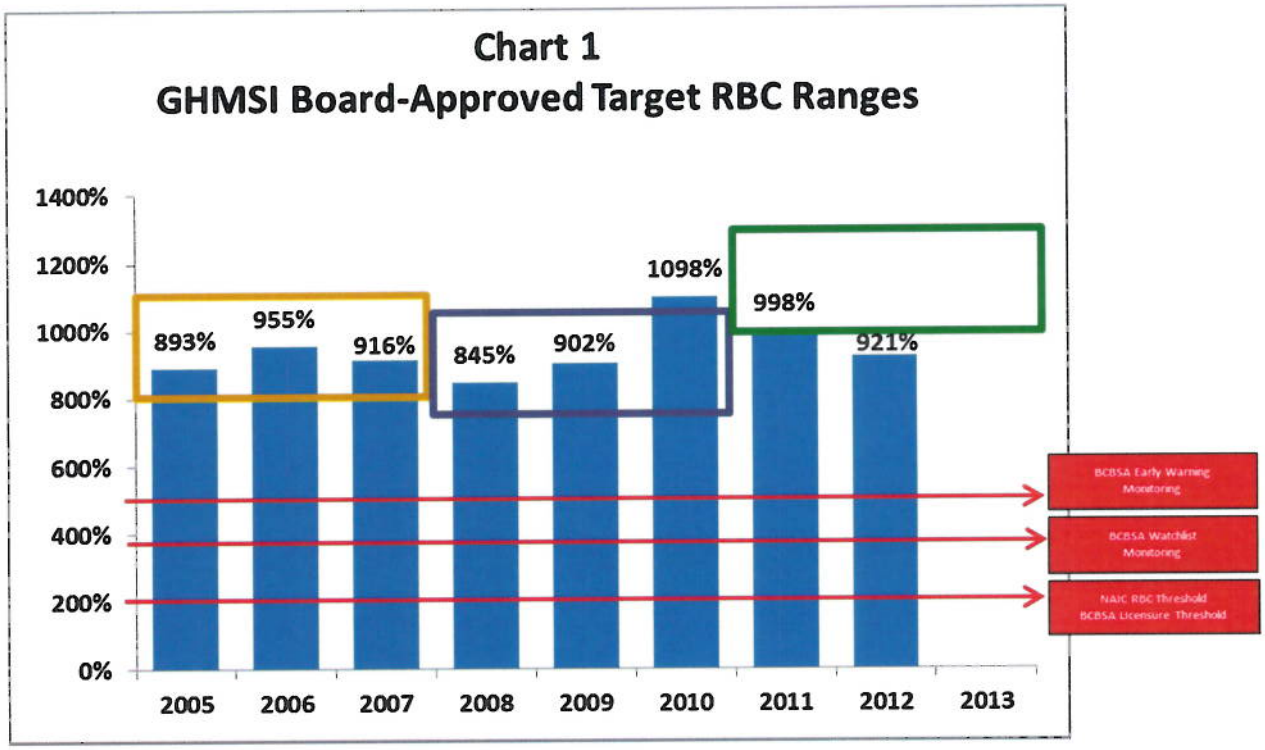
Report to the D.C. Department of Insurance, Securities and Banking Regarding GHMSI's Surplus at Year-End 2012

July 1, 2013

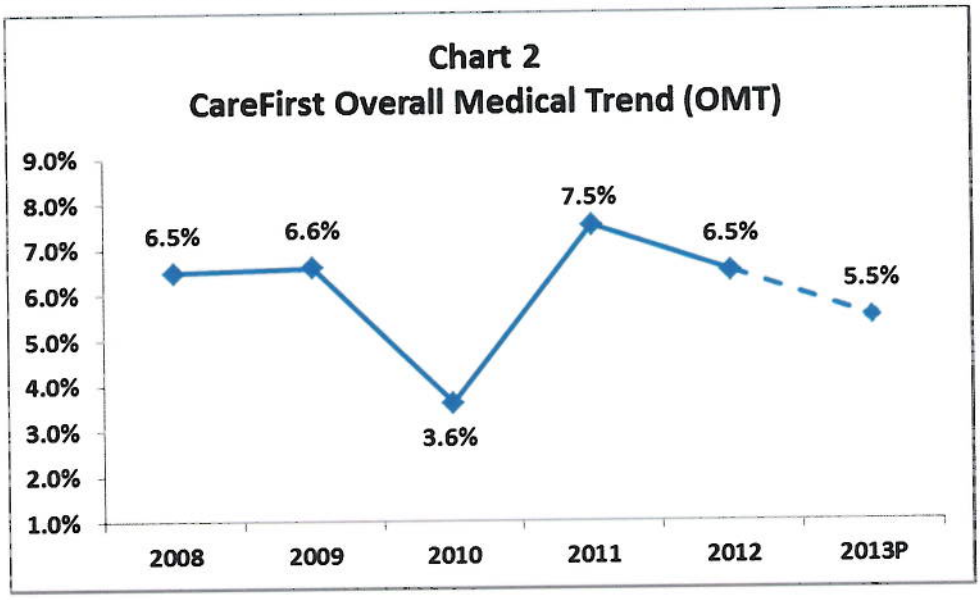
Group Hospitalization and Medical Services, Inc. ("GHMSI" or "Company") submits this report regarding its surplus at Year-End 2012 to the Commissioner of the Department of Insurance, Securities and Banking (the "DISB"), pursuant to 26A DCMR 4601.1. As outlined in greater detail below, GHMSI's 2012 surplus declined from 2011, and remained below the target levels set by the Company's Board, under its established policy and pursuant to independent actuarial advice. Those target levels have been approved by Maryland's regulator. In a September 14, 2012 Consent Order, the Commissioner of the Maryland Insurance Administration (the "MIA") upheld the recommendation of the MIA's independent actuarial consultant, RSM McGladrey, Inc. ("McGladrey"), to approve a surplus range for GHMSI consistent with that set by the GHMSI Board.

