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

Karima Woods
Acting Commissioner

BEFORE THE
INSURANCE COMMISSIONER OF
THE DISTRICT OF COLUMBIA

Re: Report on Examination – **CareFirst BlueChoice, Inc.** of December 31, 2018

ORDER

An Examination of **CareFirst BlueChoice, Inc.** (the "Company") as of December 31, 2018, has been conducted by the District of Columbia Department of Insurance, Securities and Banking ("the Department").

It is hereby ordered on this 8th day of May 2020, 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.

Dana Sheppard

Acting Deputy Commissioner

GOVERNMENT OF THE DISTRICT OF COLUMBIA

DEPARTMENT OF INSURANCE, SECURITIES AND BANKING

REPORT ON EXAMINATION

OF

CAREFIRST BLUECHOICE, INC.

AS OF

DECEMBER 31, 2018

NAIC Company Code: 96202
NAIC Group Code: 0380

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Washington, D.C.
March 11, 2020

The Honorable Karima Woods
Acting Insurance Commissioner
Department of Insurance, Securities and Banking
Government of the District of Columbia
1050 First Street, NE, Suite 801
Washington, D.C. 20002

Dear Acting Commissioner Woods:

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

CareFirst BlueChoice, Inc.

hereinafter referred to as "Company" or "CFBC," a District of Columbia domestic multi-state Health Maintenance Organization . The examination was conducted at the administrative office of the Company located at 10455 Mill Run Circle, Owings Mills, MD, 21117, and the following Report of Examination ("Report") is hereby respectfully submitted.

SCOPE OF EXAMINATION

The Company was last examined by representatives of the District of Columbia, Department of Insurance, Securities and Banking ("DISB" or the "Department") and covered the period from January 1, 2009 through December 31, 2013. The current full-scope risk-focused examination, covering the period from January 1, 2014 to December 31, 2018, and including any material transactions and/or events occurring after the examination date and noted during this examination, was conducted by examiners representing the Department.

The examination was conducted in accordance with procedures and guidelines prescribed by the NAIC *Financial Condition Examiners Handbook* (Handbook). The Handbook requires that we plan and perform the examination to evaluate the financial condition, assess corporate governance, identify current and prospective risks of the Company, and evaluate system controls and procedures used to mitigate those risks. An examination also includes identifying and evaluating significant risks that could cause an insurer's surplus to be materially misstated, both currently and prospectively.

The examination of Washington, D.C. domestic companies of CareFirst, was called by the Department in accordance with the Handbook guidelines, through the NAIC's Financial Examination Electronic Tracking System. This examination was conducted as part of a multi-state risk-focused examination (the "Coordinated Examination") of the CareFirst, Inc. group of insurance entities, in which the Department served as the lead state on the examination. The Maryland Insurance Administration (the "MIA") accepted the invitation to participate in the

Coordinated Examination of the following insurance companies examined at the same time during the above examination:

Company and State of Domicile	NAIC#	Acronym [1]
CareFirst, Inc. (MD)	47201	CFI
Group Hospitalization and Medical Service, Inc. (DC)	53007	GHMSI
CareFirst of Maryland, Inc. (MD)	47058	CFMI
The Dental Network, Inc. (MD)	13130	TDN
First Care, Inc. (MD)	60113	FirstCare

Concurrent with this examination, we have also examined the Company's affiliate, Group Hospitalization and Medical Service, Inc., a District domiciled non-profit corporation. A report on an examination of GHMSI will be issued under a separate cover. In addition, reports of examination for each of the four (4) Maryland domiciled entities will be issued under separate covers by the MIA.

All accounts and activities of the Company were considered in accordance with the risk-focused examination process. This may include assessing significant estimates made by management and evaluating management's compliance with Statutory Accounting Principles. In planning and conducting our examination, we gave consideration to the concepts of materiality and risk, and our examination efforts were directed accordingly. The examination does not attest to the fair presentation of the financial statements included herein. If, during the course of the examination, an adjustment is identified, the impact of such adjustment will be documented separately following the Company's Financial Statements.

In addition to the above, the examiners have reviewed work papers prepared by Ernst & Young, LLP, the Company's independent auditors, in their audit of the Company's accounts and records for the year ended December 31, 2018. The firm expressed unqualified opinions on the Company's financial statements for calendar years 2014 through 2018. A portion of the auditor's workpapers have been incorporated in the workpapers of the examiners and have been utilized in certain phase of the examination.

The examination Report includes significant findings of facts, as mentioned in Section 31-1404 of the District of Columbia Code and general information about the Company and its financial condition. There may be other items identified during the examination that, due to their nature (e.g., subjective conclusions, proprietary information, etc.), are not included in the Report but may be separately communicated to the other regulators and/or the Company.

SUBSEQUENT EVENTS

[1] This Report uses the term "CareFirst" in a broad sense to refer to CFI, GHMSI, CFBC, CFMI, TDN, and FirstCare, collectively. When necessary, the report uses the term GHMSI, CFBC, CFI, CFMI, TDN and FirstCare to refer to the respective entities.

Maryland 1332 State Innovation Waiver

The state of Maryland established a state assessment under the Maryland Health Care Access Act of 2018 to provide funding for a reinsurance program of the state's individual health insurance market. Insurance entities subject to the 2019 assessment are assessed 2.75% of 2018 premiums. The Company paid its entire assessment of $63,655,000 in March 2019. At December 31, 2019, the Company recognized its total assessment, of which $21,732,000 was recorded as a reduction of premiums earned and $41,923,000 was recorded as general and administrative expense. Only insurers of the Affordable Care Act individual products are eligible for reinsurance recoveries from the risk pools. The coinsurance rate for 2019 is 80% of per member claims between $20,000 and $250,000. The Company included actual paid claims in calculating the receivable, which is included within amounts recoverable from reinsurers and recorded as a reduction of claims incurred. The Company recorded a receivable of $193,345,000 at December 31, 2019. The receivable is expected to be collected from the state in 2020.

