Group Hospitalization and Medical Services, Inc.

EXHIBIT LIST

DISB Review of GHMSI Surplus Pursuant to the Medical Insurance Empowerment Act of 2008, D.C. Code §31-3501, *et seq.*

June 10, 2014

Primary Hearing Submissions

Exhibit 1 - *Report by Group Hospitalization and Medical Services, Inc. (GHMSI) on 2013 Community Giving*, June 10, 2014 ("GHMSI 2013 Community Giving Report")

Exhibit 2 - *Report by Group Hospitalization and Medical Services, Inc. (GHMSI) on the Impact of the Affordable Care Act on GHMSI's Surplus*, June 10, 2014 ("ACA Impacts Report")

Exhibit 3 - *Pre-Filed Testimony of Phyllis Doran, F.S.A., M.A.A.A.*, April 14, 2014

Other GHMSI Documents

Exhibit 4 - *Letter to Commissioner Therese Goldsmith from GHMSI CEO Chester Burrell,* April 11, 2013

Exhibit 5 - *Letter to Commissioner William White from GHMSI CEO Chester Burrell and Report Accompanying CareFirst Coverage Plan and Rate Filings in the District of Columbia Pursuant to the Affordable Care Act*, May 31, 2013

Exhibit 6 - *Letter to Commissioner Therese Goldsmith from GHMSI CEO Chester Burrell*, July 1, 2013

Exhibit 7 - *Report to the D.C. Department of Insurance, Securities and Banking Regarding GHMSI's Surplus at Year-End 2012*, July 1, 2013 ("DISB 2013 Report")

Exhibit 8 - *Summaries of the Risk Adjustment, Transitional Reinsurance, and Risk Corridors Programs, prepared by Group Hospitalization and Medical Services (GHMSI)*

Exhibit 9 – *Report by Group Hospitalization and Medical Services (GHMSI) on the Financial Impact of DC Individual and Small Group Pricing Decisions*

Exhibit 10 – *Group Hospitalization and Medical Services (GHMSI) 2011 and 2013 Surplus and Benefit Expenses*

Exhibit 11 - *Group Hospitalization and Medical Services (GHMSI) Underwriting Margins From 2009 through 2013, Including Proportionate Experience of BlueChoice*

Milliman Documents

Exhibit 12 - *Development of Optimal Surplus Target Range*, June 29, 2011 ("Milliman 2011 Report")

Exhibit 13 - *Group Hospital and Medical Services, Inc.: Review and Consideration of Optimal Surplus Target Range*, June 28, 2013 ("Milliman 2013 Update")

Maryland Insurance Administration Documents

Exhibit 14 - *In re: Targeted Surplus Ranges for CareFirst of Maryland, Inc. and Group Hospitalization And Medical Services, Inc.*, Case No. MIA-2011-05-040 (May 26, 2011) ("MIA 2011 Consent Order")

Exhibit 15 - *In re: Targeted Surplus Ranges for CareFirst of Maryland, Inc. and Group Hospitalization And Medical Services, Inc.*, Case No. MIA-212-09-006 (September 14, 2012) ("MIA 2012 Consent Order")

Other Exhibits

Exhibit 16 - *Recommended Surplus Range for CFMI: Approach and Considerations for Determining the Appropriate Range of Surplus in 2011,* June 24, 2011 ("Lewin 2011 Report")

Exhibit 17 - Excerpts from *Cost of the Future Newly Insured under the Affordable Care Act (ACA)*, Society of Actuaries (Mar. 2013), *available at* http://www.soa.org/files/research/projects/research-cost-aca-report.pdf

Exhibit 18 - *Financial Reporting Implications Under the Affordable Care Act* (American Academy of Actuaries, June 2013), *available at* http://actuary.org/files/HPFRC_White_Paper_on_ACA_and_FR_final_062513.pdf

EXHIBIT 1

GHMSI 2013 Community Giving Report

I. Introduction

This report provides information about Group Hospitalization and Medical Services, Inc. (GHMSI)'s nonprofit mission and community giving in recent years. The Medical Insurance Empowerment Act of 2008 (D.C. Code § 31-3505.01) requires GHMSI to engage in community health reinvestment to the maximum feasible extent consistent with financial soundness and efficiency. As this report demonstrates, GHMSI continues to engage in significant community health reinvestment in the National Capital Area, in accordance with D.C. law and CareFirst's nonprofit mission.