GHMSI's Current Surplus Level

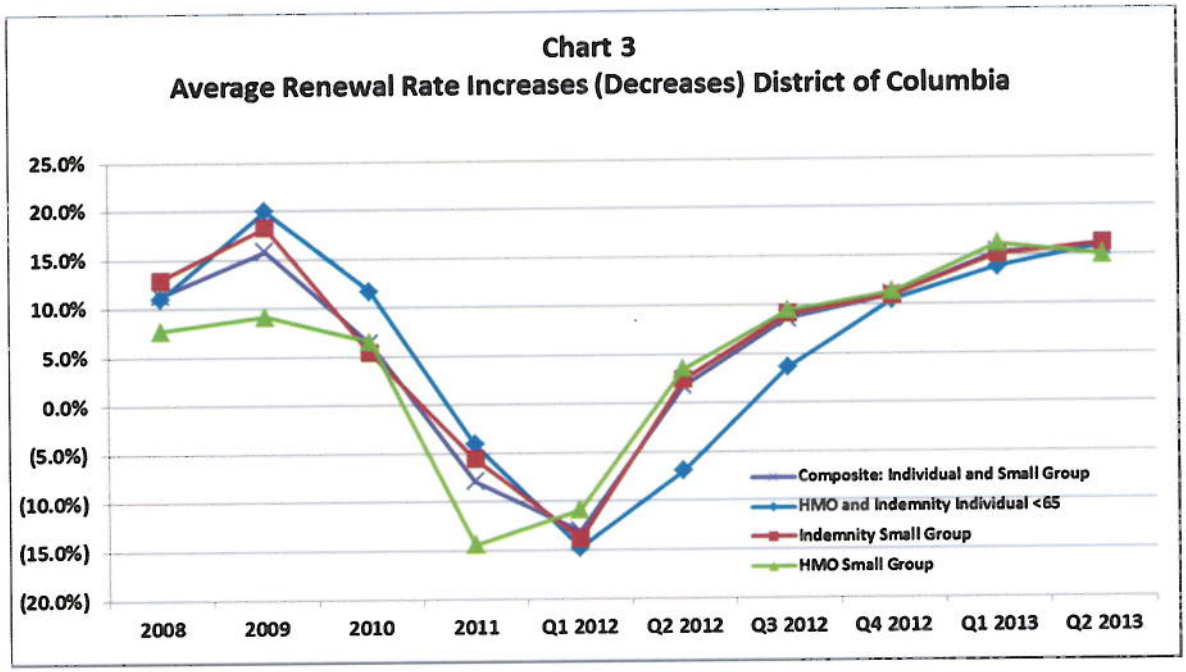
At Year-End 2012, GHMSI's surplus stood at 921 percent Risk-Based Capital-Authorized Control Level ("RBC-ACL") – a 77 point decline from the Company's 2011 Year-End RBC-ACL surplus of 998 percent. This reduction largely reflects actions taken by the Company, under Board-approved policy, to reduce or moderate premium rates whenever GHMSI's surplus rises above the mid-point in its optimal range. As noted in our 2012 Report, such a rise had occurred in 2010 when GHMSI's surplus exceeded the then-target optimal surplus range of 750-1050 percent RBC-ACL after health care cost increases had temporarily moderated to their lowest rate of increase in many years (See **Chart 1** below).



