

Government of the District of Columbia
Department of Insurance, Securities and Banking



Gennet Purcell
Acting Commissioner

BEFORE THE
INSURANCE COMMISSIONER OF
THE DISTRICT OF COLUMBIA

Re: Report on Examination – **Group Hospitalization and Medical Services, Inc. (GHMSI)** as of December 31, 2008

ORDER

Pursuant to Examination Warrant 2009-2, an Examination of **GHMSI** as of December 31, 2008 has been conducted by the District of Columbia Department of Insurance, Securities and Banking (“the Department”).

It is hereby ordered on this 25th day of September, 2009, that the attached financial condition examination report be adopted and filed as an official record of this Department.

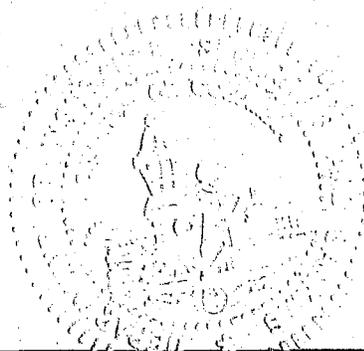
Pursuant to Section 31-1404(d)(1) of the D.C. Official Code, this Order is considered a final administrative decision and may be appealed pursuant to Section 31-4332 of the D.C. Official Code.

Pursuant to Section 31-1404(d)(1) of the D.C. Official Code, within 30 days of the issuance of the adopted report, the company shall file affidavits executed by each of its directors stating under oath that they have received a copy of the adopted report and related order.

Pursuant to Section 31-1404(e)(1) of the D.C. Official Code, the Department will continue to hold the content of the report as private and confidential information for a period of 10 days from the date of this Order.

A handwritten signature in black ink, consisting of several loops and a long horizontal stroke.

Gennet Purcell
Acting Commissioner



GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF INSURANCE, SECURITIES AND BANKING



REPORT ON EXAMINATION

GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC.

AS OF

DECEMBER 31, 2008

NAIC COMPANY CODE 53007

Group Hospitalization and Medical Services, Inc.

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REPORT ON EXAMINATION OF FINANCIAL CONDITION

Washington, D.C.
July 30, 2009

Honorable Alfred W. Gross, Commissioner
Chairman, Financial Condition (E) Committee, NAIC
State Corporation Commission
Bureau of Insurance
Tyler Building
1300 East Main Street
Richmond, Virginia 23219

Honorable Joel Ario
Secretary, Northeastern Zone, NAIC
Commissioner
Insurance Department
Commonwealth of Pennsylvania
1345 Strawberry Square
Harrisburg, Pennsylvania 17120

Honorable Gennet Purcell
Acting Commissioner
Department of Insurance, Securities and Banking
Government of the District of Columbia
810 First Street, NE, Suite 701
Washington, D.C. 20002

Dear Commissioners:

In accordance with Section 31-1402 of the District of Columbia Official Code, we have examined the financial condition and activities of

Group Hospitalization and Medical Services, Inc.
840 First Street N.E.
Washington, D.C. 20002

hereinafter referred to as "GHMSI" or "the Company". The examination was conducted at the administrative office of the Company located at 10455 Mill Run Circle, Owings Mills, MD, 21117. The following Report of Examination thereon is respectively submitted.

Group Hospitalization and Medical Services, Inc.

Report on Examination
December 31, 2008

SCOPE OF EXAMINATION

The examination, covering the period from January 1, 2004 to December 31, 2008, and including any material transactions and/or events noted occurring subsequent to December 31, 2008, was performed as an association examination of Group Hospitalization and Medical Services, Inc. The examination was performed by examiners representing the District of Columbia Department of Insurance, Securities and Banking (“DISB”) representing the Northeastern Zone of the National Association of Insurance Commissioners (NAIC).

The last examination as of December 31, 2003 was conducted by the examiners of the District of Columbia Department of Insurance, Securities and Banking.

This examination was conducted in accordance with the NAIC Financial Condition Examiners Handbook, incorporating the risk-focused examination techniques and in accordance with examination policies and standards established by the District of Columbia Department of Insurance, Securities and Banking. Accordingly, included in the examination were such tests of the accounting records and such other procedures as we considered necessary in the circumstances.

Our examination included a review of the Company’s principles used and significant estimates made by management; business policies and practices; management and corporate governance; and verification and evaluation of assets and a determination of the existence of liabilities to evaluate the overall financial statement presentation in compliance with Statutory Accounting Principles and annual statement instructions. In addition, our examination included tests to provide reasonable assurance that the Company was in compliance with applicable laws, rules and regulations. Risk-focused techniques were used in planning and conducting our examination. We identified prospective risks of the Company by obtaining information about the Company including corporate governance, identifying and assessing inherent risks within the Company and evaluating system controls and procedures used to mitigate those risks.

The Company was audited annually by an independent certified public accounting firm. The firm expressed an unqualified opinion on the Company’s financial statements for calendar year 2008 and each year during the examination period. We concentrated our examination efforts on the year ended December 31, 2008. We reviewed the working papers prepared by the independent certified public accounting firm related to the audits for the years ended December 31, 2008 and 2007, and directed our efforts to the extent practical to those areas not covered by the firm’s audit.

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STATUS OF PRIOR EXAMINATION FINDINGS

This examination included a review to determine the current status of the three exceptions commented upon in the preceding Report of Examination dated March 15, 2005. The examination determined that the Company had satisfactorily addressed the three items.

SUMMARY OF SIGNIFICANT FINDINGS

DISB defines material adverse finding as follows:

“A finding, typically made by a financial examiner or financial analyst, with respect to an event, trend, transaction or series of transactions, fluctuation, agreement, arrangement, operating results or violation of law, which either has, or reasonably could have, a significant negative impact on a company's financial position.”

No material adverse findings were noted during the examination. In addition, no material changes were made to the financial statements. Other non-compliance findings are noted under “Comments and Recommendation” section of this report.

SUBSEQUENT EVENTS

Restructure

The Company has prepared a restructuring plan whereby GHMSI and CareFirst of Maryland, Inc. would contribute the stock of their subsidiary companies to a holding company. Both companies would be 50% owners of the new holding company. The plan has been presented to DISB and Maryland Insurance Administration for approval.