Medicare Advantage

A Form D Prior Notice of Transaction and Statement of Proposed Action dated August 20, 2019, was filed with the DISB on behalf of CFI, CFMI, GHMSI, and CFBC, (collectively "CareFirst") seeking approval to create and provide initial funding for a new corporation for the purpose of offering Medicare Advantage ("MA") coverage and to further the liquidity repositioning of CareFirst.

CareFirst intends for this new carrier, referred to here as "CareFirst Advantage," to enter the Maryland market with coverage beginning on January 1, 2021. CareFirst Advantage will offer health maintenance organization ("HMO") and point of service ("POS") plans. The initial service area is not yet defined, but CareFirst expects CareFirst Advantage ultimately to offer coverage throughout the entire Service Territory. CFBC provided initial funding of $3,025,000 for the establishment of the new entity. The Department approved the Form D filing on September 18, 2019.

Mergers and Acquisition

On December 20, 2019, CareFirst Filed a Form A Statement regarding the Acquisition of Control of a Domestic Insurer with the Department requesting approval on behalf of CFBC to merge CapitalCare, Inc., an existing subsidiary of CFBC, with Trusted Health Plans, Inc., which is the holding company and Trusted Health Plan (District of Columbia), Inc.'s parent. Concurrent with the filings of Form A, CareFirst filed a Form D with the Department on behalf of CFI, CFMI, GHMSI, and CFBC, providing notice and seeking approval from the Department among a number of corporate actions to acquire Trusted Health Plan (District of Columbia), Inc., a licensed HMO domiciled in the District of Columbia that participates in the District's Medicaid program. The acquisition was approved by the Department on January 24, 2020.

Pursuant to a Form A filing with the MIA on December 20, 2019, CFBC intends to acquire 100% of the stock of University of Maryland Health Partners, Inc. ("UMHP"), a licensed Managed Care Organization ("MCO") that currently administers Medicaid managed care plans in 21 Maryland counties. According to the Company, upon closing, UMHP will be renamed CareFirst

Community Partners, Inc. ("CareFirst Community Partners"). Concurrent with the filing of this Form A, CareFirst filed a Form D application with the MIA and DISB on behalf of CFI, CFMI, GHMSI, and CFBC, providing notice and/or seeking approval of a number of corporate actions required to effectuate the Acquisition. Forms A and D were approved by the MIA on January 24, 2020, and by DISB on January 28, 2020.

Administrative Services Agreement Amendments:

Effective September 29, 2019, the Company amended the Administrative Services Agreement, described below in the "Intercompany Agreements" section of this Report, to add CareFirst Advantage as a party to the agreement. Effective January 28, 2020, the agreement was again amended to add CareFirst Community Partners, Trusted Holdco, and Trusted DC as parties to the agreement.

CFI Fee Sharing Agreement Amendments:

Effective September 29, 2019, the Company amended the CFI Fee Sharing Agreement, described below in the "Intercompany Agreements" section of this Report, to add CareFirst Advantage as a party to the agreement. Effective January 24, 2020, the agreement was again amended to add CareFirst Community Partners and Trusted DC as parties to the agreement.

COVID-19 Pandemic:

The Company and the industry at large are impacted by economic conditions triggered by the global pandemic crisis of SARS-Cov-2 (COVID-19 or CoronaVirus Infectious Disease 2019). Although, as of the date of this report, it is early in the event, the Company continues to monitor and model the various associated financial impacts of COVID-19 on a group basis, including the potential cost of COVID-19 related care, the deferment of elective and non-emergent care, and the various short-term and long-term impacts of economic downturn. In response to the COVID-19 Pandemic, the organization has established a Coronavirus Task Force and implemented a framework to facilitate the day-to-day decision making and response coordination, including identifying and managing operational risks related to COVID-19. The Company has a diverse mix of business, as well as a surplus and a liquidity position that it anticipates will sustain the Company for an extended period. However, the Company is in the midst of evaluating the financial and operational impacts of the COVID-19 Pandemic, as well as continues to monitor and assess the impacts of decisions being made in response including closely monitoring revenue streams, claims volumes, and payment and investment activities. Furthermore, the organization maintains comprehensive business continuity plans and indicates that it is working to minimize disruption through this pandemic.

HISTORY

General

The Company was incorporated on June 22, 1984, in the District of Columbia under the name of CapitalCare, Inc. On July 26, 2001, the Company's name was changed to CareFirst BlueChoice, Inc. to reflect management's intent to create a regional health maintenance organization (HMO)

for the CareFirst, Inc. group of insurance affiliates. On October 10, 2002, one of CareFirst of Maryland, Inc.'s wholly-owned subsidiaries, CFS Health Group, Inc. (CFS), transferred the net assets of certain of its subsidiaries, including FreeState Health Plan, Inc. (FSHP), Delmarva Health Plan (DHP) and Preferred Health Network of Maryland, Inc. (PHN), to the Company.

CFBC is a state-licensed HMO that provides managed health care products and services to individuals and employees of businesses and governmental agencies in the Washington, D.C. metropolitan area, Northern Virginia, and the State of Maryland. Benefits are provided to members through fee for services and capitation agreements with local area physicians, hospitals, and other health care providers.

CFBC and its subsidiaries are wholly-owned subsidiaries of CareFirst Holdings, LLC (CFH). CFH, a Maryland limited liability company, was formed on December 31, 2010, by contributed assets from CareFirst of Maryland, Inc. (CFMI) and Group Hospitalization and Medical Services, Inc. (GHMSI). CFH and its subsidiaries are owned 50.001% by CFMI and 49.999% by GHMSI. CFMI and GHMSI are both affiliates of CareFirst, Inc. (CFI). These affiliates do business as CareFirst BlueCross BlueShield.

Capitalization

The Company's Articles of Incorporation authorized the Company to issue 25,000 shares of common capital stock with a par value of $1.00 per share. As of December 31, 2018, the number of shares issued and outstanding was 10,000. These shares had an aggregate par value of $10,000 and were all issued to the Company's parent, CFH. The number of issued shares and the par value per share were unchanged during the examination period. The amount of the gross paid in and contributed surplus remains unchanged at $50,615,750.

Surplus Note

The Company has issued no surplus notes during the examination period.

Dividends to Stockholders

The Company did not declare or pay dividends to its parent during the period covered by the examination.

