to the estimate premium or fee income by jurisdiction of residence. This attribution was performed separately for GHMSI’s “risk” business (excluding FEP business); FEP business; and non-risk business.

After attributing each year’s underwriting gain/loss by jurisdiction of residence, the other components of the change in surplus were attributed in proportion to premium and fee income, with the exception of investment returns. Attribution of the annual investment return was based in part on premium income and in part on the attribution of the prior year’s ending surplus value. Additional detail regarding Milliman’s attribution methodology is contained in Exhibit A to the GHMSI Pre-Hearing Report.

EXHIBIT 1

SUMMARY OF R&A REVISIONS TO MILLIMAN LOSS CURVE ASSUMPTIONS USED IN THE DETERMINATION OF THE TARGETED RBC RANGE FOR GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC.

*Adjustments to the Milliman Loss Curve as a Percentage of GHMSI Premiums
(Not Including FEP Business)*

Loss Curve Component	90% Confidence at 375% RBC	99% Confidence at 200% RBC
Milliman Assumptions		
Rating Adequacy and Fluctuation	0.00%	0.00%
Unpaid Claims Liabilities	0.00%	0.00%
Interest Rate and Asset Values	-0.75%	-1.75%
Overhead Expense Recovery	0.00%	0.00%
Other Business Risk, ASC Defaults	0.00%	0.00%
Growth and Development	-1.75%	-1.25%
Catastrophic Events	-1.50%	-2.00%
Additional Assumptions		
Pension Plan	+1.00%	+1.75%
Management Intervention Actions		
Reserve Margins	-0.50%	-1.50%
Pricing Margins and Underwriting Standards	-1.50%	-1.50%
Infrastructure Investments	0.00%	-1.00%

EXHIBIT 2

GHMSI COMMUNITY REINVESTMENT EXPENDITURES

2008 GHMSI Community Reinvestment Expenditures

Community Giving

Corporate Memberships	\$18,485.00
Corporate Sponsorships	\$388,400.00
Targeted Health Giving	\$439,586.00
Program Initiatives	\$1,462,784.24
Catalytic Giving	<u>\$579,688.00</u>
Total Community Giving	\$2,888,943.24

Additional Expenditures

Open Enrollment Subsidies	\$3,103,580.00
Program Administration Costs	\$439,248.00
Premium Taxes	<u>\$7,124,000.00</u>
Total Additional Expenditures	\$10,666,828.00

TOTAL 2008 EXPENDITURES \$13,555,771.24

2009 GHMSI Community Reinvestment Expenditures

**(Includes Actual Expenditures Through 9/30/09
plus Fourth Quarter 2009 Projections)**

Community Giving

Corporate Memberships	\$18,600.00
Corporate Sponsorships	\$363,500.00
Targeted Health Giving	\$196,636.00
Program Initiatives	\$838,312.00
Catalytic Giving	<u>\$1,833,085.00</u>
Total Community Giving	\$3,250,133.00

Additional Expenditures

Open Enrollment Subsidies	\$4,078,255.00
Program Administration Costs	\$275,000.00
Premium Taxes	<u>\$8,991,955.00</u>
Total Additional Expenditures	\$13,345,210.00

**TOTAL 2009 EXPENDITURES
(Actual and Projected) \$16,595,343.00**