DISB legislation

The D.C. City Council in December 2008 passed legislation to require the Commissioner of the Department of Insurance, Securities, and Banking to determine whether the portion of a hospital and medical services corporation's surplus that is attributable to the District is excessive, to require the Commissioner to order hospital and medical services corporations to divest themselves of excess surplus through community health reinvestment, to require hospital and medical services corporations to continue to offer the open enrollment program to subscribers as long as the

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subscribers renew their coverage under the program, to set affordability and adequacy standards for the open enrollment program, to require hospital and medical services corporations to advertise the availability of the open enrollment program, and to prohibit hospital and medical services corporations from converting to for-profit entities. The Company has initiated discussions with the Council to amend the legislation, as well as discussions with the Regulators (both DC and Maryland) to propose solutions that would better define and limit risk responsibility and loss exposure.

HISTORY

The Company is a not-for-profit corporation, chartered by the U.S. Congress. The Company provides comprehensive health insurance and managed health care products and services to individuals, businesses and governmental agencies in Washington D.C. and portions of the State of Maryland and Commonwealth of Virginia. With the issuance of the Certificate of Authority on November 19, 2001, the DISB became the Company's primary regulator. The Company was formed in 1985 through the merger of Group Hospitalization, Inc. ("GHI") and Medical Service of the District of Columbia ("MSDC").

Effective January 16, 1998, CareFirst of Maryland, Inc. ("CFMI") and the Company became affiliates when CareFirst, Inc ("CFI") became their parent managing member. CFMI is a not-for-profit Maryland company.

The historical transactions that occurred prior to the issuance of the Company's Certificate of Authority by DISB and the merger referred to above are as follows:

- Group Hospitalization, Inc ("GHI") began operations on March 15, 1934 as a not-for-profit corporation. GHI subsequently was ordered to reorganize as a stock or mutual insurance company in order to be subject the same regulation and taxation as commercial insurance companies. In response, GHI's trustees sought Congressional action to preserve and maintain the civic, charitable and nonprofit status of GHI. On August 11, 1939, Congress passed an act which authorized GHI to contract with individuals or groups of individuals to provide benefits for their hospital care. In addition, the act authorized GHI to operate only for the benefit of its subscribers and be a not-for-profit institution.
- In 1942, the American Hospital Association authorized the use of the Blue Cross service mark as its symbol of approved prepayment plans. GHI's Board of Trustees authorized full participation in the Blue Cross system in 1951.

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- MSDC was incorporated in the District of Columbia on April 1, 1948 to provide prepaid coverage for a limited number of physician services to all subscribers who had contracts with GHI. In 1952, MSDC was authorized to use the Blue Shield service mark.
- On October 17, 1984, Congress granted GHI the authority to create affiliates and subsidiaries by amending its Congressional Charter.
- In 1985 GHI and MSDC merged after amendment of GHI's Congressional Charter. The successor entity, Group Hospitalization and Medical Services, Inc. ("Company"), continued the Blue Cross and Blue Shield affiliation and adopted the trade name Blue Cross and Blue Shield of the National Capital Area. Inc.
- Effective October 5, 1992, Congress enacted legislation to require the Company to be domiciled in and regulated by the District of Columbia. On February 12, 1993, the Company entered into a Consent Order with the District of Columbia Commissioner of Insurance under which the Company would be regulated by the District of Columbia. The Consent Order set out the existing statutes that would be applicable to the Company.
- The Company subsequently was issued its Certificate of Authority from the District of Columbia, Department of Insurance, Securities and Banking (formerly known as the Department of Insurance and Securities Regulation) effective November 19, 2001 as a hospital and medical services corporation.

MANAGEMENT AND CONTROL

Board of Trustees

The Company's by-laws call for one class of member. CareFirst, Inc., a not for profit organization organized under Maryland Law, has been designated as the sole member of the GHMSI. The by-laws also state that the governing body of the Company shall be the Board of Trustees, which shall conduct the business and affairs of the Company. All trustees are nominated by the sole member and are elected by the Board of Trustees of GHMSI. The by-laws currently call for at least five (5) trustees. In addition, DC Code §31-706(c)(3) requires one-third of trustees be independent; and DC Code §31-706(c)(3) requires the Audit Committee, Compensation

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Committee for Corporate Officers, Nomination Committee, and Officer Performance Committee to be composed entirely of non-employees of the Company. The Company complied with these requirements.

The following Board of Trustees are listed on the jurat page of the Company's 2008 Annual Statement:

Company Trustees

Chester Burrell	Trustee, President
Jeanne Kennedy	Trustee, Treasurer
John Piccotto	Trustee, Secretary

Independent Trustees

Michel Daley
Elizabeth Lisboa- Farrow
Robert Willis
Natalie Ludaway
James Wallace
Larry Bailey
Nathaniel Connally
Robert Sloan
Linda Cropp
Carlos Rodriquez
Faye Fields
Ralph Rohner

Officers

The Board of Trustees elects the officers of the Company at its annual meeting. Each officer serves until a successor is elected or until removed by the Board of Trustees. On December 31, 2008, the officers are as follows:

Chester Burrell	President
Jeanne Kennedy	Treasurer
John Piccotto	Secretary

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Corporate Governance

The Company's corporate governance was evaluated through a review of the Company's Corporate Governance Guidelines, Executive Officer and Board member interviews, Board of Director general meeting minutes, committee minutes, and other various examination documentation obtained during the examination. The Corporate Governance review followed the format provided by Exhibit M of the NAIC Financial Condition Handbook. From this review, it was determined, overall, the Company maintains an effective corporate governance structure. The Board and key executives set an appropriate "tone at the top" with a clear commitment to promote integrity and ethical behavior throughout the Company.

Evidence of this commitment was the creation in 2006 of a Sarbanes-Oxley Department to evaluate internal controls when the Company was not subject to the Sarbanes-Oxley Act. The Company believed it important because rating agencies and regulators have placed new emphasis on the importance of risk management.