Overall health care cost trends again began rising sharply in mid-2011, reaching 7.5 percent for the year, as reflected in **Chart 2** below. Overall Medical Trend ("OMT") represents the total change in allowed costs for all benefits and customer segments of CareFirst, Inc. (risk, FEP, and non-risk).[1]



In setting premium rates, the Company closely follows medical spending trends, as reflected by Overall Medical Trend. When health care cost increases temporarily moderated in 2010 to their lowest rate of increase in many years, driving GHMSI's RBC-ACL level above the Board-approved target range, GHMSI reacted by voluntarily reducing rates substantially in 2011 and early 2012. When OMT again began rising sharply in 2011, the Company initiated rate increases throughout the remainder of 2012 to keep its surplus as stable as possible. See **Chart 3** below.



[1] OMT varies from pricing trends embedded in rate filing submissions due to actuarial factors, including shifts in demographics and benefit mix which apply to individuals and small groups, and vary by legal entity and jurisdiction.

As noted above, GHMSI's surplus at Year-End 2012 remained below the bottom of the revised optimal range of 1000 - 1300 percent RBC-ACL that had been established by the CareFirst, Inc. ("CareFirst") and GHMSI Boards in mid-2011. The Boards established this range following independent reviews of GHMSI's surplus requirements by two leading independent actuarial firms that factored in a more comprehensive understanding of the impacts of federal health care reform under the Affordable Care Act ("ACA"). It should be noted that the surplus held by CareFirst of Maryland, Inc. ("CFMI") also remains significantly below the updated optimal range approved by the CareFirst, Inc. and CFMI Boards, based on two similar reviews undertaken in 2011 and subsequently updated in 2012.

Determining the "Right" Level of GHMSI Surplus

1) The Challenge of Calculating Surplus

In determining the "right" level of surplus, GHMSI considers its unique business risks, including:

1. Rating adequacy, fluctuation and uncertainty risks
2. Unpaid claims liabilities and estimation uncertainty risks
3. Interest rate and portfolio asset value fluctuation risks
4. Catastrophic event risks
5. Business development and growth risks
6. Cost of capital and credit risks
7. Operational performance risks
8. Payment and credit risks of customers
9. Product design and market assessment risks, and
10. Regulatory risks

All of these risks can and do occur in different degrees, at different times and in different combinations under innumerable scenarios. In ensuring that it has sufficient resources to meet its promises to its policyholders, the Company engages independent actuarial experts to advise it on appropriate surplus levels. Since every possible uncertainty the Company could face cannot be eliminated, these advisers have recommended that the Company seek to maintain a level of surplus within a range that ensures a certain "confidence level" that it will not experience a situation in which it will fall below the minimum levels established by the NAIC or the early warning triggering thresholds established under the BCBSA's licensing standards.

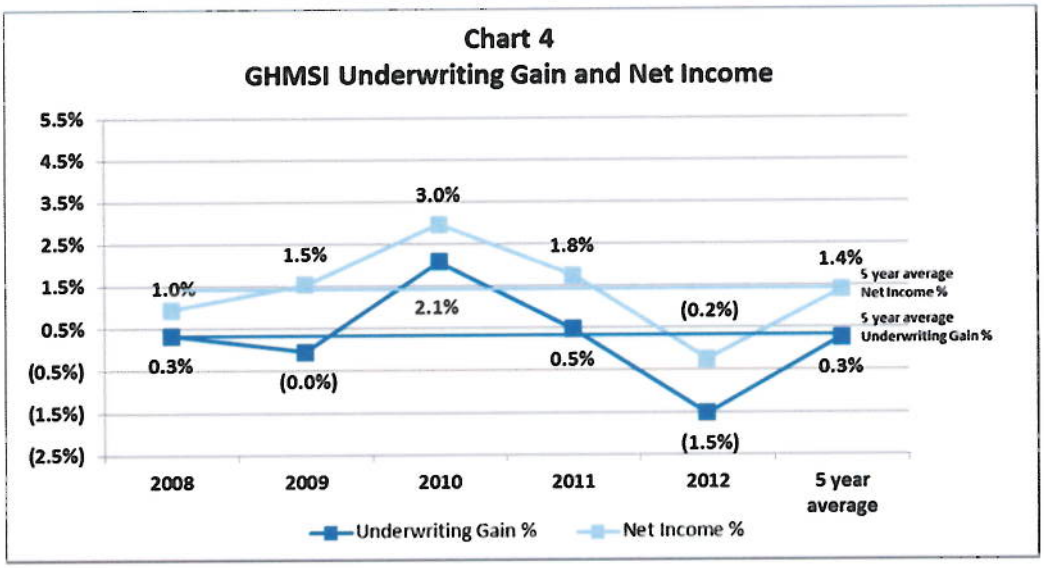
The actuarial experts engaged by GHMSI have recommended surplus ranges that achieve a "confidence level" between 95–98 percent certainty that the Company would not fall below the 200 percent RBC-ACL level adopted by the NAIC (and now embodied in District law) and between 90-95 percent certainty that it would not fall below the 375 percent RBC-ACL that triggers the BCBSA early-warning threshold. These thresholds are reflected in District law as relevant considerations in evaluating the Company's surplus. *See* 26A DCMR 4601.4. This is appropriate because the thresholds serve as important warning signals for insurers: An insurer that falls below 200 percent RBC-ACL is deemed at significant risk of financial failure and is therefore subject to significant corrective regulatory oversight and action. Similarly, a Blues Plan that drops below the BCBSA early-warning threshold is subject to additional monitoring; if the surplus shortfall is not corrected, sanctions may be applied, ultimately including the loss of license to operate under the Cross and

