EXHIBIT A

MARYLAND INSURANCE ADMINISTRATION

IN RE:	*	
TARGETED SURPLUS RANGES FOR:	*	
CAREFIRST OF MARYLAND, INC. NAIC #47058 10455 MILL RUN CIRCLE OWINGS MILLS, MARYLAND 21117	*	
	*	Case No. MIA-2012-09-006
AND	*	
GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC. NAIC #53007 840 FIRST STREET NE WASHINGTON, DC 20065	*	
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CONSENT ORDER

Pursuant to the authority granted in §§ 2-108 and 2-204 of the Insurance Article, Annotated Code of Maryland,[1] the Maryland Insurance Commissioner ("Commissioner"), CareFirst of Maryland, Inc. ("CFMI"), Group Hospitalization and Medical Services, Inc. ("GHMSI"),[2] and CareFirst, Inc. ("CareFirst") (collectively, the "Parties"), enter into this Consent Order (the "Order") to establish the terms and conditions under which the Commissioner hereby approves the targeted surplus ranges adopted by the CareFirst, Inc. Board of Directors, the CFMI Board of Directors and GHMSI Board of Trustees (collectively, the "Boards") on September 22, 2011, as to CFMI and May 25, 2011, as to GHMSI. The Parties enter into the Order pursuant to and in accordance with the terms of a Consent Order dated May 26, 2011, by and between former Acting Commissioner Beth Sammis, CFMI and GHMSI (MIA Case No. MIA-2011-05-040) ("the 2011 Consent Order"), and hereby represent and acknowledge that this Order replaces and supersedes the 2011 Consent Order in its entirety.

The grounds on which this Order is based are as follows:

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[1] All statutory references are to the Insurance Article, Annotated Code of Maryland.

[2] This Order sometimes refers to CFMI and GHMSI individually as a "Company" and collectively as the "Companies."

The Parties

1. CFMI holds a certificate of authority to operate as a nonprofit health service plan in Maryland and is chartered and domiciled in Maryland.

2. GHMSI holds a certificate of authority to operate as a nonprofit health service plan in Maryland and is a congressionally chartered entity domiciled in the District of Columbia.

3. CFMI and GHMSI are under the common control of CareFirst, which holds a certificate of authority to operate as a nonprofit health service plan in Maryland and is chartered and domiciled in Maryland.

4. The Commissioner is responsible for enforcing the Insurance Article.

Applicable Law

5. As nonprofit health service plans, CareFirst, CFMI, and GHMSI are charged with carrying out a three-part statutory mission: (1) to provide affordable and accessible health insurance to the respective plan's insureds and those persons insured or issued health benefit plans by affiliates or subsidiaries of the plan; (2) to assist and support public and private health care initiatives for individuals without health insurance; and (3) to promote the integration of a health care system that meets the health care needs of all the residents of the jurisdictions in which the nonprofit health service plan operates. § 14-102(c), (d).

6. To qualify for a certificate of authority, an insurer, including a nonprofit health service plan, must maintain assets and surplus that are "reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs." § 4-103(c)(1). In determining whether an insurer's assets and surplus are reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs, the following factors, among others, shall be considered:

(i) the size of the insurer as measured by its assets, capital and surplus, reserves, premium writings, insurance in force, and other appropriate criteria;
(ii) the extent to which the insurer's business is diversified among the several lines of insurance;
(iii) the number and size of risks insured in each line of insurance;
(iv) the geographical dispersion of the insurer's insured risks;
(v) the nature and extent of reinsurance of the insurer's risks;
(vi) the quality, diversification, and liquidity of the insurer's investment portfolio;
(vii) the recent past and projected future trends in the size of the insurer's surplus as regards policyholders;
(viii) the surplus as regards policyholders maintained by comparable insurers; and
(ix) the financial position of the insurer, after excluding from assets investments in and other transactions with persons that directly or indirectly, through one or more intermediaries, control, are controlled by, or are under common control with another person.

§ 4-103(c)(2).

7. Further, to safeguard the solvency of the insurance business in the State, an insurer, including a nonprofit health service plan, should maintain an amount of capital in excess of certain minimum risk based capital ("RBC") levels as set forth in Title 4, Subtitle 3 of the Insurance Article. That Subtitle provides that it is "the public policy of the State" that "additional capital is used and useful in the insurance business and helps to secure an insurer against various risks inherent in, or affecting, the insurance business and not accounted for or only partially measured by the [RBC] requirements contained in this subtitle." §4-302(2).

