

Chet Burrell
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June 19, 2015

Hon. Chester A. McPherson
Interim Commissioner
Department of Insurance, Securities, and Banking
810 First Street NE, Suite 701
Washington, DC 20002

Dear Interim Commissioner McPherson:

I write on behalf of Group Hospitalization and Medical Services, Inc. ("GHMSI" or "Company") to submit the enclosed report regarding GHMSI's surplus at Year-End 2014, pursuant to 26A DCMR 4601.1. GHMSI's overall surplus at Year-End 2014 was 878 percent risk-based capital, authorized control level ("RBC-ACL"), compared to 932 percent at Year-End 2013. This is far below the target surplus range of 1,050% to 1,350% RBC-ACL approved by the GHMSI Board based upon the Milliman reports.

In June 2014, GHMSI obtained a full, actuarial surplus analysis performed by Milliman. A copy of this analysis was filed with the Department of Insurance, Securities, and Banking ("DISB") as part of GHMSI's June 2014 surplus report. In that analysis, Milliman noted the uncertainties caused by federal health care reform with respect to product pricing, the impact of risk adjustment mechanisms, medical loss ratio and rating constraints, the potential unavailability of the risk corridors program, and other uncertainties that relate to the major market changes due to the implementation of the ACA. The Board considered and relied upon this analysis in its December 2014 review of surplus ranges.

In June 2015, GHMSI obtained from Milliman an updated analysis, which is attached hereto. Milliman concludes that there has been no material variation in the analysis that it performed in 2014 and Milliman's recommended target surplus range has not changed. The chart attached shows the RBC ranges of CFMI and GHMSI as approved by the Board of both affiliates and the CFI Board.

December 30, 2014, the DISB issued an order finding that the portion of the surplus attributable to the District of Columbia was "excessive." GHMSI continues to disagree with that conclusion and remains seriously concerned by the large gap between the midpoint of the target surplus range recommended by Milliman and the Company's actual position as well as the overall direction/trend in RBC that has been emerging.

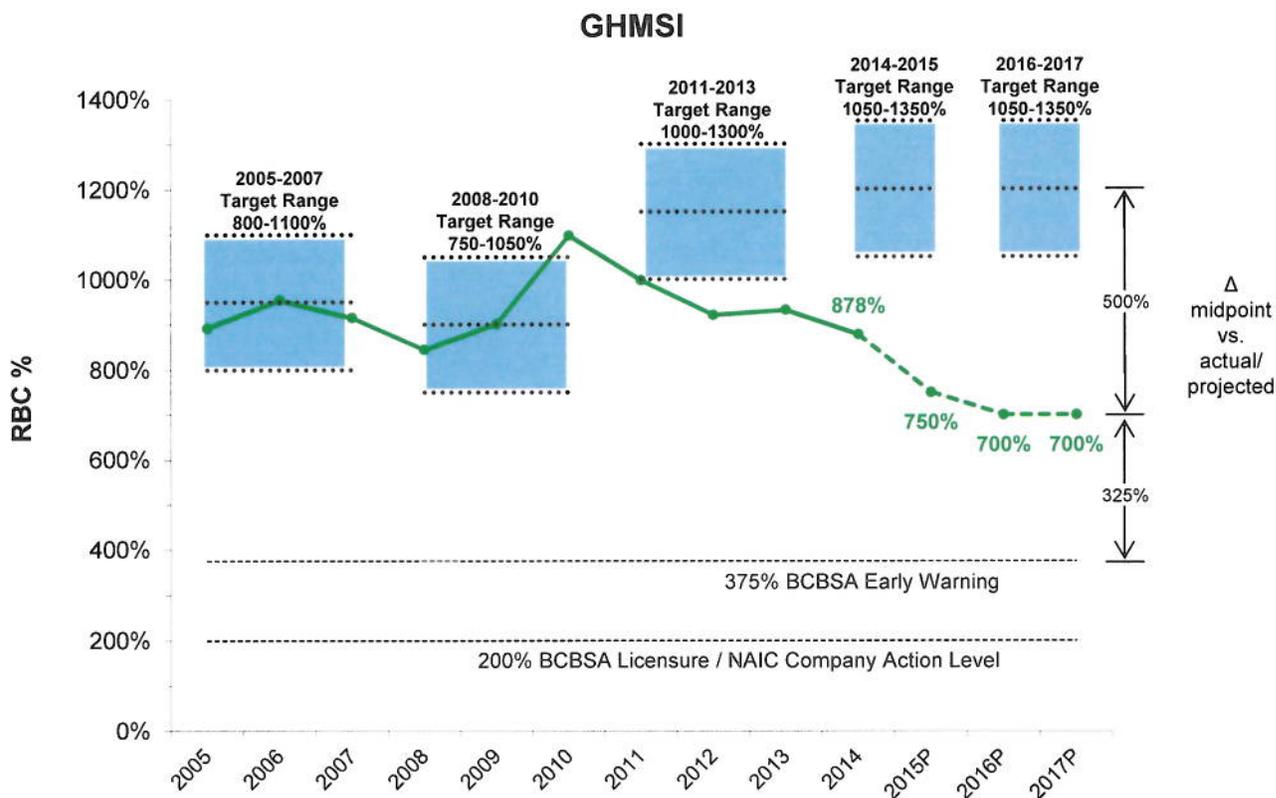
Please do not hesitate to contact me if you have any questions.