Shield name and mark. The confidence levels are designed to ensure that, in 90 to 98 percent of all possible scenarios, the Company's RBC-ACL remains above those "red flag" warning levels.

One Product, One Region, Non-Profit Company Profile Poses Greater Risks

As a not-for-profit company selling only one product in one region, GHMSI faces additional risks that affect the determination of what constitutes an appropriate surplus level. With no geographical diversity and limited alternate means for generating revenue, the Company is subject to forces within its own region from which it cannot escape or fully offset with other lines of business or geographic results. A combination of adverse regional forces - competitive or otherwise either simultaneously or in an unexpected combination, particularly over an extended period of time – could severely affect GHMSI's financial soundness. Further, the Company is limited in its ability to respond to such a situation since, as a not-for-profit enterprise, it cannot access the capital markets and has limited borrowing capacity to which to turn to meet its solvency requirements.

In essence, the Company sells products whose costs it cannot directly control or precisely predict. Its business is inherently risky, especially given the extremely small operating margins that are generated through its underwriting/risk-taking activities. Although there have been years in which it was higher or lower, the Company's average underwriting margin (gain) over the past 5 years has averaged just 0.3 percent, as reflected in **Chart 4** below.



Positive underwriting results can turn negative quickly due to volatile health care cost trends, as was clearly demonstrated in 2012. With billions of dollars at stake, even small variants in the assumptions used to calculate future premiums can materially affect GHMSI's surplus. The Company generates surplus from these small underwriting gains it has accumulated over the years and from earnings on investing its surplus in the financial markets. Although the Company invests its surplus extremely conservatively and with strictest discipline, it nevertheless faces the significant risks inherent in investing in the increasingly volatile capital markets.

Federal Health Care Reform Presents Significant New Uncertainties

The inherent risks of providing health insurance coverage to GHMSI's members are magnified by the massive new uncertainties posed by federal health care reform. The ACA profoundly changes the way health insurance products are designed, sold, rated and presented to buyers. These unprecedented changes are being implemented with no trial "break-in" period. As such, ACA

increases the risks the Company faces and fundamentally changes the rules governing those risks while placing major new constraints on how GHMSI can respond to these new rules.

The impact of ACA's changes can be most clearly seen in the proposed premium rates GHMSI has filed for new Individual <65 and Small Group products to be offered on the D.C. Health Benefits Exchange, beginning in 2014. A wide range of assumptions was used in developing these proposed rates, the most significant of which are the changes to the underlying morbidity or illness level of the combined risk pools – Individual and Small Group members. For example, it seems possible that a disproportionate number of consumers now enrolled in the DC Open Enrollment Program, a high-risk insurance product for consumers unable to qualify for health insurance due to pre-existing conditions that is exclusively offered by CareFirst, will remain with CareFirst. These members on average have a medical risk profile triple that of the average medically underwritten member. The addition of these disproportionately sicker members could lead to losses in the Individual market that could significantly reduce GHMSI's RBC-ACL level.

Nevertheless, in furtherance of its not-for-profit mission to provide affordable and accessible health coverage, CareFirst opted to set rates at the extreme lower end of potential increased morbidity. As a result, we believe that the rates that we filed will likely not adequately cover the health care costs of CareFirst members next year. In fact, it seems highly probable that CareFirst will incur significant losses on these D.C. Exchange products that will materially impact GHMSI's statutory surplus and RBC-ACL.