8. As defined in § 14-117(a)(4), a nonprofit health service plan's "surplus" is the amount by which certain defined assets exceed liabilities described in § 5-103. Those liabilities applicable to CareFirst, CFMI and GHMSI are the amounts needed to pay: all reported or unreported losses and claims incurred as of the date of the respective company's annual statement; the expenses of adjustment or settlement of those losses and claims; taxes, expenses, and other obligations due or accrued at the date of the annual statement; the amount of reserves equal to the unearned parts of the gross premiums charged on policies in force; and any additional reserves that the Commissioner reasonably requires. § 5-103.

9. Additionally, the Insurance Article provides that a nonprofit health service plan generally is required to maintain a surplus in an amount equal to the greater of: (1) $75,000; and (2) 8% of the total earned premium received by the corporation in the immediately preceding calendar year. § 14-117(b). The Commissioner may require a nonprofit health service plan to maintain a surplus in a larger amount if the Commissioner determines after a hearing that a larger surplus is necessary for the protection of the plan's subscribers. § 14-117(d).

10. Section 14-117(e) defines when the Commissioner may consider the surplus of a corporation authorized under Title 14 to act as a nonprofit health service plan to be excessive and the procedure by which excessive surplus may be distributed. The surplus of a nonprofit health benefit plan "may be considered excessive only if: (i) the surplus is greater than the appropriate risk based capital requirements as determined by the Commissioner for the immediately preceding calendar year; and (ii) after a hearing, the Commissioner determines that the surplus is unreasonably large." § 14-117(e)(1). After the Commissioner has determined that a corporation's surplus is excessive, the Commissioner may order the corporation to prepare a plan for distribution of the excess surplus. Such a distribution "may be made only to subscribers who are covered by the corporation's nonprofit health service plan at the time the distribution is made." § 14-117(e)(3)

Procedural Background and Expert Reports

11. In 2008, the Companies retained Milliman, Inc. ("Milliman") to analyze the Companies' surplus, and Milliman recommended that the Companies maintain target surplus ranges of 900% to 1200% of authorized control level RBC (ACL-RBC) for CFMI and 750% to 1050% ACL-RBC for GHMSI. These ranges were adopted by the Companies' Boards after receiving Milliman's report. In 2009, then-Commissioner Ralph S. Tyler engaged the Invotex Group ("Invotex") to perform a comprehensive review of Milliman's analysis, as well as the

target surplus ranges recommended by Milliman and adopted by the Companies' Boards. Invotex was engaged to evaluate the reasonableness and appropriateness of the analysis and underlying assumptions. Invotex also conducted an independent analysis of the surplus requirements of the Companies, identified assumptions and risk factors that should be considered in performing such an analysis, and recommended targeted surplus ranges of 825% to 1,075% of authorized control level RBC (ACL-RBC)[3] for CFMI and 700% to 950% of ACL-RBC for GHMSI. While the Invotex review was in progress, the Companies retained The Lewin Group ("Lewin") to conduct an additional independent analysis of GHMSI's surplus, and Lewin recommended a target surplus range for GHMSI of 750% to 1000% ACL-RBC. The Invotex, Milliman, and Lewin reviews reached "similar conclusions" that were expressed as overlapping surplus ranges, as outlined in the Maryland Insurance Administration, Report on CareFirst Premiums and Surplus, at 8 (Jan. 2010) ("2010 MIA Surplus Report").[4] Commissioner Tyler conducted a hearing on the surplus of CFMI and GHMSI in Case No. MIA-2009-11-017, and in January 2010, adopted the targeted surplus ranges recommended by Invotex. *See id.*

12. On May 26, 2011 then-Acting Commissioner Beth Sammis, CFMI and GHMSI entered into the 2011 Consent Order, which was intended "to establish a new working relationship" in which the parties would work to maintain the Companies' surpluses within targeted surplus ranges approved by the Commissioner. Among other things, the 2011 Consent Order provided that the Companies would maintain up-to-date targeted surplus ranges that meet their solvency and other needs, and that those ranges would be disclosed to the Commissioner together with the underlying methodology, data, and assumptions and any expert, independent evaluation upon which the Boards may have relied in determining those targeted surplus ranges. The 2011 Consent Order also recognized that "it is the responsibility of [CareFirst's] Board of Directors to oversee the establishment by the respective Boards of CFMI and GHMSI of targeted surplus ranges for CFMI and GHMSI to provide for the financial soundness of the Companies and allow sufficient capital for the Companies to satisfy the requirements of § 14-102 of the Insurance Article." 2011 Consent Order ¶ 9.