This report describes our *CareFirst Commitment* – our approach to community giving; community benefit through rate moderation in GHMSI's service area; subsidies given to District of Columbia programs; specific examples of direct community giving; and our commitment to improving health care delivery through collaboration and development of health innovations.

II. CareFirst Commitment – Our Commitment to the Community

CareFirst plays an important role in improving the quality of and access to health care for the communities we serve. In 2005, CareFirst launched CareFirst Commitment, a multi-faceted initiative that seeks to address health care needs in the communities we serve. Through CareFirst Commitment, more than $341 million has been invested over the past seven years in worthwhile programs and organizations benefiting the community. These figures include contributions made by GHMSI to health programs in D.C., such as the offering of an open enrollment product and an annual contribution of $5 million to the Healthy DC Fund.

Including community giving as well as payment to DC and Maryland health programs, CareFirst spent a total of nearly $57 million on grants and public access programs in 2013.

A budget is established annually to reflect the health care needs and priorities of the communities we serve in Washington, D.C., Maryland and Northern Virginia with an overarching goal of dedicating resources to initiatives that catalyze change and create systemic efficiencies in the health care delivery system. In priority order, CareFirst focuses its charitable giving to:

1. **Subsidies and Enhanced Health Care Access Programs:** Supporting programs that increase access to care for large vulnerable populations, those unable to otherwise receive health care services or who have only limited access to those services. This represents the largest portion of our giving budget.

2. **Catalytic Giving:** Supporting programs and other initiatives to stimulate change and improvements in the health care system over the long term.

3. **Programmatic Initiatives:** Providing support for programs targeting a specific population and/or addressing a major health care issue, and that has specific measurements for success.

4. **Targeted Health-Related Giving through Others:** Seeking opportunities to support organizations that provide direct health care or related services for the underserved.

5. **Corporate Memberships and Community Sponsorships:** Funding corporate sponsorships and memberships with business/civic organizations that build strong relationships and develop visible partnerships with the community.

CareFirst employs an evaluative framework to guide its community giving, and seeks to provide support in ways that can be put to good and immediate use, but that also will have a lasting impact on individuals and families in our region. CareFirst's most intense focus is upon expanding access to health care by subsidizing health coverage for many of the region's most vulnerable residents. This focus is represented by the base of the pyramid above. Second, CareFirst seeks to act as a catalyst in developing systemic improvements in health care delivery in ways that benefit all in the community. Investments in electronic health records, expansion and support for patient-centered medical homes in community clinics and investment in telemedicine to expand access to behavioral health services in rural and underserved areas are examples of programs that seek to catalyze change in the health services delivery system. Third, CareFirst supports targeted programmatic initiatives undertaken by qualified charitable, nonprofit community organizations and government agencies and that focus on specific health improvement opportunities.

In 2013, GHMSI provided an estimated $22.5 million in community reinvestment, including reinvestment provided through corporate giving, operation of an open enrollment product in the District, and funding for Healthy DC. An overview of GHMSI's community reinvestment figures are provided in **Table 1** on the following page. A list of organizations that received funding through GHMSI's giving in 2013 is included at the end of this report.

Table 1. GHMSI Community Reinvestment Expenditures: 2011 – 2013

2011 GHMSI COMMUNITY REINVESTMENT EXPENDITURES

	DC only	Total
Corporate Giving	$3.4 million	$7.3 million
Open Enrollment Subsidies	$4.5 million	$4.6 million
DC HealthCare Alliance Program Funding	$5.0 million	$5.0 million
TOTAL 2011 EXPENDITURES:	**$12.9 MILLION**	**$16.9 MILLION**

2012 GHMSI COMMUNITY REINVESTMENT EXPENDITURES

	DC only	Total
Corporate Giving	$3.9 million	$6.6 million
Open Enrollment Subsidies	$7.5 million	$8.7 million
DC HealthCare Alliance Program Funding	$5.0 million	$5.0 million
TOTAL 2012 EXPENDITURES	**$16.4 MILLION**	**$20.3 MILLION**