Conflicts of Interest

Directors and officers of the Company regularly respond to conflict of interests questionnaires. When possible conflicts are disclosed on the questionnaires, Company management and legal counsel scrutinize the conflicts further. Our review of the conflict of interest questionnaires for non-employee directors for the period under examination did not disclose any conflicts of interests that would adversely affect the Company. Employee officers and directors reported no conflict of interest upon completion of the annual on-line Code of Conduct training.

Corporate Records

We reviewed the minutes of the meetings of the Board of Trustees for the period under examination. Based on our review, it appeared that the minutes documented the Company's significant transactions and events, and that the trustees approved those transactions and events.

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AFFILIATED COMPANIES

As of December 31, 2008, GHMSI was affiliated with CareFirst of Maryland, Inc. (“CFMI”), a Maryland domiciled (also licensed in DC) non-profit health service organization through its non-profit parent, CareFirst, Inc (“CFI”). GHMSI has no stockholders and its sole member is CFI.

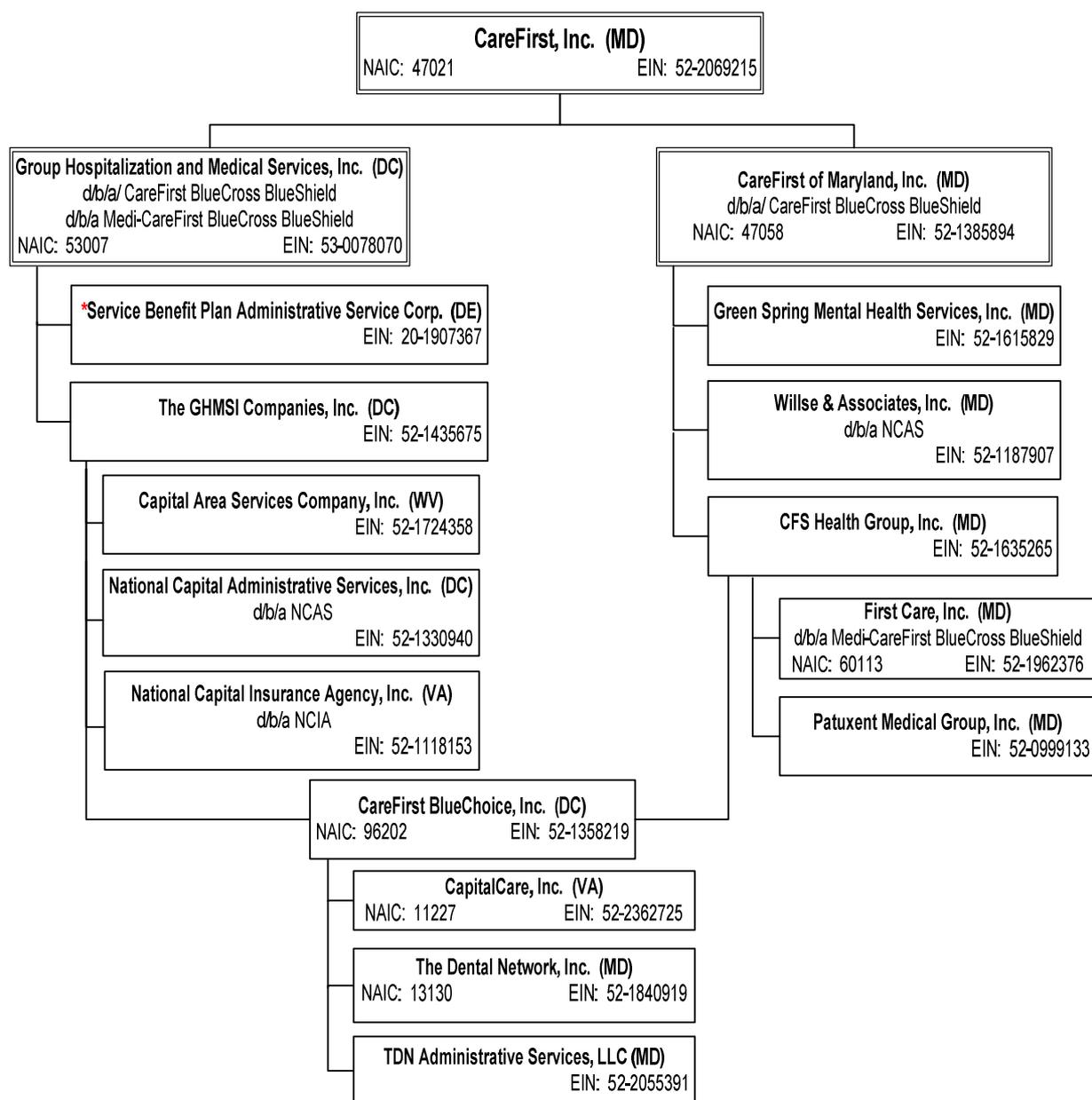
GHMSI has numerous affiliates. The holding company structure for the entire group is depicted in the organization chart on the next page:

Group Hospitalization and Medical Services, Inc.

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CareFirst Organizational Chart

Revised July 2008



*Service Benefit Plan Administrative Services Corporation is owned 90% by Group Hospitalization and Medical Services, Inc. and 10% by the Blue Cross and Blue Shield Association.

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Subsidiaries

The following is a brief description of the Company's subsidiaries and affiliates:

Service Benefit Plan Administrative Service Corp – (90% owned directly)

Service Benefit Plan Administrative Service Corp (SBC) was created effective January 1, 2005 to operate the Federal Employee Program (FEP) Operations Center. BCBSA is the owner of the 10% stock not owned by GHMSI.

The GHMSI Companies, Inc. – (100% owned, directly)

The GHMSI Companies, Inc. was incorporated on December 6, 1985 in the District of Columbia to hold the stock of several subsidiaries of GHMSI.

Capital Area Services Company, Inc. – (100% owned, indirectly)

Capital Area Services Company, Inc. (CASCI) is a non-profit West Virginia corporation incorporated on March 4, 1992. CASCI operates in West Virginia and provides claims administration for certain lines of business including the FEP program.

National Capital Administrative Services, Inc. – (100% owned, indirectly) (TPA)

National Capital Administrative Services, Inc. (NCAS) was incorporated on November 3, 1983 in the District of Columbia. NCAS is a third-party health care plan administrator, which primarily administers health and managed care services for self-insured clients in the Mid-Atlantic area.