Sincerely,

A handwritten signature in blue ink that reads "Chet Burrell".

Chet Burrell
President and CEO

Board Approved RBC Ranges 2005 – Present



Note: In 2014, 40% of GHMSI's surplus represents its ownership share of the value of BlueChoice which is illiquid.

Note: There is a huge and growing gap between the midpoint of the target range and GHMSI's actual and projected RBC level and a far smaller and shrinking gap between the Company's actual RBC level and the early warning threshold of BCBSA. This is extremely concerning to the Company in an environment where restoration of lost surplus is made extremely difficult under the Affordable Care Act.

Surplus Studies: GHMSI 2005 – Present

Study Year	Consultant	Engaged by	RBC Range GHMSI
2005	Milliman <i>Board Adopted for 2005-2007</i>	CareFirst	800-1100 800-1100
2008	Milliman Lewin <i>Board Adopted for 2008-2010</i>	CareFirst CareFirst	750-1050 750-1000 750-1050
2009	InvoTex Rector	MIA DISB	700-950 600-850
2011	Milliman* Lewin <i>Board Adopted for 2011-2013</i> RSM McGladrey	CareFirst CareFirst MIA	1050-1300 1000-1550 1000-1300 1000-1300
2012	Milliman Lewin	CareFirst CareFirst	1000-1300 1000-1300
2013	Milliman	CareFirst	1000-1300
2014	Rector** Milliman*** <i>Board Adopted for 2014-2017</i> DISB 12/30/2014 Order	DISB CareFirst DISB	875-1040 (958) 1050-1350 (1200) 1050-1350 721
2015	Milliman Lewis & Ellis VBOI/Lewis & Ellis	CareFirst MIA VBOI	1050-1350 (1200) TBD 798-963

* Range adjusted for ACA impacts:

- + 100-150 points for GHMSI after exchanges
- + 50-100 points for CFMI after exchanges

** Specific target and benchmark range defined

*** Target defined - built range from standard deviations from target



Group Hospitalization and Medical Services, Inc.

Review and Consideration of Optimal Surplus Target Range

June 15, 2015

Prepared by:

**Phyllis A. Doran, FSA, MAAA
James A. Dunlap, FSA, MAAA
Ronald J. Harris, FSA, MAAA**

A. INTRODUCTION

In June of 2014 Milliman issued a report titled "*CareFirst, Inc. Group Hospitalization and Medical Services, Inc.; Development of Appropriate Surplus Target and Optimal Surplus Target Range*". The purpose of the report and its underlying analysis was to address the need for statutory surplus for GHMSI, including its ownership share of CareFirst Holdings, LLC, (CFH) and to quantify an appropriate surplus target and optimal surplus target range within which we believe the company should strive to operate, under normal circumstances.

Milliman has been asked by GHMSI to carry out a brief, limited review of circumstances and developments affecting GHMSI subsequent to our 2014 study, and to determine whether any of these would be expected to materially affect the company's surplus target range. This report presents our response.