2013 ESTIMATED GHMSI COMMUNITY REINVESTMENT EXPENDITURES

	DC only	Total
Corporate Giving	$3.4 million	$7.6 million
Open Enrollment Subsidies[1]	$9.4 million	$9.9 million
DC HealthCare Alliance Program Funding	$5.0 million	$5.0 million
TOTAL 2013 ESTIMATED EXPENDITURES	**$17.8 MILLION**	**$22.5 MILLION**

GHMSI PREMIUM TAX PAYMENTS – DC ONLY

2011 Premium Taxes $14.1 million
2012 Premium Taxes $14.2 million
2013 Premium Taxes $15.4 million

In addition to the Community Reinvestment Expenditures set out above, GHMSI and CareFirst BlueChoice, Inc. moderated rates in the District of Columbia individual and small group markets in the amount of nearly $27 million between 2011 and 2013.

[1] Open Enrollment Subsidies figure reflects claims received as of March 27, 2014; this figure is subject to change.

III. Rate Moderation

A significant portion of CareFirst's community commitment is demonstrated through major rate moderation efforts, a benefit that goes directly to GHMSI subscribers. GHMSI and CareFirst BlueChoice, Inc. moderated rates in the District of Columbia individual and small group markets in the amount of nearly $27 million between 2011 and 2013. ***Exhibit 9*** provides a detailed breakdown on rate moderation for GHMSI individual and small group products in the years 2011 through 2013.[2] This rate moderation is community benefit provided in addition to the $22.5 million in community giving in 2013, for a combined total of approximately $33 million of community benefit in 2013.

For 2014, both GHMSI and CareFirst BlueChoice, Inc. utilized aggressive pricing assumptions, erring on the side of affordability and reducing potential "sticker shock" associated with the new Affordable Care Act products, in accordance with GHMSI's not-for-profit mission. The proposed 2014 rate increases were far below what some actuarial models suggested would be necessary. As a result, there is a significant chance that the 2014 rates ultimately will be inadequate, as suggested by both companies' favorable rates on the Exchange.

IV. Subsidies and Public Access Programs in the District of Columbia

GHMSI provides subsidies to the Healthy DC Fund as well as operating an open enrollment product in the District of Columbia. GHMSI provides $5 million annually to Healthy DC. Open enrollment subsidies vary by year, depending on the amount of losses in the program. In 2013, GHMSI's reinvestment in open enrollment subsidies is currently estimated at $9.9 million.

V. Examples of Direct Community Giving

CareFirst's efforts in four key areas, described below, illustrate the principles we use to improve health in our community. In these focused areas, CareFirst has sought to improve maternal and child health, battle the obesity epidemic, empower the region's safety net clinics, and address the shortage of nurses.

1. Maternal & Child Health Initiative - Improving Birth Outcomes for Mothers & Babies

Through our *Maternal and Child Health Initiative,* CareFirst has committed nearly $11 million since 2006 to community-based efforts throughout our service area to improve maternal, infant and child health in communities where the need is greatest. CareFirst has funded nearly two dozen such programs, having a positive effect on the lives of tens of thousands mothers and children. These programs seek to affect behaviors, and create safe environments and healthy outcomes for infants in our region.

Examples of grants of this type in GHMSI's service area include:

- A grant to the DC Department of Health's DC Case Management Program, which provided home visiting services to pregnant women and women with children under the age of 2 in Wards 7 and 8. ($346,000, three-year grant);
- A grant to the Family Health and Birth, Fostering Health People in DC's Vulnerable Neighborhood Breastfeeding program, ($345,276 three-year initiative); and
- Two grants to the Latin American Youth Parent's program, providing guidance and health

[2] The cited document has been filed with DISB as Exhibit 9 to GHMSI's Prehearing Brief, filed in advance of the April 29, 2014 hearing on GHMSI's 2011 surplus.

education to teen parents. ($50,000, two-year initiative).