National Capital Insurance Agency, Inc. – (100% owned, indirectly)

National Capital Insurance Agency, Inc. ("NCIA") was incorporated on April 20, 1978 in Virginia. NCIA offers group life, short and long-term disability insurance and financial planning products for individuals in groups such as payroll deduction universal life insurance, disability income, 401(k) and 403(b) retirement saving programs.

CareFirst BlueChoice, Inc. (40% owned indirectly)

CareFirst BlueChoice, Inc. (CFBC) was incorporated on June 22, 1984 in the District of Columbia under the name of Capital Care, Inc. CFBC is an individual practice association health maintenance organization, which provides managed health care products and services to individuals, businesses and governmental agencies in the State of Maryland, Washington, D.C. and Northern Virginia. Benefits are provided to members through fee for services and capitation agreements with local area physicians, hospital and other health care providers. On July 26, 2001, the subsidiary's name was changed to CareFirst BlueChoice, Inc.

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INTERCOMPANY AGREEMENTS

Intercompany Agreement

GHMSI is party to an Intercompany Agreement with CareFirst, Inc., CareFirst of Maryland, Inc., and various affiliates of these entities. The agreement was entered into on March 22, 2000 and amended on September 22, 2006. The purpose of the Agreement is to combine business operations, centralize certain managerial and administrative functions, facilitate intercompany transfers of assets and liabilities, and to provide a proportional share of financial resources to any affiliate unable to meet its financial obligations, regulatory capital and/or reserve requirements. Settlements of amounts due occur on a monthly basis. Almost all of the other intercompany cost sharing arrangements are covered under this Agreement.

Administrative Services Agreement

GHMSI is party to an administrative services agreement dated 11/1/2001 with its affiliate, CareFirst of Maryland, Inc., and subsidiaries CareFirst BlueChoice, Inc., and CapitalCare, Inc. The Agreement calls for the Company to provide its subsidiaries and affiliate with administrative and operational support services and a reimbursement methodology for all services performed under the agreement. Settlements of amounts due occur on a monthly basis. This agreement along with CareFirst of Maryland, Inc. also provides reinsurance coverage for CareFirst BlueChoice (both are licensed in DC). This agreement is reviewed in the Reinsurance section of this report for evaluation of transfer of risk and appropriate presentation in the Annual Statement.

Shared Services Agreement

Shared Services Agreement, dated 1/1/2005 for services to be provided by GHMSI and CareFirst of Maryland, Inc. to Service Benefit Plan Administrative Services Corporation (services provided to SBC are management, human resources, legal, corporate services, finance, and accounting). Settlements of amounts due occur on a monthly basis. SBC is a 90% owned subsidiary of GHMSI and is owned 10% by the Blue Cross Blue Shield Association (BCBSA). BCBSA and SBC have entered into a contract effective 1/1/2005 under which SBC will administer an operations center for the FEP program of the BCBSA.

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Tax Sharing Agreement

The Company is party to a Tax Sharing Agreement with CFI and CareFirst of Maryland, Inc., and all eligible affiliates and subsidiaries. The Tax Sharing Agreement was effective September 21, 2007. The tax sharing agreement calls for allocation of current federal income tax liability/recoverable attributable to the Company on the basis of the percentage of the consolidated federal income tax liability/recoverable attributable to the Company computed on a separate company basis to the total consolidated federal income tax liability/recoverable.

AFFILIATION WITH OTHER PLANS

GHMSI through CFI, operates under a licensing agreement with the Blue Cross and Blue Shield Association (BCBSA), a non-profit Illinois Corporation, which is the national coordinating agency for member plans. The Company must meet specified membership standards, and participate in various national and inter-plan programs and agreements required of all members of the Association.

The purpose of these national and inter-plan programs is to provide membership services between the licensees, efficiencies, convenience and ease of claims processing for customers receiving benefits outside of the plan's service area.

BlueCard Program

The BlueCard Program enables members who are traveling or living in another Plan's service area to receive all of the same benefits, claims processing and customer service of their contracting BCBS Plan and access to other BlueCard providers and savings.

Inter-Plan Teleprocessing System (ITS) and electronic submittal of claims

ITS sets standards, policies and procedures used for the identification and processing of all eligible member claims and claims data electronically, instead of manually. The Company must use electronic submittal for all ITS eligible claims processing.

National Account Program Manual

The purpose of the National Account Program Manual is to provide a reference guide to help Plans market, implement, and support national account business according to the National Account Program Policies and Provisions.

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National Accounts Agreement

National Accounts are groups of subscribers located in different areas serviced by more than one participating plan. The National Account groups are enrolled through a participating plan called a control plan. The control plan is usually the plan servicing the geographical area of the group's headquarters. National accounts are normally handled under a local benefit agreement or on a syndicated account basis.

Business Associate Agreement for licensees

This agreement became effective as of April 14, 2003 and sets standards, requirements and guidelines for each licensee's obligation under the Administrative Simplification provisions of HIPAA and the related HIPAA Rules.

Federal Employee Program

The Company participates in the Federal Employee Health Benefits Program (FEHBP) with other Blue Cross Blue Shield Plans. The Blue Cross Blue Shield Association ("BCBSA"), on behalf of the Company and other Blue Cross Blue Shield Plans, and the Office of Personnel Management (OPM), are parties to this contract. Premium rates are developed by BCBSA and approved by OPM annually. Premiums in excess of charges for the life of the program are considered the special reserve. Each year, OPM also allocates additional funds to a contingency reserve, which may be utilized by the participating plans in the event that funds set aside from annual premiums are insufficient or fall below certain prescribed levels. However, amounts incurred for claims and expenses, in excess of special reserves and contingency reserves held by OPM, would not be reimbursed to the Company. Reserves held by OPM attributable to the Company at December 31, 2008 and 2007 were \$455,675,000 and \$384,456,000 respectively. The amounts being held in the contingency reserve attributable to all Blue Cross Blue Shield plans are \$5,284,003,000 at September 30, 2008 and \$5,048,031,000 as of December 31, 2007. FEP premiums earned were \$1,493,793,000 and \$1,439,371,000 for the years ended December 31, 2008 and 2007 respectively. The Company is subject to audit by the OPM for compliance with FEHBP requirements.