Subsidiaries

The Company has three subsidiaries, CapitalCare, Inc. (CapCare)[2], The Dental Network, Inc. (TDN), and CareFirst Advantage, Inc. (CFAI). CapCare commenced doing business on May 1, 2002, as a health maintenance organization (HMO), which provided managed health care products and services to individuals and businesses in the Commonwealth of Virginia. Effective July 31, 2010, CapCare terminated all of its insurance coverage obligations. The groups insured by CapCare were transferred to Anthem Health Plans of Virginia, Inc. on July 31, 2010. Effective

[2] Effective January 30, 2020, CapCare merged with and into Trusted Health Plans, Inc. ("THP"), with THP surviving. As a result CapCare is no longer a subsidiary of the Company and THP and its direct subsidiary, Trusted Health Plan (Distrct of Columbia), Inc. are subsidiaries of the Company.

December 13, 2011, CapCare withdrew its HMO license and became a non-insurance entity, which is dormant. CapCare is no longer subject to statutory or regulatory reserve requirements.

TDN was formed on September 20, 2007, to meet the regulatory requirements of selling freestanding dental products in the State of Maryland. In March 2008, TDN obtained a license to sell insurance products in the State of Maryland from the Maryland Insurance Administration. TDN became operational in April 2008.

CFAI was created in September 2019. CFAI is seeking licensure as an HMO and plans to offer Medicare Advantage benefits and services upon receipt of all necessary approvals.

MANAGEMENT AND CONTROL

Board of Directors

The By-Laws state that the governing body of the Company shall be the Board of Directors, which shall conduct the business and affairs of the Company. All board members are elected at the annual meeting of shareholders. The By-Laws currently call for at least three (3) members.

The following individuals were serving on the Company's Board of Directors as of December 31, 2018:

Name and Address	Principal Occupation
John F. Reim, Chair Potomac, MD	Managing Director Morgan Stanley
Brian D. Pieninck Baltimore, MD	President and Chief Executive Officer CareFirst
Wendell L. Johns Washington, DC	Retired
Jeffrey P. DiLisi, M.D. Vienna, VA	Senior Vice President and Chief Medical Officer Virginia Hospital Center
Ann B. Mech, RN, JD[3] Dayton, MD	Director of Legal Affairs The University of Maryland School of Nursing

Officers

The By-Laws require the following officers: Chairman of the Board of Directors, a president, a secretary, and a treasurer. The Board elects these officers of the Company and other officer positions at its annual meeting. Each officer serves until a successor is elected or until removed by

[3] Effective December 3, 2019, Ann B. Mech resigned her board position due to term/age limits. On February 19, 2020, Amy Schwab Owens was elected to the Board.

the Board. The following persons were serving as the Company's officers as of December 31, 2018:[4]

Name	**Title**
Brian D. Pieninck	President and Chief Executive Officer
Jeanne A. Kennedy [5]	Corporate Treasurer and Vice President
Meryl D. Burgin	Corporate Secretary, Executive Vice President and General Counsel
Gregory M. Chaney [6]	Executive Vice President and Chief Financial Officer
John D. Kaecher	Executive Vice President and Chief Information Officer
David J. Corkum	Executive Vice President, Large Group SBU
Rose V. Megian	Executive Vice President, Small and Medium Group SBU
Wanda K. Oneferu-Bey	Executive Vice President, Consumer Direct & Government Programs SBU
Stacia A. Cohen	Executive Vice President, Medical Affairs
Maria H. Tildon	Executive Vice President, Marketing Communication and External Affairs
Jennifer A. Baldwin	Senior Vice President, Patient-Centered Medical Home Program
Stacey R. Breidenstein	Senior Vice President, Networks Management
Michelle J. Wright	Senior Vice President, Human Resources
Peter A. Berry	Senior Vice President, Chief Actuary
Vickie S. Cosby	Senior Vice President, Consumer Direct SBU
Sandra A. Dilworth	Senior Vice President, IT Operations
Andrew J. Fitzsimmons	Senior Vice President, Chief Informatics Officer
Kenneth P. Sullivan	Senior Vice President, IT Applications
Melvelyn M. Greene	Senior Vice President, FEP Local Operations
Jonathan N. Kromm	Senior Vice President, Marketing and Communication
Usha Nakhasi	Senior Vice President and General Manager, Service Benefit Plan Administrative Services Corporation and FEP Operations Center

Committees

As of December 31, 2018, the Company's Board of Directors had not established any committees. Instead, the Company relies on the committees of CFMI, GHMSI, and CFI. The Company's Board of Directors designated the Audit and Compliance Committee of its ultimate parent (CareFirst Inc.) as its independent audit committee to perform the committee requirements of Section 31-706(c)(5) of the District of Columbia Official Code.

Conflict of Interest

[4] Effective February 19, 2020, Randolph S. Sergent was elected as Secretary and Robert E. Glaze was elected as Assistant Secretary

[5] On February 19, 2020, the Board of Directors elected Brian J. Keefe as Treasurer replacing Jeanne A. Kennedy, who retired on November 1, 2019.

[6] Effective December 27, 2019, Gregory Mark Chaney retired as Executive Vice president and Chief Financial Officer. He is replaced by Jenny L. Smith effective April 6, 2020.

The By-Laws state that the Board of Directors shall adopt a code of business conduct and compliance that governs the conduct of the Company's directors, officers, and associates. In accordance with the By-Law, the Company adopted a conflict-of-interest policy. This policy requires all directors, officers, and associates to annually complete a Conflict of Interest Disclosure Statement documenting any potential conflicts.

A review of the completed questionnaires for calendar years 2014 to 2018 indicated no reported conflicts. In addition, we did not note any potential conflicts of interest during the examination.