2. *Battling Obesity - Supporting Programs That Promote Fitness and Nutrition*

Since 2006, CareFirst has invested $3.8 million in efforts to reduce childhood obesity. Funding has supported numerous efforts, including the YMCA's *Physical Healthy Driven (PhD)* and *Fit 'N Fun* Childhood Obesity programs that seek measurable improvements in body mass index, flexibility, muscular endurance, and cardio fitness. In 2012, 3,818 children across the region participated in after-school programs, and another 96,243 children, families and adults have benefited from the programs' summer camps and community events. More than 8,900 children overall participate in CareFirst-funded programs that focus on nutrition, healthy choices and physical activity. Thousands of adults and children also received health and nutrition information through mobile units which promote wellness at health fairs, schools and special events. Grants of this type in GHMSI's service area include:

- $1 million over six years to the YMCA of Metropolitan Washington, PHD (Physical, Healthy & Driven) youth exercise and nutrition program; and

- $600,000 over six years to Girl Scout Grow Strong, a healthy lifestyles program designed especially for girls who represent high-risk populations in the Washington metropolitan area.

In addition, CareFirst provided $2.5 million over five years to the YMCA of Metropolitan Washington for the Fit & Well Seniors Program, which provides exercise activities to seniors in all eight wards of the District.

3. *Strengthening Safety Net Clinics - Caring for our Region's Most Vulnerable Citizens*

By investing in the region's safety net health clinics, CareFirst helps to provide the medically underserved an alternative to emergency rooms by enabling the clinics to expand capacity and therefore increase access to health care services in clinics conveniently located in their neighborhoods. Since 2006, CareFirst has invested more than $19 million in programs throughout our service area that support additional direct services as well as efforts that enhance the clinics' ability to transform and improve care quality through the creation of electronic health records and other means. Grant recipients and initiatives included:

- *2013 Promise of Telemedicine in Addressing the Region's Behavioral Health Needs RFP* - This 2013 initiative seeks to expand telecommunication technology giving health care providers the ability to remotely assess, diagnose, educate and treat patients with behavioral health and substance use disorders. CareFirst is providing $1.3 million in grants to community health centers, nonprofit organizations and public health entities to serve underserved and rural areas in Maryland and the national capital region. La Clinica del Pueblo will use its $424,635 grant to expand remote access to its bilingual counselors and health care providers through teleconferencing to 650 patients in the Greater Washington Area.

- In 2012, CareFirst launched the Safety Net Health Center PCMH initiative to assist local safety net clinics in developing and/or enhancing their ability to become Patient-Centered Medical Homes. CareFirst committed more than $8 million to support this effort in 11 safety net health centers throughout our service area over a three year period including: Unity Health Care, Mary's Center, Community Clinics Inc., Arlington Free Clinic and Primary Care Coalition and their partners Proyecto de Salud and Holy Cross.

- Unity Health Care, Inc. received a grant of $913,802 over 3 years (*2012-2014)* to improve care coordination and expand access to evening and weekend hour among individuals with multiple chronic diseases in households accessing emergency services. Over the past 10 years we have given

over $1.7 million in Unity Health Care.

- Whitman Walker Health received support for the Gay Men's Health and Wellness/Sexually Transmitted Disease Clinic testing and treatment program. ($150,000 over two years). In addition, since 2003, we have provided nearly $800,000 in community investment to Whitman Walker Health.

- Bread for the City, Dental Clinic Project, provided dental equipment to establish the dental practice and a renewal grant to support uncompensated care. ($180,192 over three years).

4. Responding to the Nursing Shortage - Expanding the Future Nursing Workforce

The lack of a sufficient number of nurse educators has had a significant and direct impact on nursing school capacity to accommodate aspiring nurses. To address this systemic problem, CareFirst initiated a grant program to help fund individuals seeking graduate nursing degrees in exchange for their commitment to teach for at least three years in nursing education programs in the District of Columbia, Northern Virginia, or Maryland. These *"Project RN"* stipends enable nurses to complete graduate degrees and to qualify to teach in nursing education programs within two years.