It should be noted that we have not performed an update of our 2014 surplus target analysis; the modeling and analytical framework required to carry out such an update is beyond the scope of this current assignment. If and when we do complete such an update, it is possible that our conclusions will differ from those presented in this report, due to the differences in the nature of the assignment and the scope of the accompanying analysis, as well as potential subsequent developments; however, at this time we would not expect any such differences in conclusions to be material.

For the purpose of this report, GHMSI is understood to mean the combination of 100% of the business of GHMSI itself and 50% of the business of CFH, the vast majority of which consists of CareFirst BlueChoice, an HMO operating in the District of Columbia, Maryland and certain counties in Virginia. For consistency with our 2014 report, we will refer to CareFirst BlueChoice or CFBC rather than CareFirst Holdings or CFH when discussing the GHMSI ownership share of those companies. The business of CFMI is not reflected in this report.

Based on our limited review and the observations presented in this report, we would not expect the GHMSI surplus target range to vary materially from that produced in our 2014 study, if we were to undertake a similar study today. This is not to say that certain factors will not differ if and when we do update our analysis, or that the overall results will not change. However, in the absence of having completed such an update, at this time we would not expect materially differing results.

B. BACKGROUND: 2014 STUDY

Surplus Target Range from 2014 Study -- Based on the analysis presented in Milliman's June 27, 2014 report, we concluded at that time that an appropriate target for GHMSI's surplus is 1200% of RBC-ACL, and that an optimal surplus target range is 1050% to 1350% of RBC-ACL¹,

In developing this surplus target and optimal range we considered, among other factors, the changes in the health care marketplace resulting from federal health care reform legislation. Our analysis recognized the considerable uncertainty that remained, and continues to remain today, with respect to both the implementation of the health care reform initiatives, and the financial implications for a health plan such as GHMSI, including increased potential for adverse financial outcomes over the next several years.

Our modeling approach involves an assessment of the risks and contingencies faced by GHMSI. The most important of these -- which we refer to as the rating adequacy and fluctuation contingency -- relates to the risk that actual claims and expenses incurred by the company will differ from the amounts for which provision is made in premium rates. While this risk, also characterized as the underwriting risk, is a fundamental component of any insurance program, it is heightened in today's health care reform environment.

A surplus target range is by its nature a multi-year target. While it should be updated periodically, it should also be designed to allow for adequate planning and implementation of actions consistent with financial objectives, and to be applicable over a period of time beyond the immediate next year. For these reasons, in our surplus target modeling we focused on the period beyond the health care reform transition, beginning in 2017 when most of the ACA provisions have been fully implemented and the temporary risk mitigation programs have been eliminated. We also carried out testing to determine whether this target range is likely to be appropriate from now through the transition period, and concluded that it is.

Therefore our surplus target of 1200% of RBC-ACL is intended to apply through and beyond the transition period of 2014 to 2016. Developments over the next several years should be monitored closely, however, to evaluate the continued appropriateness of this target.

Impact of Health Care Reform -- The passage of federal health care reform legislation in the form of the Patient Protection and Affordable Care Act (ACA) in 2010 has resulted in significant changes in the health insurance marketplace. The effects of these changes continue to emerge with the implementation of the health care exchanges and risk mitigation programs, and the ongoing evolution of the regulatory environment. GHMSI and other health plans will continue to face uncertainty and challenges over the next several years, as the longer-term effects of the various components of the law unfold.

¹ RBC-ACL refers to the Risk Based Capital Authorized Control Level, a key reference value for the National Association of Insurance Commissioners (NAIC) risk based capital formula and a commonly accepted measure of surplus levels for insurance organizations. Multiples of the RBC-ACL (e.g., 1000% of RBC-ACL) are used to establish surplus thresholds, with higher multiples producing an increased likelihood of security against insolvency.

The ACA has brought a wide range of operational changes to the health care marketplace, including an individual mandate for coverage and an employer mandate (which was delayed as a result of regulatory changes). A number of new market rules have been implemented, requiring guaranteed availability of coverage and premium rating restrictions. Along with the health care exchanges are the premium subsidies and the standardization of benefits sold through the exchanges. The extension of the small group market to include group sizes 51 to 100 will become effective in 2016, with transition periods in the District of Columbia (DC) and Virginia.