GHMSI's risks extend well beyond the underwriting loss likely to be incurred in 2014. The DISB's recent comparisons of the 2014 filed rates by carriers participating on the D.C. Exchange indicate that, for most products and metal tiers, CareFirst's filed rates are significantly lower than those of other competitors in the marketplace. The result is likely to be an increase in CareFirst enrollment and revenue, which in turn will require a larger surplus just to maintain a stable level of RBC-ACL. Further, these challenges and risks do not subside after 2014. If, as seems likely GHMSI incurs significant underwriting losses as a result of its filed rates, the Company will need to begin implementing higher rates over multiple years to return underwriting results to levels that no longer draw down surplus or decrease RBC-ACL levels. But, that will bring its own ACA-related challenges: Even raising rates to necessary levels is problematical under ACA's "unreasonable rate review" limitations. And, it remains uncertain how much regulators can or will approve in the future or how much members can afford.

Ironically, GHMSI faces an entirely separate set of risks in the event that cost-of-care trends are lower than expected. That is so because of federal health care reform's Minimum Loss Ratio (MLR) requirements. If health care spending falls below the minimum MLR established under the law – due to lower-than-projected health costs – GHMSI must reimburse affected members through rebates, as occurred last year based on the Company's MLR in 2011. However, if costs go up, the Company's ability to increase its rates are constrained. This resulting asymmetric risk (that is, the loss on rates that are not adequate and issuance of rebates when more gain is realized than expected) makes it far easier to lose than to win and far harder to recover from losses when they occur. The only source of protection for the Company and its policyholders in coping with ACA's new uncertainties is its surplus. GHMSI cannot – and should not – rely on government at any level to bail it out if it encounters severe financial distress, especially given the fiscal restraints already faced by governments at all levels.

By the decisions to file lower rates than the Company believes necessary for Individual and Small Groups, the Company has demonstrated its commitment both to achieving the goals of federal health care reform and to its not-for-profit mission. Yet, a strong financial foundation, as reflected

in an appropriate level of surplus, enables the Company to fulfill its mission and continue to positively impact the broader communities that we serve. Balancing these competing goals has become especially challenging – and especially risky – in the ACA era.

2) The CareFirst (GHMSI and CFMI) Approach and Policy Regarding Surplus

Since 2005, CareFirst and its affiliates have relied on recommendations by external, independent actuarial experts in establishing appropriate, or "optimal," levels of surplus. Those recommendations are reviewed by management and the Boards periodically. The Company has initiated five full-scale independent studies since 2005, as well as less intensive updates in 2012 and 2013, by actuarial consultants Milliman, Inc. ("Milliman") and The Lewin Group ("Lewin"). Using their own proprietary methodologies, both consultants conducted actuarial analyses of each affiliate's "optimal" surplus position, expressed as a recommended range for the appropriate level of surplus that GHMSI and CFMI should hold. The range reflects different levels of certainty in avoiding the NAIC and BCBSA minimum surplus regulatory and licensure standards, while considering the inherent constant fluctuation that occurs in each affiliate's underwriting experience and other factors impacting surplus.

In the wake of the most recent of these five analyses in mid-2011, management and the Boards adopted optimal surplus ranges for GHMSI and CFMI consistent with, but somewhat lower than, the experts' recommendations. The full reviews performed in mid-2011 by Milliman and Lewin resulted in recommendations for a surplus range for GHMSI that were largely overlapping. Milliman recommended a range of 1050 - 1300 percent RBC-ACL, while Lewin recommended a range of 1000 - 1550 percent RBC-ACL. The CareFirst and affiliate Boards extensively reviewed and discussed the experts' recommendations and decided to adopt the lower recommended figure for both the top and bottom of the range, thus producing a target range for GHMSI of 1,000 - 1,300 percent RBC-ACL.

Each Company seeks to maintain surplus in the middle of an "optimal" range – neither too high nor too low – given the risks each Company faces. If the underwriting or investment results of one of the Companies were to cause surplus to rise too high in or move above the approved range – as occurred with GHMSI in 2010, as noted above – the Company adjusts premiums to return the surplus level toward the middle of the range. If, conversely, one of the Companies had a surplus too low in the range or below the range – as is currently the case with both CFMI and GHMSI – the Company adds additional margin to its rates to generate revenues that would gradually build surplus toward the middle of the optimal range.

Both GHMSI and CFMI update their surplus ranges at least every three years, and Milliman again has been engaged to conduct a new, full-scale analysis of both affiliates' surplus later this year. Management and the Boards will use the results of that analysis to inform their decision on the appropriate range of surplus going forward.