Corporate Records

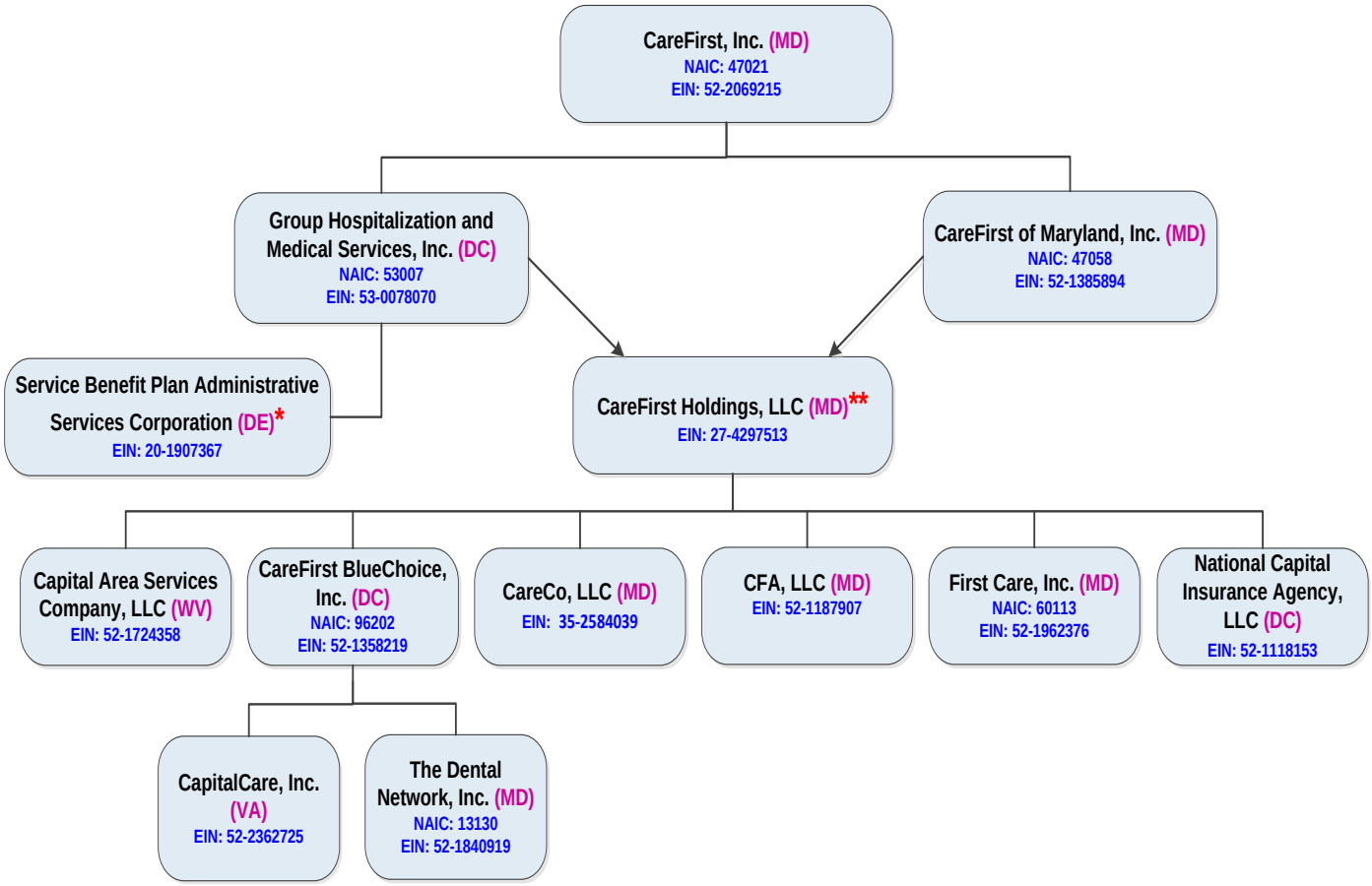
The Company's Articles and By-Laws were unchanged during the examination period. The minutes of the meetings of the Company's shareholder(s) and the Board of Directors for the period under examination were also reviewed. The Company designated the audit committee of its ultimate parent, CareFirst, Inc., to perform certain required functions on its behalf (see "Committees" section above). The minutes documented the Company's significant transactions and events, which the directors then approved.

AFFILIATED COMPANIES

The Company is a wholly-owned subsidiarity of CFH. CFH was formed on December 31, 2010 by contributed assets from CFMI and GHMSI. CFH and its subsidiaries are owned 50.001% by CFMI and 49.999% by the GHMSI. Both CFMI and GHMSI do business as CareFirst BlueCross BlueShield and are both affiliates of a not-for-profit parent company, CFI.

Organization Structure

The company is a member of an insurance holding company system pursuant to the provisions of the District of Columbia Code Section 31-701. The CareFirst, Inc. holding company structure as of December 31, 2018, is depicted in the following organizational chart:



***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.

****CareFirst Holdings, LLC** is owned 50.001% by CareFirst of Maryland, Inc. and 49.999% by Group Hospitalization and Medical Services, Inc.

Intercompany agreements

In addition to intercompany reinsurance agreements described below under the "Reinsurance" caption of this Report, the Company has entered into the following intercompany contracts and transactions disclosed as part of Form B – Holding Company Registration Statement, and filed with the Department, as required, in accordance with DC Code § 31–706(a)(2):

Financial Support Agreement

Effective December 31, 2010, CFI, CFMI, GHMSI and CFH entered into an intercompany agreement which requires that in the event that the capital reserves of the entities or their respective subsidiaries (including the Company), who are required by law to maintain a statutory or regulatory requirement, fall below their respective statutory, regulatory, or Blue Cross Blue Shield Association (BCBSA) requirements, the party with the shortfall shall notify all other parties of the shortfall. The other parties, subject to specific terms, conditions, and limitations, shall transfer to the requesting party such financial resources as needed to satisfy the shortfall. In addition to reserve shortfalls, the agreement provides for financial support for other situations, including the inability to pay claims and/or other legally enforceable obligations including, but not limited to, creditor

demands, judgments, and surplus notes. The determination as to whether any of the aforementioned conditions exists shall be made by the Board of Directors of CFI.