The combination of these marketplace changes can be expected to continue to lead to increased adverse selection, both in terms of the population choosing to enroll and in the selection of benefit levels. The transition provisions in DC and Virginia that allow groups of 51 to 100 to choose between the small group and large group markets, in particular, will almost certainly increase adverse selection in the small group market in those jurisdictions. More generally, adverse selection may also arise in all three jurisdictions from the opportunity for groups with favorable cost characteristics to elect self-funding.

At the same time, health plans are subjected to extended timelines for the filing of new premium rates, as well as increased regulatory scrutiny of such rates. GHMSI must file its individual and small group premium rates in April and May for the following year. This timing does not allow the company to assess any of the experience of the current year in making assumptions for the subsequent year. Given the rapidly changing environment, such timing lags add significantly to the risk of inadequate premium rates.

The medical loss ratio standards and rebate requirements established by the ACA were first implemented in 2011. These provisions require GHMSI to separately report experience by market segment (individual, small group and large group), jurisdiction (D.C., Maryland and Virginia), and company (GHMSI and CFBC), resulting in 18 different segments for reporting purposes. Rebates must be paid for any such segment that does not meet the minimum medical loss ratio, with no opportunity to offset losses in other segments or jurisdictions. This situation severely limits the ability of the company to increase surplus levels if they should become depleted.

In addition to the impacts of these marketplace changes and medical loss ratio standards, the ultimate costs of the exchange plans are affected by the cost and payment transfers under the new premium stabilization or risk mitigation programs which became effective on January 1, 2014. These include the permanent risk adjustment provision as well as the transitional reinsurance and temporary risk corridor programs, both of which will expire at the end of 2016. The effects of these new programs are still unknown and will not be determined until after the close of each respective plan year – and after the submission of the following year's premium rates.

In view of the intended role of the temporary programs outlined above, the period from 2014 through 2016 can be considered a transition period. During this period the risks and uncertainties facing health plans are high, and could produce serious adverse financial outcomes. At the same time the risk mitigation programs have the potential to limit and offset these adverse effects, depending on the still-unknown details of their implementation.

It is important to note that the likelihood that GHMSI will receive its full risk corridor payments due in accordance with the risk corridor payment formula is questionable at this time, given the lack of government funding for such payments beyond amounts collected from other health plans. According to a recent S&P commentary, Standard & Poor's Ratings Services expects the ACA risk- corridor pool to be significantly underfunded if the government enforces budget neutrality. An S&P risk-corridor study indicates that the aggregate risk-corridor payables recorded by U.S. insurers for 2014 are less than 10%

of the aggregate risk-corridor receivables booked by insurers for the same year². The lack of full risk corridor payments in accordance with the initial intent of the ACA would mean that this program fails to provide its intended stabilization impact on the marketplace.

Pricing Margins – In our 2014 modeling, we assumed an average pricing margin of 3.0% on underwritten business (excluding the Federal Employee Program). The assumed overall average underwriting margin was 1.7%, including FEP business and gains/(losses) from ASC business, expressed as a percentage of total underwritten premium (non-FEP and FEP).

The 3.0% margin for non-FEP insured business that we assumed reflected the longer-term average pricing expectation for GHMSI (including its ownership share of CFBC), where in this context longer term refers to 2016 and beyond. This assumption was based on analysis of emerging experience and forward-looking information provided by CareFirst staff.

Based on the information provided, average pricing margins for 2014 and 2015 were expected to be less than half of this 3.0%. If we were to have reduced the assumed pricing margin by 50%, to 1.5%, the resulting surplus target produced by our assumptions would be 1300% of RBC-ACL, rather than the 1200% produced in our study. Further, we estimated that in order to maintain the company's surplus at a level equal to the 1200% of RBC-ACL target, an average margin of 4.3% would be required for the non-FEP insured business, assuming that premiums were to grow at an annual rate of 9% and that experience were to develop as anticipated in pricing.

In the absence of financial experience more favorable than that currently anticipated, there is significant potential for the company's surplus levels to erode, in an environment where recovery will be made more difficult by the impact of health care reform provisions as discussed above.