13. The 2011 Consent Order provided that by July 1, 2011, CFMI and GHMSI would submit to the Commissioner targeted surplus ranges for approval and that, upon completion of her review, the Commissioner "shall inform the Companies whether, based on the Commissioner's independent review, the Commissioner intends to approve the targeted surplus range established by each of the Companies or adopt an alternative targeted surplus range for each of the Companies." Under the terms of the 2011 Consent Order:

> [in] determining the appropriateness of the targeted surplus ranges by the Companies [sic], the Commissioner shall consider:

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[3] Maryland law defines various "action level" and "control level" events in relation to an insurer's risk based capital. When an insurer's total adjusted capital falls below its ACL-RBC, the Commissioner may, among other things, take any action necessary to place the insurer under conservation, rehabilitation, or liquidation, if she considers it in the best interest of the insurer's policyholders, the insurer's creditors, and the public. Clearly, an insurer in sound financial health would have a surplus in excess of the level at which such regulatory intervention would be warranted.

[4] The Report is available at http://www.mdinsurance.state.md.us/sa/documents/CareFirstSurplusReport-final010610.pdf.

1. The risks identified by CFMI and GHMSI
2. The availability of capital within the group of companies controlled directly or indirectly by CFI, including CFMI and GHMSI and their subsidiaries and affiliates;
3. The distribution of the business of CFMI and GHMSI, including both risk and non-risk business;
4. The missions of CFMI and GHMSI;
5. Whether the surpluses are adequate for the protection of the subscribers of CFMI and GHMSI; and
6. Any other relevant factors.

14. The 2011 Consent Order further provided: "In the event the Commissioner intends to adopt an alternative targeted surplus range, the parties shall attempt to resolve their differences. In the event that the Commissioner and the Companies are unable to resolve their differences, the Commissioner will hold a quasi-legislative hearing to consider the appropriate targeted surplus range for either CFMI or GHMSI as the case may be."

15. In accordance with the 2011 Consent Order, on June 30, 2011, CareFirst submitted for the Commissioner's approval targeted surplus ranges for CFMI and GHMSI. In support of those targeted surplus ranges, CareFirst submitted reports by two independent actuarial firms, Milliman and The Lewin Group ("Lewin"), engaged to assist the Companies in establishing proposed targeted surplus ranges. Milliman and Lewin used proprietary models to independently determine recommended targeted surplus ranges for CFMI and GHMSI based upon the firms' analyses of the business risks faced by the Companies. Both firms considered, among other things, potential impacts of Affordable Care Act ("ACA") implementation on the health insurance markets and on the Companies' potential need to draw upon surplus to satisfy their statutory missions. Milliman recommended a targeted surplus range of 1,050% to 1,300% of ACL-RBC for each Company. Lewin recommended targeted surplus ranges of 1,050% to 1,600% of ACL-RBC for CFMI and 1,000% to 1,550% of ACL-RBC for GHMSI.

16. Considering the targeted surplus ranges recommended by Milliman and Lewin, the respective Boards adopted, with one exception, the lower recommended figures for both the bottom and top of each range: 1,050% to 1,350% of ACL-RBC for CFMI and 1,000% to 1,300% of ACL-RBC for GHMSI. With regard to the top of the range for CFMI, management recommended that the Board increase the lower 1,300% recommended figure to 1,350% to maintain "the 300% span from the low to the high end of the range that is consistent with CFMI's past practices." *See* Letter from Chet Burrell to Commissioner Therese Goldsmith (June 30, 2011).[5]

17. In accordance with the 2011 Consent Order, the Commissioner initiated a review of the Companies' Board-approved targeted surplus ranges. To assist with this review, the Maryland Insurance Administration ("MIA") engaged a professional services firm, RSM McGladrey, Inc. ("McGladrey"), to perform an independent analysis of the appropriateness of

[5] In its January 2010 Report on CareFirst Premiums and Surplus, the MIA adopted 250-point targeted surplus ranges.

the Board-approved targeted surplus ranges. McGladrey's engagement included a review and evaluation of information concerning the business risks faced by the Companies and the development of the Board-approved targeted surplus ranges, an evaluation of the models used by Milliman and Lewin in developing their recommended targeted surplus ranges, and consideration of whether alternative targeted surplus ranges would be appropriate. In a report dated May 29, 2012, McGladrey concluded that the Board-approved targeted surplus ranges appear reasonable and supported by the analyses completed by Milliman and Lewin.[6]

18. In addition to McGladrey's conclusions regarding the Board-approved targeted surplus ranges, the McGladrey Report contains a number of observations and recommendations for the Companies related to potential enhancements to their financial projections, surplus management and liquidity.