COMPLIANCE WITH BCBSA MEMBERSHIP STANDARDS

Per review of GHMSI's Risk Based Capital calculation as of December 31, 2008, and Annual Statement to the Commissioner that the Company filed with the NAIC and the Company's audited financial statements, the Company indicates compliance with the BCBSA minimum statutory standards.

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CONTINGENT LIABILITES

A line of credit was obtained by CFI through a commercial bank in which CFI and certain of its affiliates, including GHMSI, may borrow up to a maximum of \$60,000,000. There have been no draws made on this line of credit during 2008 and no amounts were outstanding as of December 31, 2008.

FIDELITY BOND AND OTHER INSURANCE

The Company is a named insured on a fidelity bond issued to CFI. Other affiliated insurance and non-insurance companies are also named insureds. The bond provides coverage in the amount of \$5,000,000. The coverage exceeds the minimum amount of fidelity bond coverage recommended by the National Association of Insurance Commissioners for GHMSI and its insurance affiliates.

In addition, GHMSI has other insurance policies (e.g., directors and officers liability, business property, etc.). GHMSI has adequate insurance coverage from all risk exposures.

PENSION, STOCK OWNERSHIP AND INSURANCE PLAN

Pension Benefits

GHMSI maintains a noncontributory defined benefit retirement plan, which covers substantially all full-time employees hired prior to January 1, 2009. The plan provides for eligible employees to receive benefits based principally on the employee's years of service and a percentage of certain compensation before retirement. The District of Columbia Department of Insurance, Securities and Banking retained an independent pension actuary to conduct a review in association with the financial examination of the Company as of December 31, 2008. The reviewing pension actuary determined that the Company's accruals for Pension Liabilities as of December 31, 2008 and Pension Expenses for the year ending December 31, 2008 were adequate.

GHMSI also sponsors a 401(k) plan for its eligible employees. The plan allows the employees to contribute 1% to 50% pretax annual compensation to the 401(k) plan. The Company provides a matching contribution to the plan, which is equal to 50% of the employees' contribution up to a maximum of 3% of the employees' compensation.

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In addition to the above, GHMSI maintains nonqualified supplemental retirement benefit plans, which provide for eligible employees to receive additional benefits based principally on compensation and years of service.

Post-Retirement Benefits

In addition to retirement benefits (pension, etc.), The Company provides certain health care benefits for retired employees. Substantially all employees become eligible for those benefits if they have at least ten years of service, are at least age 55, and have the Company's medical benefit coverage at the time of termination or retirement. The Company's postretirement benefit program provides for a specific credit amount, which may be used to purchase health insurance upon retirement. The credit amount is based upon the retiree's age and years of service with the Company.

Other Insurance and Benefits

The Company provides Medical and Dental Insurance (with the Company paying most of the cost), a Vision Plan, Short Term and Long Term Disability, Life Insurance, a Flexible Spending Account, Tuition Reimbursement, and Paid Time Off (in the form of "vacation time" and "sick leave").

STATUTORY DEPOSIT

GHMSI is not required to maintain a deposit with the DISB or other regulatory authority.

TERRITORY AND PLAN OF OPERATION

Policy Forms and Underwriting

GHMSI offers prepaid health service coverages to individuals and groups. Group coverage is the most prevalent and the Federal Employees Program (FEP) is the largest group. The Company is required to file all of its District of Columbia contract forms, policies and rates with the District of Columbia, Department of Insurance, Securities and Banking. The Office of Personnel Management has jurisdiction over all contracts and rates subject to the FEP Program. The forms and rate filings were reviewed to determine compliance with the filing requirements of DC Code, Section 31-3508. A sample of the application of appropriate rates to contract holders and subscribers was reviewed. The Company was in compliance with both the filing requirements and application of rates.

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Territory and Plan of Operation

The Company is authorized to transact business as a nonprofit health services plan in the District of Columbia, Maryland and Virginia. The Company is authorized to use the BlueCross BlueShield trade names and service marks in the District of Columbia, Prince Georges and Montgomery Counties in Maryland, and limited areas of Virginia in proximity to the District of Columbia Metropolitan Area.

The Company contracts with various health care providers, including hospitals, nursing homes, home health care facilities, alcohol and drug treatment facilities, pharmacies, physicians, and dentists, as participating providers to render services to subscribers of health care plans administered by the Company. In most instances, those providers accept the usual and customary or reasonable allowance set by the Company for a particular service as payment in full. Provider contracts were filed with DISB as required by DC Code, Section 31-3507.

Treatment of Subscribers

A cursory review of claims settlement practices were performed to determine the Company's compliance with the requirements of the "DC Prompt Pay Regulations", which requires that claims be settled timely and fairly upon receipt of all pertinent information. The Company filed with DISB the Prompt Pay Report as required by DC Code, Section 31-3132. In 2008, 94.2% of paid claims were paid within 30 days.

MARKET CONDUCT

A limited review of Market Conduct Activities was performed by the Market Conduct Branch of the District of Columbia, Department of Insurance, Securities and Banking. The last Market Conduct Examination of this Company by the District of Columbia, Department of Insurance, Securities and Banking was also a limited review as of December 31, 2003.

The Company has in place a system which systematically determines the degree to which products and services satisfy its customers. The focus of the information from these systems is the development of process improvements. Data is collected on factors of customer satisfaction such as responsiveness, reliability, accuracy, and ease of access. Other customer satisfaction measurement systems focus on identifying variations in quality of service and the effect on consumer expectations.

When customer feedback data indicates a problem or when a goal is set to raise the level of customer satisfaction, the organization focuses on improving the processes that delivers both the

Group Hospitalization and Medical Services, Inc.

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healthcare product and service. In order to ensure that customer service processes are continuously improved, the Company collects and analyzes consumer data on a continuing basis, with attention to variation in processes. The causes of variation are examined to determine whether they result from special causes or from recurring or common causes. Management adopts different strategies to correct each type of cause on a scheduled time cycle.