Administrative Services Agreement

Effective January 1, 2009, CFI, CFMI, GHMSI, and all of their respective subsidiaries (including the Company) entered into an administrative services agreement. The agreement calls for CFMI and GHMSI to provide its parent and other related entities, including each other, with administrative and operational support services. In consideration of the services provided, CFMI and GHMSI are paid a fee based upon direct and indirect costs plus a mark-up based on market rates. Settlements of amounts due occur on a monthly basis. Total charges for services provided by CFMI and GHMSI were $379,810,000 for the year ended December 31, 2018. These allocations are included in general and administrative expenses.

Administrative Services Agreement with Capital Area Services Company, LLC

Effective January 1, 2010, the Company, CFMI, GHMSI, FirstCare, and TDN entered into an administrative services agreement with Capital Area Services Company, LLC (CASCI). The agreement calls for CASCI to perform the following services: 1) Claims processing, adjudication, and customer services; 2) Document storage and retention; and 3) Miscellaneous administrative services. In consideration of the services provided, CASCI is paid a fee based upon direct and indirect costs plus a mark-up based on market rates (as approved by the Commissioners of Maryland and the District of Columbia). Settlements of amounts due occur on a monthly basis.

Network Access Agreement

Effective April 1, 2008, the Company and GHMSI entered into a Network Access Agreement with TDN. The agreement calls for TDN to provide the Company and GHMSI access to its provider network in the state of Maryland and its benefits administration services. In exchange, the Company and GHMSI will pay TDN a set amount per member per month to be paid monthly.

Tax Sharing Agreement

Effective December 31, 2010, the Company entered into a Tax Sharing Agreement with its subsidiaries, CapCare and TDN. The agreement calls for the allocation of current federal and state (where permitted) income tax liability/recoverable attributable to the companies based on the percentage of the consolidated federal income tax liability/recoverable attributable to the companies computed on a separate company basis to the total consolidated federal income tax liability/recoverable. The agreement also provides that to the extent the Company's subsidiaries tax attributes (e.g., NOLs) reduce the consolidated federal income tax liability, CFBC shall pay the subsidiaries for the use of such attributes in the year utilized.

CFI Fee Sharing Agreement

Effective January 29, 2014, the Company, CFMI, GHMSI, First Care, and TDN entered into a Fee Sharing Agreement with CFI pursuant to the Affordable Care Act, which required covered

entities, including health insurance issuers, health maintenance organizations, and insurance companies, to pay the annual Health Insurer Fee (the "HIF"). According to the Fee Sharing Agreement, each entity shall pay CFI the entity's individual HIF liability based upon each entity's proportional share of net premiums as reported.

Quota-Share Reinsurance Agreement between the Company, CFMI, and GHMSI

Effective April 1, 2014, the Company, CFMI, and GHMSI entered into a Quota-Share Reinsurance Agreement. In certain instances, CFI offers large groups the option to purchase indemnity products from the CFMI or GHMSI, and HMO products (dual option policies) from CFBC at a uniform rate increase (blended rate). The purpose of this agreement is to transfer premiums among entities to achieve an equivalent medical loss ratio for the dual option policies on the Company, CFMI, and GHMSI. The companies do not apply reinsurance accounting for this agreement as there is no transfer of risk. The agreement is accounted for as an intercompany agreement. Total premiums allocated from CFBC for these products were $14,917,000 for the year ended December 31, 2018.

Point-of-Service Agreement between the Company, CFMI, and GHMSI

The Company bears all of the in-network (HMO) underwriting risk, and CFMI and GHMSI bear the out-of-network (indemnity) underwriting risk for certain fully insured point-of-service (POS) health care products. Effective January 1, 2018, the Company entered into an agreement with CFMI and GHMSI in which the Company pays a two dollar per member per month fee to CFMI and GHMSI for providing the out-of-network (indemnity) benefits for its POS products. The fee is based on actual membership and paid in exchange for the Company's POS products gaining access to CFMI's and GHMSI's regional provider network and claims processing for the out-of-network services. All premiums cost of care and operating expenses of the Company's POS products are recorded directly by the Company. Total fees paid from the Company to CFMI and GHMSI were $2,570,000 for the year ended December 31, 2018.

Intercompany Loan Agreements between the Company, CFMI, and GHMSI

On November 29, 2018, CFBC entered into five-year term loan agreements with CFMI and GHMSI to increase the liquidity of CFMI and GHMSI and to facilitate a transfer of additional funds from CFMI and GHMSI to CFH. Under the loan agreements, CFBC provided $150,000,000 each in securities and cash to CFMI and GHMSI on identical terms. The loan amount is subject to interest, which is accrued and paid quarterly at the mid-term applicable federal rate set by the Internal Revenue Service. The loan amount and any outstanding interest on such loan amounts shall be repaid in full to CFBC on or before the end of the term.

REINSURANCE

The Company was party to the following affiliated reinsurance agreements during the examination period:

Quota-Share Reinsurance Contract between the Company and TDN

Effective April 1, 2008, the Company entered into a Quota-Share Reinsurance Contract with TDN. Under the terms of the agreement, the Company assumes all underwriting risk for TDN. The Company assumed revenue from TDN in the amount of $3,689,000 and incurred an underwriting loss in the amount of $3,473,000 for the year ended December 31, 2018. Settlements of amounts due occur on a monthly basis. The Company will contribute capital to TDN as necessary to maintain sufficient levels of capital and surplus to maintain all regulatory, statutory, and BCBSA requirements.

Stop Loss Reinsurance Contract between the Company, CFMI, and GHMSI

Effective January 1, 2009, CFMI and GHMSI (collectively the Reinsurers) entered into a Stop Loss Reinsurance Contract with the Company. Under the terms of the agreement, the Reinsurers provide stop-loss coverage for all of the Company's claims that exceed 105% Medical Loss Ratio. The reinsurers share any liability based upon their respective ownership percentage in the Company at the beginning of the calendar year.

FIDELITY BOND AND OTHER INSURANCE

The Company, along with other affiliates, was included as named insureds in a fidelity bond issued to the Company's parent, CFI. The Company was protected under a Fidelity Bond with a single loss limit and an aggregate loss limit of $25,000,000, and a deductible of $100,000. The coverage exceeded the minimum amount of fidelity bond coverage recommended by the NAIC for these companies on a consolidated basis.