Findings

19. The analysis and conclusions of three independent consultants – two retained by the Companies and one retained by the MIA – support a finding that the targeted surplus ranges adopted by the Companies are appropriate, at present, to provide a high level of confidence that the Companies' surpluses will not fall below levels that could result in corrective regulatory action or jeopardize the Companies' use of the Blue Cross Blue Shield trademark, thereby potentially eroding consumer confidence and undermining the Companies' ability to satisfy their statutory mission and obligations to policyholders and creditors. Risk factors cited by the Companies or the consultants include, but are not limited to, underwriting risk; asset risk; cost of capital and credit risk; operational and business risk; planned capital expenditures; anticipated business plan changes; Company subsidization of the health care markets in some instances; and the statutory mission of nonprofit health service plans. According to the Companies and consultants, there also are additional, potentially substantial risks associated with implementation of the ACA, in the short term at least, such as significant potential shifts in the risk profiles and volumes of blocks of business being insured by the Companies, and new underwriting and rating regulations under the ACA.

20. The details of programs designed to mitigate risks associated with implementation of the ACA, including risk adjustment, reinsurance, and risk corridor programs, have not yet been fully defined, and their potential impact on CareFirst is uncertain at present.

21. As nonprofit health service plans, the Companies are required under § 14-106(d) to offer health care products in the individual and small employer group markets, which are smaller and less lucrative market segments than the large group market. According to an independent report, CareFirst affiliated entities (CFMI, GHMSI and CareFirst BlueChoice, Inc.) have approximately a 70% share of the individual and small group markets in the State. *See* Mercer, *Report of Market Rules and Risk Selection for the State of Maryland for the Maryland Health Benefit Exchange*, (November 9, 2011)

[6] The McGladrey Report and CareFirst's response are included as Attachment 1.

http://dhmh.maryland.gov/exchange/pdf/FinalMDStudyofMarketRules-and-RiskSelectionReport.pdf.

22. The Companies lack access to equity markets, and must rely on accumulated surplus and any future gains from underwriting and investment to fund their obligations.

23. The Companies' business is not diversified among several lines of insurance. Rather, CFMI and GHMSI underwrite only health insurance and cannot offset risk with other lines of business.

24. Unlike many of their competitors, the Companies operate in only one geographic region: Maryland, the District of Columbia, and Northern Virginia. The Companies cannot offset risk in this region with business in other geographic regions.

25. As noted by Invotex in 2009 and McGladrey in 2012, substantial proportions of the Companies' surplus levels are attributable to their 50% joint venture investment in CareFirst Holdings, LLC. ("CF Holdings").[7] This is particularly true for CFMI.

26. CareFirst's surplus, inclusive of both GHMSI and CFMI, was at 859% of ACL-RBC at the end of 2011, placing CareFirst below the median for Blue Cross and Blue Shield Plans around the country.

27. Based upon a review of the factors listed in § 4-103(c)(2) and those listed in the 2011 Consent Order, as well as the expert opinions referenced in paragraphs 15 through 18 above, the Commissioner finds that, at present, targeted surplus ranges of 1,050% to 1,350% of ACL-RBC for CFMI and 1,000% to $1,300% of ACL-RBC for GHMSI are adequate and are neither excessive nor unreasonably large.

ACCORDINGLY, it is hereby mutually agreed among the Parties and therefore **ORDERED** by the Maryland Insurance Commissioner this 14th day of September, 2012, as follows:

A. The approved targeted surplus range for CFMI effective from the date of this Order shall be 1,050% to 1,350% of its authorized control level risk based capital.

B. The approved targeted surplus range for GHMSI effective from the date of this Order shall be 1,000% to 1,300% of its authorized control level risk based capital.

C. The Companies agree to review the appropriateness of the approved ranges annually during the three year period from 2013 through 2015. During this annual review period, the Companies will submit by July 1 of 2013, 2014 and 2015 a report to the Commissioner assessing the continued appropriateness of the ranges approved in this Order, or those subsequently approved by the Commissioner and then in effect. Such submissions shall

[7] The majority of the value of CF Holdings is the carrying value of its investment in the Companies' for-profit affiliate, CareFirst Blue Choice, a health maintenance organization that operates in Maryland, the District of Columbia, and Virginia.

include all relevant supporting facts, analysis, assumptions, and external analyses and opinions relating to the targeted surplus ranges of the Companies, including, but not limited to, how developments in the implementation of the ACA, and any corresponding reduction in risks or uncertainties, have affected the Companies' surplus needs. The parties agree that the Companies may designate information as confidential commercial information, when appropriate and subject to a determination by the Commissioner under the Public Information Act, and that a consultant retained by the MIA may be required to sign a reasonable confidentiality agreement with the Companies before confidential commercial information is provided to the consultant.