For the purposes of this Report, as well as a similar report to the Maryland Insurance Administration (the "MIA") on CFMI and GHMSI, the Company asked Milliman to confirm the appropriateness of the present surplus ranges that the CFMI and GHMSI Boards have adopted. A letter from Milliman to this effect is attached to this report. The letter demonstrates that Milliman considered developments affecting CFMI and GHMSI subsequent to its 2011 studies and concluded that it would not expect the CFMI or GHMSI surplus target ranges to vary materially from the respective ranges recommended in its 2011 studies. In their earlier analyses, Milliman, in particular, noted the uncertainties caused by federal health care reform with respect to product pricing, new risk adjustment mechanisms, medical loss ratio and rating constraints, and other

uncertainties that relate to the major market changes beginning in 2014. Milliman did not recommend any immediate change to the target surplus ranges for either CFMI or GHMSI.

3) GHMSI's Surplus Level Is Among the Most Reviewed in the Nation

In addition to the Company's own independently conducted actuarial reviews, both the DISB and the MIA have conducted independent reviews of GHMSI's surplus, assisted by their own consultants. The MIA has undertaken this twice, once in 2009 through The Invotex Group ("Invotex") and again in 2011 through RSM McGladrey, Inc. ("McGladrey"). The Invotex review resulted in a recommendation that the MIA approve ranges consistent with those set by the Boards for GHMSI and CFMI. This was upheld by the Commissioner in a January 2010 report and reflected in a subsequent Order, dated May 26, 2011. In 2012, the McGladrey review also resulted in a recommendation to the MIA to approve ranges consistent with those set by the GHMSI and CFMI Boards. The Maryland Commissioner approved that recommendation in a September 14, 2012 Consent Order.

Similarly, the DISB in 2009-2010 examined GHMSI's surplus position at Year-End 2008, resulting in Orders dated August 6, 2010 and October 29, 2010 upholding the appropriateness of GHMSI's surplus. In 2012, the D.C. Court of Appeals vacated those Orders and remanded to the DISB, ordering the DISB to give additional consideration to the question whether GHMSI's surplus reflects that the Company is engaging in community health reinvestment to the maximum feasible extent consistent with financial soundness and efficiency. Consistent with the Court of Appeals opinion, this report discusses GHMSI's community health reinvestment activities – i.e., rate moderation and community giving – at length. Data on the Company's community giving is set forth below.

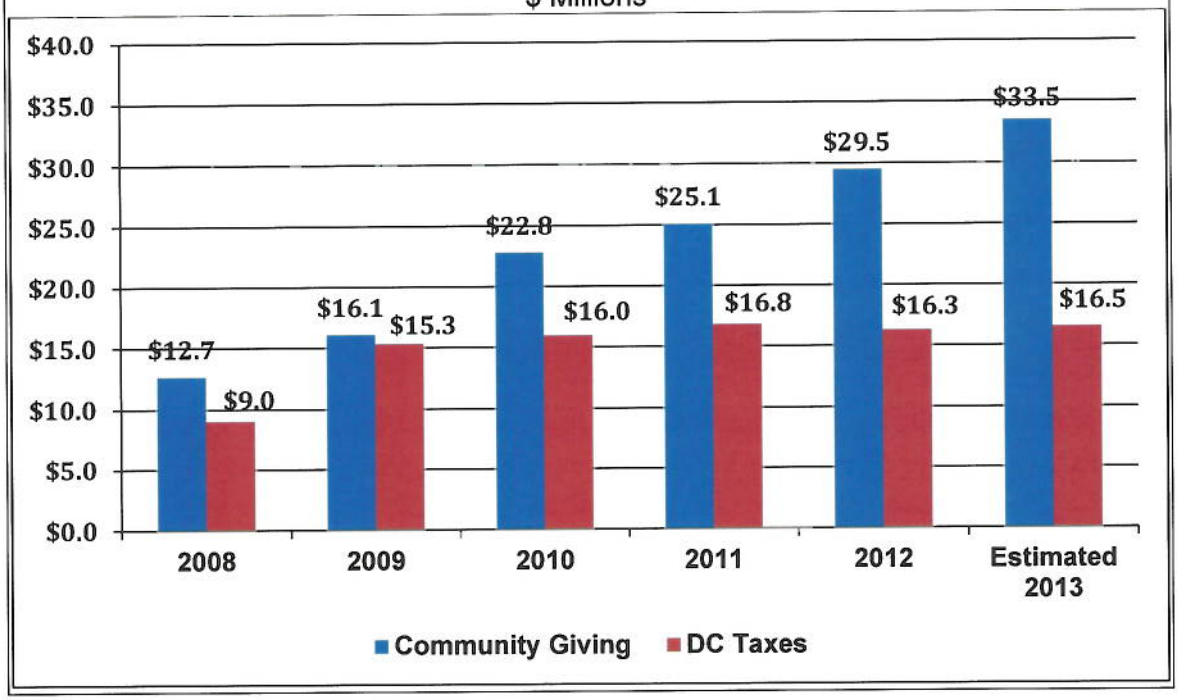
The DISB has since launched a second review of GHMSI's surplus. DISB engaged Rector & Associates, Inc. ("Rector"), the same firm that assisted the agency with the 2009-10 review, and Rector is expected to present a report to the DISB shortly.