Additionally, the Company's ultimate parent, CFI, had a cyber-liability policy that had an aggregate limit of liability of $10,000,000, with a single loss deductible of $2,500,000, covering the CareFirst entities. The Company was also a named insured in its ultimate parent's excess cyber liability policy covering the same companies. The CareFirst cyber liability tower has $125,000,000 in Cyber Liability Coverage. The tower is made up of multiple excess layers above the primary $10,000,000 policy. Each layer can have one insurer or multiple insurers that provide the coverage. All excess carriers in the tower follow the terms and conditions of the primary policy.

In addition, the Company had other insurable risks. In this regard, the Company had insurance policies that provided coverage for other operational risks incurred by the Company and its affiliates (e.g., general liability, workers' compensation, and business property).

PENSIONS, STOCK OWNERSHIP, AND INSURANCE PLANS

The Company has no employees. All personnel and their related costs are allocated to the Company through administrative service agreements described above under "Intercompany Agreements."

STATUTORY DEPOSITS

In compliance with Section 31-3412(b) of the District of Columbia Official Code requirement of maintaining a minimum deposit of $300,000 value, the Company had deposited in trust with SunTrust Bank, a United States Treasury Bond, with a total par value of $400,000 and a fair market value of $396,264 as of December 31, 2018. These funds were held for the protection of all of the Company's policyholders and creditors.

In addition, as of December 31, 2018, the Company had deposits, consisting of Short-Term Investments and a United States Treasury Bond with Maryland and the Commonwealth of Virginia, respectively. The Maryland Special Deposit is required to satisfy obligations to external providers for services rendered on behalf of members of the Company. The Virginia Special Deposit was held for the protection of the policyholders in Virginia.

Jurisdiction	Par-Value	Market Value	Security Type
District of Columbia	$400,000	$396,264	Bond
Maryland	7,539	2,899	S/T Investment
Virginia	800,000	773,848	Bond
Totals	$1,207,539	$1,173,011	

TERRITORY AND PLAN OF OPERATION

The Company is an HMO that provides managed health care products and services to individuals and employees of businesses and governmental agencies in the Washington, D.C. metropolitan area, Northern Virginia and the state of Maryland. Benefits are provided to members through fee-for-service and capitation agreements with local area physicians, hospitals, and other health care providers. CFBC's lines of business are further segmented in market categories, including Federal Employees Health Benefits Program (FEHBP), individual members under the age of 65, small employer groups with fewer than 50 eligible enrollees, and large groups consisting of those employer customers with 51 or more eligible enrollees. CareFirst uses CFBC as its HMO product in all of its service areas.

ACCOUNTS AND RECORDS

The Company's accounting procedures, practices, account records, and supporting data were reviewed and tested to the extent deemed necessary. A review of the Company's Information Technology General Controls (ITGC) and General Application Controls (GAC) was also performed as required by the Handbook. Based on the scope of the Information Technology (IT) examination, certain items were noted and discussed with the Company. However, the review did not disclose any significant deficiencies in these records.

FINANCIAL STATEMENTS

The following financial statements are based on the statutory financial statements filed by the Company with the Department and present the financial condition of the Company for the period ended December 31, 2018. The accompanying comments on the financial statement reflect any examination adjustment to the amounts reported in the annual statement and should be considered an integral part of the financial statements.

Statement of Admitted Assets, Liabilities, Capital and Surplus

Assets		
Bonds	$	398,828,410
Common stocks		103,798,960
Cash, cash equivalents and short-term investments		21,965,478
Other invested assets (Schedule BA)		300,000,000
Subtotal, Cash and invested assets		824,592,848
Investment income due and accrued		3,504,087
Uncollected premiums and agents' balances		84,332,046
Accrued retrospective premiums and contracts subject to redetermination		31,356,033
Amounts recoverable from reinsurers		204,148
Other amounts receivable under reinsurance contracts		425,782
Net deferred tax asset		9,957,148
Receivables from parent, subsidiaries and affiliates		93,269,127
Health care ($123,577,664) and other amounts receivable (**Note 2**)		166,167,688
Total admitted assets	$	1,213,808,907
Liabilities		
Claims unpaid (**Note 1**)	$	184,910,604
Unpaid claims adjustment expenses (**Note 1**)		5,911,300
Aggregate health policy reserves, including the liability of $60,640,000 for medical loss ratio rebate per the Public Health Service Act (**Note 2**)		143,826,651
Premiums received in advance		65,335,295
General expenses due or accrued		72,933,918
Current federal and foreign income tax payable and interest thereon, including $(793,385) on realized capital gains (losses)		925,043
Amount withheld or retained fo the account of others		6,353,799
Amounts due to parent, subsidiaries and affiliates		3,152,033
Aggregate write-ins for other liabilities		9,405,086
Total liabilities	$	492,753,729
Capital and Surplus		
Common capital Stock		10,000
Gross paid in and contributed surplus		50,615,750
Unassigned funds (surplus)		670,429,428
Total capital and surplus		721,055,178
Total liabilities, surplus	$	1,213,808,907

Statement of Revenue and Expenses
For the Year Ended December 31, 2018

Member months		7,653,064
Net premium income	$	3,664,646,716
Change in unearned premium reserves and reserve for rate credits		(47,205,972)
Aggregate write-ins for other health care related revenues		3,041,121
Total revenues		3,620,481,865
Hospital and Medical:		
Hospital/medical benefits		1,857,982,753
Other professional services		182,086,156
Outside referrals		7,094,735
Emergency room and out-of-area		76,714,849
Prescription drugs		646,831,299
Subtotal		2,770,709,792
Less: Net reinsurance recoveries		(4,201,367)
Total hospital and medical		2,774,911,159
Claims adjustment expenses, including $68,883,835 cost containment expenses		169,616,831
General administrative expenses		590,501,053
Total underwriting deductions		3,535,029,043
Net underwriting gain (loss)		85,452,822
Net investment income earned		24,335,476
Net realized capital gains or (losses) less capital gains tax of ($793,385)		(2,984,639)
Net investment gains (losses)		21,350,837
Aggregate write-ins for other income or expenses		58,934
Net income or (loss), after capital gains tax and before all other federal income taxes		106,862,593
Federal and foreign income taxes incurred		42,945,666
Net income (loss)	$	63,916,927