D. Unless otherwise agreed to by the Parties or ordered by the Commissioner, after July 15, 2015, the Companies shall undertake a review of their targeted surplus ranges by qualified actuarial experts no less frequently than every three years and shall submit such targeted surplus ranges to the Commissioner for approval. These submittals shall contain all of the information listed in paragraph C.

E. In reviewing each targeted surplus range for each Company submitted in accordance with paragraphs C and D above, the Commissioner may procure, at the expense of each Company, appropriate experts to advise the Commissioner on the appropriateness of the targeted surplus range. To facilitate the Commissioner's review, the Companies agree to ensure reasonable access to the relevant data, assumptions, and expert opinions and analyses relied upon or in the possession of the Companies and to the experts providing such opinions and analyses and whatever other materials of the Companies and their affiliates and subsidiaries the Commissioner considers reasonably necessary for her review.

F. Pursuant to § 2-210(a)(1), and in accordance with COMAR 31.02.06, the Commissioner may conduct a quasi-legislative hearing before determining whether the revised targeted surplus ranges submitted pursuant to paragraph C and D are appropriate. If the Commissioner determines that the surplus ranges submitted under paragraphs C and D are not appropriate, the Commissioner will set out her findings and conclusions in an Order.

G. The Companies agree to strive to maintain an actual surplus position for each Company at the midpoint of the surplus ranges approved by the Commissioner, and to move surplus to the midpoint in a gradual manner. Consistent with these two principles, in each rate filing submitted to the Commissioner for approval, each Company will provide its actual surplus as of its most recent quarterly filing, expressed in absolute dollar values and as a percentage of the Company's most recently calculated ACL-RBC, as well as the Company's projected surplus over the next 12 months, expressed in those same terms, to include, without limitation, the projected impact to the total surplus resulting from changes in contribution to surplus factor approved in prior rate filings and any pending changes in contribution to surplus factor that have yet to be approved. The Company also will provide in each rate filing an explanation of that portion of the requested rates or change in rates that relates to the Company's contribution to or reduction of its surplus.

H. The Companies agree and recognize that the Commissioner may consider the information provided to the Commissioner as required by paragraph G, in determining whether

to approve, disapprove, or modify the form or table of rates filed by CFMI or GHMSI, along with the other relevant factors.

I. CFMI, GHMSI and CareFirst will provide a joint report reviewed and approved by the applicable Boards to the Commissioner, on or before December 30, 2012, regarding the Companies' plans to address the observations and recommendations contained in the McGladrey Report on the Companies' financial projections, surplus management, and liquidity.

J. In their annual statements filed with the Commissioner under § 14-121, both GHMSI and CFMI shall specify:

1. their targeted surplus range applicable to the calendar year for which the annual statement is filed; and
2. their actual surplus in absolute dollar values and as a percent of authorized control level RBC at the close of the calendar year for which the annual statement is filed.

So ORDERED this 14th day of September, 2012.

Signature on original

Therese M. Goldsmith
Maryland Insurance Commissioner

CONSENT OF CAREFIRST OF MARYLAND, INC., GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC., AND CAREFIRST, INC.

CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc., and CareFirst, Inc. hereby consent to the entry of this Consent Order, as well as to the terms contained herein. Furthermore, Chet Burrell acknowledges, in his capacity as the President and Chief Executive Officer of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc., and CareFirst, Inc. that he has the authority to enter into this Consent Order and bind CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc., and CareFirst, Inc. to the terms contained herein.

CAREFIRST OF MARYLAND, INC.
GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC.
CAREFIRST, INC.

By: Signature on original
Name: Chet Burrell
Title: President and Chief Executive Officer

9/13/12
Date

RIGHT TO REQUEST A HEARING

Pursuant to § 2-210 of the Insurance Article of the Annotated Code of Maryland and COMAR 31.02.01.03, a person aggrieved by this Order may request a hearing. The request must be in writing and be received by the Commissioner within 30 days of the date of this Order.

Pursuant to § 2-212 of the Insurance Article, the Order shall be stayed pending a hearing only if a request for a hearing is received by the Commissioner within ten days of the date of this Order.

The written request for a hearing must be addressed to the Maryland Insurance Administration, 200 St. Paul Place, Suite 2700, Baltimore, Maryland 21202, ATTN: Sharon Kraus, Appeals Clerk. Failure to request a hearing timely or to appear at a scheduled hearing will result in a waiver of the right to contest this Order and the Order shall be made final on its effective date.