One of the more remarkable aspects of all of the studies conducted over the past five years – whether by the Company's independent experts or the regulators' consultants – is how similar their opinions have been. Each study commissioned by DISB, MIA, or CareFirst has upheld the appropriateness of the Company's surplus position at the time the study was conducted.

4) GHMSI and CFMI Have Given Generously to the Community

Over the past five years, CFMI and GHMSI have collectively contributed nearly $250 million to a wide variety of community health initiatives dedicated, in various ways, to providing access to health care to the communities they serve. Much of this giving is focused on vulnerable populations that would have little access to health care absent those contributions. **Chart 5** below shows the level of community giving by GHMSI since 2008.

Chart 5
GHMSI Community Benefits[1] to the National Capital Area and Direct Taxes[2] Paid to the District of Columbia
$ Millions



[1] Community benefits include direct Corporate Giving, losses incurred on HMO & PPO plans offered under the DC/VA Open Enrollment Programs, as well as subsidies for the Maryland Senior Rx Assistance and Prescription Drug Assistance Programs, DHMH, Maryland Community Health Resources Commission, Maryland Donut Hole Coverage since 2009 and contributions to the Healthy DC Fund since January 2010.

[2] Includes taxes paid on D.C. Corporate Income, Premiums (both HMO & PPO), Personal Property and Real Property.

[3] Open Enrollment losses are estimates based on claims data available at the time of submission.

The Company's generosity is well recognized. Indeed, GHMSI again this year has been recognized in the *Washington Business Journal* as the third most generous corporate contributor in the National Capital Area. As can be seen, the level of community giving by GHMSI has risen steadily in recent years, totaling $106.2 million for the years 2008-12. GHMSI's contributions that benefit communities in the Greater Washington Region are projected to total another $33 million in 2013.

It also is important to note that, although a not-for-profit, GHMSI is not exempt from taxes. In fact, the Company paid nearly $73.4 million in corporate income, premium, personal and real property taxes to the District over the past five years – over and above its charitable contributions to the community.

Areas of Giving:

Each year GHMSI establishes a budget to reflect the health care needs and priorities of the communities it serves. The overarching goal is to dedicate resources to initiatives that expand access to health care and catalyze change through systemic efficiencies in the health care delivery system. In priority order, the highest proportion of our Community Benefit program goes toward:

1. **Subsidies and Enhanced Health Care Access Programs:** Support for City and State programs providing access for vulnerable populations – those individuals with no or little access to health care services. This represents the largest portion of our giving budget. Examples of community investments include GHMSI's annual $5 million contribution to the Healthy DC Fund as well as the significant losses incurred as the only carrier offering coverage to high-risk individuals in the DC Open Enrollment Program.

2. **Catalytic Giving:** Support for programs and other initiatives that stimulate productive change and improvements in health care systems over the long term. Examples of funded programs include Mary's Center's Patient-Centered Medical Chronic Care Initiative and Unity Health Care's Patient-Centered Medical Home Enhancement both of which are part of an $8.5 million investment in enhancing patient-centered care in the region's safety net centers over three years.

3. **Targeted Health-Related Giving Through Others:** Support to organizations that provide direct health care or related services for the underserved, including Community of Hope's South Capital Health and Resource Center and Capital Breast Care Center's Screening & Patient Navigation initiative.

4. **Programmatic Initiatives:** Program support targeting a specific population and/or addresses a major health care issue with specific measurements for success. Examples of programs funded include the YMCA's Fit N Well Seniors Program and the D.C. Department of Health's Maternal and Child Case Management Program.

5. **Corporate Memberships & Community Sponsorships:** Funding for corporate sponsorships and memberships with business/civic organizations designed to strengthen long-lasting partnerships with the community. Examples of memberships include the DC Chamber of Commerce and Greater Washington Board of Trade. Sponsorships include the Food & Friends Chef's Best Dinner and Georgetown University Hospital's Pediatrics Gala.