The Company recently restructured its internal service team. Customer inquiries are directed to individuals with the experience and knowledge that would be required to respond more effectively to the customer. The objective is to ensure that the Company's customer service personnel are assigned customer inquiries that best align with their expertise. This change is designed to meet the following consumer service objectives:

- Reduce rework of complaints to achieve the desired outcome;
- Reduce waste in the healthcare delivered;
- Reduce customer complaint cycle time; and
- Improve accuracy

As the Company's new president put a strategic plan in place to enhance policyholder services through the use of advanced technology, an adequate measurement of all planned system deliverables could not be concluded with efficacy and effectiveness during the course of this examination. The Company's market conduct activities will be monitored through DISB's use of continued management interviews and meetings and off-site monitoring options. DISB has the option to require the Company to establish a compliance plan should the Company fail to meet its planned deliverables' expectations.

REINSURANCE

Assumed Business

GHMSI & FirstCare Quota Share Reinsurance Contract (Medicare D business)

Effective January 1, 2006, FirstCare, Inc. (FirstCare), a wholly-owned subsidiary of CFS Health Group, Inc. (CFS), which in turn is a wholly-owned subsidiary of CFMI, began serving as a plan sponsor offering Medicare Part D prescription drug insurance coverage under a contract with the Federal Centers for Medicare and Medicaid Services (CMS). Effective January 1, 2006, the Company entered into a quota-share reinsurance contract with FirstCare. The agreement relates to all Medicare Part D insurance policies written by FirstCare for individuals living in the

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Company's service areas. Under the terms of the agreement, the Company assumes all underwriting risk on the business written in its service areas. Therefore all revenue and expenses related to the Company's members covered by the quota-share reinsurance contract are included in the accompanying consolidated statement of operations for the years ended December 31, 2008 and 2007.

Capital Care Stop Loss Reinsurance Contract

The Company provides stop-loss coverage to Capital Care. This coverage does not have an expiration date. For the year ended December 31, 2008, the Company assumed claims of \$104,000.

Ceded Business

GHMSI & CFMI Quota Share Reinsurance Contract (cross-jurisdictional)

Certain business has been written by CFMI and GHMSI which represents contracts outside the historic CFMI and GHMSI service areas (cross-jurisdictional sales). The Boards of CFI, CFMI and GHMSI approved redistribution of earnings between CFMI and GHMSI related to cross-jurisdictional sales. The income or loss from operations from this cross-jurisdictional business would be transferred via a quota share reinsurance contract from the company that earned them to the company in whose service area they were earned. The Company received regulatory approval for these earnings redistributions, effective January 1, 2008, and the amounts were recorded in 2008.

ACTUARIAL REVIEW

As of December 31, 2008, the Company reported "Claims Unpaid" and "Unpaid Claims Adjustment Expenses" totaling \$271,596,790 and \$10,120,800 respectively. The Company's actuarial liabilities included in the December 31, 2008 Annual Statement were reviewed by Company's actuary who provided the statement of actuarial opinion. The District of Columbia Department of Insurance, Securities and Banking also retained an independent actuary to conduct a review in association with their financial examination of the Company as of December 31, 2008.

Group Hospitalization and Medical Services, Inc.

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Actuarial standards for documentation of the development of the unpaid claims liability were followed. GHMSI's description and documentation indicated that their methodology for estimating unpaid claims uses traditional completion factors, an estimated per member per month (PMPM) incurred claim amount for the last three months. The assumptions used appear appropriate based on past history. The reviewing actuary determined that the Company's accruals for Claims Unpaid and Unpaid Claims Adjustment Expenses as of December 31, 2008 were adequate.

ACCOUNTS AND RECORDS

The Company's general accounting records consisted of an automated general ledger and various subsidiary ledgers (e.g., cash receipts, cash disbursements). Our review did not disclose any significant deficiencies in these records.

FINANCIAL STATEMENTS

The financial statements listed below are reflected on the following pages and present the financial condition of the Company as of December 31, 2008, as determined by this examination:

Balance Sheet:

Assets

Liabilities, Capital and Surplus

Statement of Operations

Statement of Capital and Surplus Account

Analysis of Changes to Surplus

The accompanying "Notes to Financial Statements" are an integral part of these financial statements.

Group Hospitalization and Medical Services, Inc.

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BALANCE SHEET

Assets

December 31, 2008

				Examination	Net Admitted
		Nonadmitted	Net Admitted	Adjsutments	Assets per
Assets	Assets	Assets	Assets	Increase (Decrease)	Examination
Bonds	\$ 611,460,470		\$ 611,460,470		\$ 611,460,470
Preferred stocks	5,385,403		\$ 5,385,403		\$ 5,385,403
Common Stocks	283,802,985		\$ 283,802,985		\$ 283,802,985
Cash	22,184,796		\$ 22,184,796		\$ 22,184,796
Other invested assets	672,701	166,667	\$ 506,034		\$ 506,034
Subtotal	\$ 923,506,355	\$ 166,667	\$ 923,339,688	\$ -	\$ 923,339,688
Investment income due and accrued	5,106,928		\$ 5,106,928		\$ 5,106,928
Uncollected premium and agents' balances	231,622,039	717,613	\$ 230,904,426		\$ 230,904,426
Amounts recoverable from reinsurers	26,363,324		\$ 26,363,324		\$ 26,363,324
Other amounts receivable under reinsurance	636,577		\$ 636,577		\$ 636,577
Amounts receivable realting to unisured plans	48,524,392	844,756	\$ 47,679,636		\$ 47,679,636
Current Federal income tax recoverable	13,275,013		\$ 13,275,013		\$ 13,275,013
Net deferred tax asset	145,559,347	136,664,227	\$ 8,895,120		\$ 8,895,120
EDP equipment and software	63,484,539	62,031,946	\$ 1,452,593		\$ 1,452,593
Furniture and equipment	4,625,895	4,625,895	\$ -		\$ -
Receivables from affiliates	8,911,990	15,990	\$ 8,896,000		\$ 8,896,000
Health care and other receivables	508,525,682	4,495,621	\$ 504,030,061		\$ 504,030,061
Aggregate write-ins for other			\$ -		\$ -
than invested assets	70,328,432	67,972,744	\$ 2,355,688		\$ 2,355,688
Total assets	\$ 2,050,470,513	\$ 277,535,459	\$ 1,772,935,054	\$ -	\$ 1,772,935,054

See accompanying Notes to Financial Statements

Group Hospitalization and Medical Services, Inc.