Statement of Changes in Capital and Surplus
From January 1, 2014 through December 31, 2018

Capital and surplus, December 31, 2013	$	733,350,796
Net income or (loss)		22,090,620
Change in net unrealized capital gains (losses) less capital gains tax		2,892,836
Change in net deferred income tax		6,890,418
Change in nonadmitted assets		(8,174,341)
Net change in capital and surplus		23,699,533
Capital and surplus, December 31, 2014		757,050,329
Net income or (loss)		(9,917,801)
Change in net unrealized capital gains (losses) less capital gains tax		(6,439,813)
Change in net deferred income tax		3,509
Change in nonadmitted assets		408,414
Net change in capital and surplus		(15,945,691)
Capital and surplus, December 31, 2015		741,104,638
Net income or (loss)		(46,101,706)
Change in net unrealized capital gains (losses) less capital gains tax		1,815,117
Change in net deferred income taxes		1,763,471
Change in nonadmitted assets		(5,291,292)
Aggregate write-ins for gains or losses in surplus		4,232,788
Net change in capital and surplus		(43,581,622)
Capital and surplus, December 31, 2016		697,523,016
Net income or (loss)		(27,820,788)
Change in net unrealized capital gains (losses) less capital gains tax		3,009,767
Change in net deferred income taxes		(9,589,783)
Change in nonadmitted assets		9,491,423
Net change in capital and surplus		(24,909,381)
Capital and surplus, December 31, 2017		672,613,635
Net income or (loss)		63,916,927
Change in net unrealized capital gains (losses) less capital gains tax		(16,733,609)
Change in net deferred income taxes		6,982,966
Change in nonadmitted assets		(5,724,741)
Net change in capital and surplus		48,441,543
Examination adjustments		-
Capital and surplus, December 31, 2018	$	721,055,178

Analysis of Examination Changes to Surplus

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

NOTES TO FINANCIAL STATEMENTS

1. Claims unpaid & Unpaid Claims Adjustment Expenses: As of December 31, 2018, the Company reported: "Claims Unpaid" and "unpaid Claims Adjustment Expenses" (collectively "Claims Reserves") totaling 184,910,604 and $5,911,300, respectively. These amounts represent management's best estimate of the cost settling all known and unknown claims that had been incurred as of December 31, 2018. The Company's Board of Trustees appointed David Markowitz, FSA, MAAA, Actuary, to render the Company's Statement of Actuary Opinion ("Opinion") in connection with the preparation of the Company's December 31, 2018, Annual Statement.

   In connection with this examination, the Department retained an independent actuary Margaret Hermann, FSA, MAAA, of INS Consultants, Inc., to conduct a review and analysis of the Company's actuarially determined accounts as of December 31, 2018. No significant adverse issues were noted as a result of that review.

2. Federal Employees Health Benefits Program (FEHBP): The Company has an experience-rated HMO contract with the U.S. Office of Personnel Management (OPM) to provide managed health care services under Federal Employee Health Benefits Program (FEHBP). The excess of gross premiums for the life of the program over the charges for the life of the program is considered the special reserve under the contract between OPM and the Company. Each year, OPM also allocates additional funds to a contingency reserve, which may be utilized by the Company if funds set aside from annual premiums are insufficient or fall below certain prescribed levels by OPM. Funds available to the Company are held at the U.S. Treasury, including amounts unused from prior periods. Any funds which remain unused upon termination of the contract, after the claims run-out and reimbursement of allowable administrative expenses, would be returned to OPM for the benefit of FEHBP. The OPM contract renews each year automatically unless either party gives written notice of termination.

   The amounts being held in the special reserve are $41,916,000 and $42,337,000 as of December 31, 2019, and December 31, 2018, respectively. The amounts being held in the contingency reserve are $100,237,000 and $77,666,000 as of December 31, 2019, and December 31, 2018, respectively. Amounts incurred in excess of the total reserves held at the U.S. Treasury for FEHBP would not be reimbursed to the Company. The Company has recorded the amount of the special reserve being held by OPM as an asset, with an equivalent amount recorded as a rate stabilization reserve. These amounts are included in health care and other amounts receivable and aggregate health policy reserves, respectively. FEHBP revenue earned was $387,958,000 and $429,595,000 for the years ended December 31, 2019 and December 31, 2018, respectively.

   Medical Loss Ratio Rebates: The Patient Protection and Affordable Care Act and a reconciliation measure, the Health Care and Education Reconciliation Act of 2010, which the Company refers to together as the Health Reform Legislation, established minimum medical

loss ratio (MLR) regulations that require payment of premium rebates (MLR rebates) to employers and individuals covered under the Company's comprehensive medical insurance if certain minimum MLRs (85% for a large group, 80% for small group and 80% for individual under 65) are not met. The MLR rebates are measured by jurisdiction at the market segment level (large group, small group, and individual under 65). As of December 31, 2019, and December 31, 2018, the Company recorded an estimated MLR rebate accrual of $72,400,000 and $60,640,000, respectively, within the aggregate health policy reserves.

Premium Stabilization Programs: Health Reform Legislation includes three programs designed to stabilize health insurance markets (Premium Stabilization Programs): a permanent risk adjustment program, a transitional reinsurance program, and a temporary risk corridor program. The risk adjustment program is a permanent program that transfers funds from insurers who enroll individuals with lower relative health risks to insurers who enroll individuals with higher relative health risks. Risk adjustment payments/receipts are determined separately for each state and individual and small-group products. The risk adjustment receivable or payable, if any, would be included within accrued retrospective premiums or aggregate health policy reserves and recorded as an adjustment to premiums earned. The Company developed an estimate of amounts to be recorded under the risk adjustment program considering data that is currently available. This data included the calculation of member risk scores for the Company, third party analysis of state average risk scores, and other data relevant to the Company's markets. Beginning with the 2018 benefit year, risk adjustment methodology incorporates a high-cost risk pool calculation. The U.S. Department of Health and Human Services establishes two new high-cost risk pool parameters: a threshold and a coinsurance rate. The high-cost risk pools for high-cost enrollees would fund 60% of the insurer's costs for individual enrollees with claims above $1,000,000. Insurer will be reimbursed for a portion of actual enrollee-level claims above the threshold. To maintain the zero-sum nature of risk adjustment across each market, the insurer will be assessed for an amount, which is calculated as a percentage of the insurer's total premiums in the applicable market. The sum of the assessments across all insurers equals the sum of the high-cost risk pool claims reimbursements across all insurers. The risk adjustment payments/receipts are reported net of the high-cost risk pool amounts. As of December 31, 2019, and December 31, 2018, the Company reported a net payable of $8,170,000 and $9,494,000, respectively.