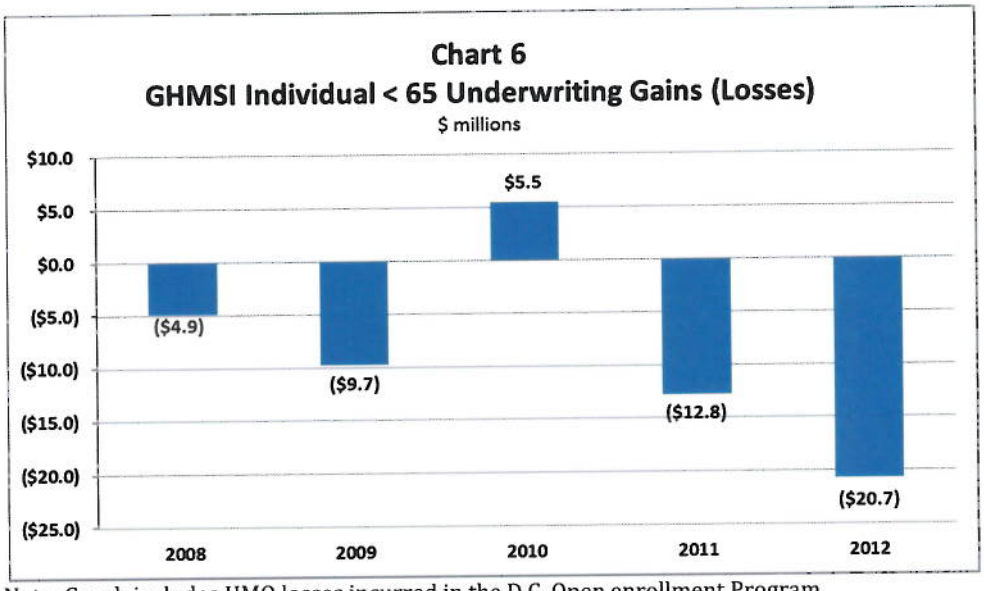
Community Health Reinvestment:

The District's Medical Insurance Empowerment Amendment Act ("MIEAA") provides a framework for the Company's "community health reinvestment" in the District, and specifically provides that the Company may meet its community health reinvestment obligation through rate moderation to its subscribers. That statutory obligation aligns with GHMSI's Congressional Charter, which establishes that the Company was created for the benefit of its subscribers.

The MIEAA and the Charter, read together, make clear that the Company's most fundamental obligation is to provide the best value possible to its subscribers in the form of quality coverage at the lowest possible premium rates. This is essential in making health care affordable and accessible to as many people as possible. As such, the Company has moderated the rates charged to its subscribers for insurance, as reflected in GHMSI's low operating margins.

Those moderated rates, in turn, have produced a surplus consistently within – and currently below – the Company's target operating range. When the Company is successfully moderating rates such that its surplus is within (or below) its target range, it is by definition engaging in community health reinvestment to the maximum feasible extent consistent with soundness and efficiency.

GHMSI has for years held the premiums it charges individual subscribers below cost in order to maximize affordability. In addition, as noted above, GHMSI has offered individual "open enrollment" products that do not require medical underwriting, causing the Company to serve as "insurer of last resort" for the community, and, not surprisingly, contributing to underwriting losses that last year exceeded $15 million. **Chart 6** below shows GHMSI's underwriting results in the Individual subscriber market.



Note: Graph includes HMO losses incurred in the D.C. Open enrollment Program

In short, the Company seeks to strike an appropriate balance between what it gives for the benefit of the broader community and the premiums that it charges those who rely on GHMSI for their health care coverage.

5) GHMSI and CFMI's Consent Order with the MIA

As previously noted, in May 2011, CFMI and GHMSI entered into a Consent Order with the MIA that provides for periodic and independent reviews by the MIA of both Companies' surplus positions. This Consent Order outlines an orderly process for the Companies to establish their surplus target ranges and for MIA review of the conclusions that come out of this process. We continue to believe this process could serve as a model for a similar approach in the District of Columbia. By coordinating their reviews of surplus, the DISB and the MIA can avoid the potential of conflicting or inconsistent orders. Coordinating these reviews could also help to significantly reduce costs to the Company and its subscribers.

Conclusion:

With the full force of ACA's federal health care reforms fast approaching, the Company now enters an era of unprecedented change, uncertainty and risk. These profound changes – coupled with the fact that GHMSI remains a single product, single region, not-for-profit health insurer – means that the Company remains especially vulnerable to adverse trends.

That GHMSI holds a surplus within or, as is presently the case, below its optimal range, should reassure the DISB that the Company's surplus is not "unreasonably large." Likewise, the fact that

GHMSI is keeping its surplus within or below its recommended range through a careful balance of giving and rate moderation means the Company's surplus is consistent with its obligation to engage in community health reinvestment to the maximum extent consistent with soundness and efficiency.

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Enclosure:

1. Milliman, Inc. Letter re: GHMSI Surplus

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