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December 31, 2008

STATEMENT OF OPERATIONS

For the Year Ended December 31, 2008

		Reported in Annual Statement	
Revenue			
Net premium income		\$	2,815,214,151
Change in unearned premium reserves and reserve for rate credit			(71,218,678)
Aggregate write-ins for other health care related revenues			13,515,534
Total Revenue		\$	2,757,511,007
Hospital and Medical Expenses			
Hospital and medical benefits	\$	1,757,032,209	
Other professional services		60,309,125	
Emergency room and out-of-area		251,354,756	
Prescription drugs		667,466,588	
Subtotal	\$	2,736,162,678	
Less reinsurance recoveries		257,634,048	
Total hospital and medical expenses	\$	2,478,528,630	
Claims adjustment expenses		85,485,704	
General and administrative expenses		183,980,707	
Total underwriting deductions		\$	2,747,995,041
Net underwriting gain (loss)		\$	9,515,966
Investment Income			
Net Investment income earned	\$	42,338,600	
Net realized capital gains (losses) less capital gains taxes		(18,019,830)	
Net investment gain		\$	24,318,770
Aggregate write-ins for other income or expense			(3,237)
Net income (loss) after capital gains tax and before federal income taxes		\$	33,831,499
Federal and foreign income taxes			7,571,329
Net Income		\$	26,260,170

See accompanying Notes to Financial Statements

Group Hospitalization and Medical Services, Inc.
 Report on Examination
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STATEMENT OF CAPITAL AND SURPLUS
For the Year Ended December 31, 2008

Surplus as regards policyholders, December 31, 2007			\$ 753,558,919
Net Income for year ended December 31, 2008	\$	26,260,170	
Change in net unrealized capital gains (losses) less capital gains tax		(10,492,177)	
Change in net unrealized foreign exchange capital gain or (losses)		(373,294)	
Change in net deferred income tax		126,262,466	
Change in nonadmitted assets		(186,120,834)	
Aggregate write-ins for gains or (losses) in surplus		(22,315,532)	
Net change in capital & surplus			\$ (66,779,201)
Surplus as regards policyholders, December 31, 2008			\$ 686,779,718

See accompanying Notes to Financial Statements

ANALYSIS OF CHANGES TO SURPLUS

There were no changes to the Company's surplus as a result of this examination.

NOTES TO FINANCIAL STATEMENTS

Note 1 - Claims unpaid & Unpaid Claims Adjustment Expenses

As of December 31, 2008, the Company reported "Claims Unpaid" and "Unpaid Claims Adjustment Expenses" totaling \$271,596,790 and \$10,120,800 respectively. The District of Columbia Department of Insurance, Securities and Banking retained an independent actuary to conduct a review in association with their financial examination of the Company as of December 31, 2008. The Company's accruals for Claims Unpaid and Unpaid Claims Adjustment Expenses were determined to be adequate as of December 31, 2008.

Group Hospitalization and Medical Services, Inc.

Report on Examination
December 31, 2008

COMMENTS AND RECOMMENDATIONS

Findings during the examination are as follows:

Reinsurance Agreement

The reinsurance agreement ceding business from GHMSI to CareFirst of Maryland Inc. does not contain a proper insolvency clause as required by DC Code § 31-501(b-1) and SSAP 61. A proper insolvency clause provides that in the event of the insolvency of the ceding insurer, the reinsurance shall be payable under contracts reinsured by the assuming insurer on the basis of reported claims without diminution because of the insolvency of the ceding insurer. **We recommend the Company either include a proper insolvency clause in the agreement or that the Company take no credit as an admitted asset or deduction from liability for reinsurance ceded under this agreement.**

Medicare Coordination of Benefits

The Company has insureds that are qualified Medicare beneficiaries. The Centers for Medicare and Medicaid Services (CMS) has written rules that determine which of the Company's insureds medical claims should be paid first by CMS or the Company (primary payor) and then the portion of the claim that would be paid by party not paying as primary payor (secondary payor). As a result of system errors, the Company incorrectly paid as the secondary payor on certain claims resulting in CMS paying as the primary payor. The issues were communicated to CMS in a letter dated May 15, 2009. The Company's liability to CMS has not been fully determined. In April 2009, corrective measures were taken to (1) correctly identify Medicare beneficiaries that should be paid primary and (2) modify software programs to correctly adjudicate claims to Medicare beneficiaries. **The Company shall establish an ongoing plan of communication with DISB regarding its remediation activities with Medicare. In addition, the Company shall submit to DISB its plan to develop and monitor the internal controls used to coordinate benefits with Medicare.**

Management Letter Comments

During our examination, in addition to the above Comments and Recommendations, we made other suggestions and recommendations to the Company with regard to record keeping and other procedures relating to its operations in a management letter. These additional suggestions and recommendations were not deemed significant for inclusion in our Report on Examination.

Group Hospitalization and Medical Services, Inc.
Report on Examination
December 31, 2008

CONCLUSION

This examination disclosed at December 31, 2008, the Company had:

Admitted assets	<u>\$ 1,772,935,054</u>
Liabilities	<u>\$1,086,155,336</u>
Unassigned funds (surplus)	<u>\$686,779,718</u>
Surplus as regards policyholders	<u>\$686,779,718</u>
Total liabilities, capital and surplus	<u>\$1,772,935,054</u>

Based on this examination, the accompanying balance sheet properly presents the statutory financial position of the Company as of December 31, 2008, and the accompanying statement of operations properly presents the statutory results of operations for the period then ended. The supporting financial statements properly present the information prescribed by the District of Columbia Official Code and the National Association of Insurance Commissioners.

Chapters 20 (“RISK-BASED CAPITAL”) and 25 (“FIRE, CASUALTY AND MARINE INSURANCE”) of Title 31 (“Insurance and Securities”) of the District of Columbia Official Code specify the level of capital and surplus required for the Company. The Company’s capital and surplus funds exceeded the minimum requirements during the period under examination.