² Standard & Poor's Financial Services LLC, *The Unfunded ACA Risk Corridor May Make The U.S. Insurance Market Less Stable, Not More*, May 1, 2015, available at: https://www.globalcreditportal.com/ratingsdirect/renderArticle.do?articleId=1396705&SctArtId=314008&from=CM&nsi_code=LIME&sourceObjectId=9141430&sourceRevid=5&fee_ind=N&exp_date=20250430-20:51:02

C. CONSIDERATION OF CURRENT GHMSI CIRCUMSTANCES

As previously mentioned, GHMSI has asked us to carry out a limited review of GHMSI's current circumstances in order to consider what, if any, developments have occurred subsequent to the development of our 2014 study that we would expect to materially affect the surplus target range produced in that study. We were not asked to update our previous surplus analysis modeling, and we have not done so. Further, we have not attempted to quantify the specific impact of any given factor on the target surplus range that we previously developed. To do so would require a level of analysis that is beyond the scope of our assignment.

Our approach has consisted of a review of the company's recent financial experience as well as the current financial forecast, and of the current health care reform environment as it affects GHMSI. Based on this limited review, we would not expect the surplus target range for GHMSI to differ materially from the results of our 2014 study, if we were to update the study based on current information.

Observations Based on Recent GHMSI Financial Information – Following are some of our observations regarding recent GHMSI financial experience compared to the assumptions underlying our 2014 surplus analysis modeling:

- **Pricing Margins** – As noted above, in our 2014 modeling we assumed an average pricing margin of 3.0% on non-FEP underwritten business. The reported underwriting margin for 2014, measured on a comparable basis³, was (1.6%). This underwriting loss was driven by a significant (20%) loss for the individual under age 65 business. Based on information provided by GHMSI and CareFirst staff, the non-FEP underwritten business is also expected to generate an underwriting loss in 2015. The incorporation of a lower assumed pricing margin in our 2014 analysis would lead to a higher surplus target, in the absence of other changes in values or assumptions.

GHMSI (along with CFBC) has filed proposed 2016 premium rates for its individual and small group product lines in each of the jurisdictions within which it operates – i.e., the District of Columbia, Maryland, and Virginia. We understand that rate increase approvals are pending at this time.

While we understand that current expectations for pricing margins in subsequent years are closer to the 3.0% assumption in our analysis, there is obviously a great deal of uncertainty regarding pricing and experience levels over the next several years.

³ The estimated premium margins presented in this report apply to the total non-FEP underwritten business of GHMSI plus its ownership share of CFBC, consistent with the values from our 2014 report.

- **Annual Premium Growth** – GHMSI's reported annual premium growth of 7.7% in 2014 was somewhat higher than in the previous two years (4.6% in 2012, and 2.7% in 2013). These growth rates reflect premium for GHMSI plus its ownership share of CFBC, and they include FEP premium. Our 2014 analysis incorporated premium growth assumptions of 7% to 11%. We believe that these assumptions continue to be appropriate.
- **Other Modeling Assumptions** – In other regards, we found GHMSI's recent reported financial experience, taken as a whole, to be generally consistent with the assumptions underlying our 2014 analysis.

Health Care Reform Environment – Health care reform has brought many changes to the health care marketplace, and the ultimate impact of those changes is still unknown. This continued uncertainty entails financial risk to GHMSI, and therefore tends to indicate the need for higher levels of surplus than would otherwise be considered prudent.

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

Conclusions – Based on our limited review and the observations summarized above, at this time we would not expect the GHMSI surplus target range to vary materially from that produced in our 2014 study, if we were to undertake a similar study today. This is not to say that certain factors would not differ if we were to update our analysis, or that the overall results would not change. However, in the absence of completing a new study, we would not expect materially differing results.

D. LIMITATIONS AND CAVEATS

This report refers to, and relates to, Milliman's June 27, 2014 report for GHMSI on the Development of an Appropriate Surplus Target and Optimal Surplus Target Range. It should be considered only in connection with that report.

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

In order to provide the information requested by GHMSI, at the time of our 2014 analysis we constructed several projection models. Differences between these projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

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

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