3. Liabilities, Contingencies, and Assessments:

The Company, along with the BCBSA, and all of the other BCBSA licensees, has been named as a defendant in multiple suits that make up the Blue Cross Blue Shield Antitrust Litigation. This matter is part of multi-district litigation combining several anti-trust cases, brought by two putative nationwide classes of plaintiffs, health plan subscribers, and providers, that challenge the exclusive service areas outlined in the BCBSA license agreements. The Company has been cooperating in the joint defense with the BCBSA. In April 2018, the U.S. District Court issued an order clarifying how specific legal standards will be applied to the case. The U.S. Circuit Court of Appeal for the Eleventh Circuit denied the Blues Plans' request for an interlocutory appeal of the order. The matter is proceeding in the trial court. In 2019, the BCBSA and the BCBSA licensees were in discussions regarding a potential settlement for the subscribers' litigation. Based on the Company's analysis of the draft terms of the settlement for the subscriber cases, the Company concluded that it is probable that a loss has been incurred and the amount of loss is reasonably estimable. Although settlement terms have been

discussed, the Company is unable to predict the timing of this settlement or whether all parties will accept the draft terms. However, the Company has recorded a liability that represents its best estimate of the loss that will be incurred. If the settlement process progresses, the Company will reconsider whether the accrual recorded is appropriate and record any necessary adjustments once that information becomes available. The Company has retained its independent counsel to continue to defend the providers' cases; however, it is unable to predict the outcome of the matter or to reasonably estimate a range of possible loss.

The Company is subject to the Health Insurer Fee ("HIF") imposed under Section 9010 of the Patient Protection and Affordable Act. In accordance with SSAP No. 106 Affordable Care Act Section 9010 Assessment (SSAP 106) the company's estimated HIF payable in the followed year is required to be reclassified from unassigned surplus to special surplus. The HIF is not deductible for income tax purposes. The Company estimated its liability for the HIF based on a ratio of the Company's applicable written premiums compared to the U.S. health insurance industry total applicable written premiums, both for the preceding calendar year. In accordance with SSAP 106, the entire HIF is recognized as general administrative expense on January 1. The Company recorded in full its estimated liability in accounts payable at the beginning of the year with a corresponding deferred asset that was amortized to the general and administrative expense on a straight-line basis over the calendar year. The Company's 2018 HIF of $65,142,000 was paid in September 2018. The allocable portion of the HIF liability that was related to the premiums for insurance provided through the FEHBP is chargeable to the Federal Employee Program contracts.

Various lawsuits, including class action lawsuits and other claims, occur in the ordinary course of business and are pending against the Company. The Company records reserves for such matters when a loss is deemed to be probable and estimable. Management, after consultation with legal counsel, believes that the lawsuits and other claims, when resolved, will not have a material adverse effect on the accompanying consolidated financial statements; however, there can be no assurance in this regard.

COMMENTS AND RECOMMENDATIONS

There were no recommended adjustments to the financial statements as of December 31, 2018 or significant adverse findings as a result of the examination.

CONCLUSION

The insurance examination practices and procedures as promulgated by the NAIC have been followed in ascertaining the financial condition of **CareFirst BlueChoice, Inc**. as of December 31, 2018, consistent with the insurance laws of the District of Columbia. Such procedures performed on this examination do not constitute an audit made following generally accepted auditing standards, and no audit opinion is expressed on the financial statements contained in this Report. No material adjustments were identified during the examination; the balance sheet in this Report of Examination reflects the financial condition of the Company as of December 31, 2018, and is summarized as follows:

Admitted assets	$1,213,808,907
Liabilities	492,753,729
Common capital stock	10,000
Gross paid in and contributed surplus	50,615,750
Unassigned funds (surplus)	670,429,428
Total capital and surplus	721,055,178
Total liabilities, capital and surplus	$1,213,808,907

Chapters 20 (“Risk-Based Capital”) and 34 (“Health Maintenance Organizations”) 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.

SIGNATURES

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:

Mark Jaster, The INS Companies, Examiner in Charge, Maryland
Neeraj Gupta, The INS Companies, Examiner in Charge, DC (6/3/19 – 8/15/19)
Don Catmull, The INS Companies, Financial Examiner
Richard Kramer, The INS Companies, Financial Examiner
Pat Neesham, The INS Companies, Financial Examiner
Carolyn Maynard, The INS Companies, Financial Examiner
April Spevak, The INS Companies, Financial Examiner
Dave Gordon, INS Services, Inc., IT Manager
John Albertini, INS Services, Inc., IT Supervisor
Terry Ryals, INS Services, Inc., IT Specialist
AJ Avezzano, INS Services, Inc., IT Specialist
Frank Edwards, INS Consultants, Inc., Reviewing Actuary
Peggy Hermann, INS Consultants, Inc., Lead Actuary
Ankush Verma, INS Consultants, Inc., Actuarial Analyst

The exam team also utilized the services of Professor Michael A. Angelina, ACAS, MAAA, CERA, Executive Director of the Maguire Academy of Insurance and Risk Management at Saint Joseph's University to review CareFirst's Own Risk and Solvency Assessment (ORSA).

Respectfully submitted,

Barry W. Lupus

Barry Lupus, CFE
Examiner-in-Charge
The INS Companies
Representing the District of Columbia
Department of Insurance, Securities and
Banking

Under the Supervision of

Yohaness Negash, CFE
District of Columbia Department of
Insurance, Securities and Banking