Group Hospitalization and Medical Services, Inc.

Report on Examination

December 31, 2008

ACKNOWLEDGMENT

In addition to the undersigned, the following examiners representing the District of Columbia Department of Insurance, Securities and Banking participated in certain phases of this examination:

Ed Fossa, CFE, Examiner – Huff Thomas & Company

Wayne Weber, CPA, Examiner – Huff Thomas & Company

Ahmed Palejwala, CFE, Examiner – Huff Thomas & Company

Chidinma Ukairo, D.C. Department of Insurance, Securities and Banking

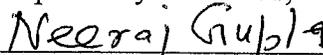
The Market Conduct review was conducted by William McCune and Janet LeGore of the District of Columbia Department of Insurance, Securities and Banking

The electronic data processing review was contracted to INS Services, Inc. by DISB to perform the IS review of the Company's systems.

The actuarial portion of this examination was completed by Donna Novak, FCA, ASA, MAAA, FLMI, HIA of NovaRest Consulting.

The independent analysis of pension liability was completed by Mitchell I. Serota, FSA, FCA, MAAA of Mitchell I. Serota & Associates.

Respectfully submitted,



Neeraj Gupta, CFE

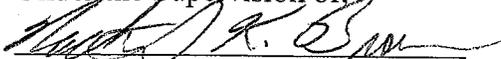
Examiner-In-Charge

Representing the District of Columbia

Department of Insurance, Securities

and Banking

Under the Supervision of,



Nathaniel Kevin Brown, CFE, CPA

Chief Examiner

District of Columbia Department of

Insurance, Securities and Banking

Government of the District of Columbia
Department of Insurance, Securities and Banking



Gennet Purcell
Acting Commissioner

September 25, 2009

William V. Stack
Vice President
GHMSI and CareFirst BlueChoice
10455 Mill Run Circle
Owings Mills, MD 21117-4208

Dear Mr. Stack:

We are in receipt of your responses dated September 18, 2009, which addresses the corrective actions taken by management to comply with the recommendations made in the Reports on Examination and Management Letters as of December 31, 2008.

The September 18, 2009 letters adequately address the recommendations made in the Reports and Management Letters. During our next examination of the Companies, we will review the implementation of the corrective actions taken.

The adopted Reports and the Orders evidencing such adoption are enclosed. Pursuant to Section 31-1404(e)(1) of the D.C. Official Code, the adopted Reports will be held private and confidential for a period of 10 days from the date of the Orders evidencing such adoption. After this 10 day period has passed, the Reports will be publicly available, and will be forwarded electronically to each Commissioner whose name is set forth on Page 1 of the Report, as well as to the National Association of Insurance Commissioners, and to each state in which the Companies are licensed, according to your Annual Statement.

Pursuant to Section 31-1404(d)(1) of the D.C. Official Code, within 30 days of the date of the above-mentioned Orders, affidavits executed by each Company's director stating under oath that he or she has received a copy of the adopted examination Report and related Order shall be filed with this Department. Please send these affidavits to my attention here at the Department.

William V Stack
September 25, 2009

Please contact me at 202-442-7785 if you have any questions.

Sincerely,

A handwritten signature in black ink, appearing to read "Nathaniel K. Brown". The signature is fluid and cursive, with a long horizontal flourish extending to the right.

Nathaniel Kevin Brown, CFE, CPA
Chief Financial Examiner

Enclosures

William V. Stack
Vice President and
Corporate Controller

CareFirst BlueCross BlueShield
10455 Mill Run Circle
Owings Mills, MD 21117-4208
Tel. 410-998-7011
Fax 410-998-6850
Cellular 410-218-6634
E-mail: Bill.Stack@carefirst.com



September 18, 2009

Kevin Brown
Chief Financial Examiner
Department of Insurance, Securities and Banking
810 First Street, N.E., #610
Washington, D.C., 20002

Dear Mr. Brown:

We would like to thank you for the opportunity to respond to your financial examination report of Group Hospitalization and Medical Services, Inc. (GHMSI) as of December 31, 2008. We have responded to certain notes and to all of the comments and recommendations in the report by including the text from the report followed by our comments.

Comments and Recommendations:

Reinsurance Agreement

The reinsurance agreement ceding business from GHMSI to CareFirst of Maryland Inc. does not contain a proper insolvency clause as required by DC Code § 31-501(b-1) and SSAP 61. A proper insolvency clause provides that in the event of the insolvency of the ceding insurer, the reinsurance shall be payable under contracts reinsured by the assuming insurer on the basis of reported claims without diminution because of the insolvency of the ceding insurer. We recommend the Company either include a proper insolvency clause in the agreement or that the Company take no credit as an admitted asset or deduction from liability for reinsurance ceded under this agreement.

GHMSI's response: The Company has amended this reinsurance to include an insolvency clause. The amended agreement was submitted to the DISB on August 27.

Medicare Coordination of Benefits

The Company has insureds that are qualified Medicare beneficiaries. The Centers for Medicare and Medicaid Services (CMS) has written rules that determine which of the Company's insureds medical claims should be paid first by CMS or the Company (primary payor) and then the portion of the claim that would be paid by party not paying as primary payor (secondary payor). As a result of system errors, the Company incorrectly paid as the secondary payor on certain claims resulting in CMS paying as the primary payor. The issues were communicated to CMS in a letter dated May 15, 2009. The Company's liability to CMS has not been fully determined. In April 2009, corrective measures were taken to (1) correctly identify Medicare beneficiaries that should be paid primary and (2) modify software programs to correctly adjudicate claims to Medicare beneficiaries. The Company shall establish an ongoing plan of communication with DISB regarding its remediation activities with Medicare. In addition, the Company shall submit to DISB its plan to develop and monitor the internal controls used to coordinate benefits with Medicare.

GHMSI's Response: The Company will continue to communicate with the DSIB regarding this issue including the corrective actions taken to resolve the internal controls associated with these claims.

If you have any questions or need additional information, please feel free to contact me at (410) 998-7011.

Sincerely,



William V. Stack
Vice President and Corporate Controller