Project RN has provided $80,000 stipends over two years to each of 31 students in Maryland, Washington, DC, and Virginia, in partnership with 13 area colleges and universities. Recipients could use the money to cover tuition, fees or even living expenses, enabling them complete their degrees quickly. So far, 14 program participants are teaching at area colleges. This year, CareFirst committed nearly $1 million over two years to provide scholarships to an additional 11 post-graduate students – raising the total investment in this worthwhile program to $3.2 million. Universities in the National Capital Area that have received Project RN awards include Catholic University, Georgetown University, George Washington University, Howard University, George Mason University, Marymount University, and Bowie State University.

CareFirst's commitment to participating as an active member of the community within its service area is reflected in the rankings of the region's most charitable organizations produced by *The Baltimore Business Journal* and *The Washington Business Journal*. This year, CareFirst was ranked first and third in total dollars of giving by the Baltimore and Washington publications, respectively.

VI. Commitment to Improving Health Care Delivery

CareFirst also routinely seeks to partner with federal, state and local government on public health care initiatives and demonstration programs designed to improve the health care delivery system. CareFirst offers its expertise and experience as the Mid-Atlantic Region's largest health insurer with the intention of serving as a valued resource to policymakers in developing and implementing health care law and policy. In particular:

- CareFirst has provided subject matter experts and counsel to various health care reform implementation teams in the National Capital Area. For example, CareFirst provided representatives to serve on the advisory committees and workgroups created to assist in the development of Maryland's Health Benefits Exchange and the DC Health Benefit Exchange Authority.

- CareFirst associates also participate on a variety of other workgroups, task forces and advisory panels to various organizations committed to improving the region's and nation's health care delivery system, including the Council for Quality, Affordable Healthcare (CAQH), the National Commission for Quality Assurance (NCQA), the Council for Graduate

Medical Education, the Blue Cross and Blue Shield Association (BCBSA) and America's Health Insurance Plans (AHIP).

In January 2011, CareFirst formally launched a new initiative that offers the potential to produce lasting, systemic improvements for health care in our region – the CareFirst Patient-Centered Medical Home (PCMH) program. CareFirst's PCMH program rewards and supports primary care providers (PCPs) – including both physicians and nurse practitioners – in their role as "quarterbacks" of teams of health care professionals working together to coordinate the care of patients with serious and costly health problems, typically those with multiple chronic conditions such as diabetes, asthma, chronic obstructive pulmonary disease, hypertension, high cholesterol, and others. The program rewards PCPs for working with CareFirst members and with other physicians, hospitals and providers to improve patient quality outcomes and constrain overall health service and total cost increases that have made health care coverage increasingly unaffordable for employers and residents Maryland, Northern Virginia and the District of Columbia. CareFirst's PCMH Program seeks to:

1. Encourage closer, more engaged relationships between PCPs and their patients with or at high risk for chronic diseases;

2. Tackle the upstream causes of poor health and aggressively pursue opportunities to promote prevention and wellness strategies benefiting the total patient population; and

3. Moderate the growth in total health care expenditures by organizing PCPs into manageable performance groups (Medical Panels) driven by powerful financial incentives to control aggregate costs while improving patient outcomes.

CareFirst's PCMH Program ranks among the nation's largest private payer-directed PCMH Programs, involving about 3,506 participating providers, and 421 provider panels. CareFirst remains optimistic about the PCMH program and its potential to improve care while slowing growth in health care costs over time. The program blends traditional fee-for-service and capitation elements and puts an intense focus on chronic disease and risk mitigation.

The extensive information technology and other supports CareFirst has put in place, coupled with meaningful financial incentives for physicians, has positioned CareFirst's PCMH program as perhaps the most comprehensive and extensive effort of its type ever undertaken by a payer. In 2012, the second year of the PCHM program, health care costs for 1 million CareFirst members covered by the effort were $98 million less than the company projected. The results represent a savings of 2.7 percent on the total projected 2012 health care costs for PCMH-covered members and improve upon the 1.5 percent savings against projected costs registered by the program in 2011. To better understand the overall impact of the program, CareFirst has engaged three independent consulting groups to evaluate it, comprised of leading health policy and health economists from George Mason University, Westat, and Harvard-Brandeis-Massachusetts Institute of Technology.

VII. Conclusion

As the foregoing information demonstrates, CareFirst continues to reinvest to the maximum extent feasible in community health efforts in GHMSI's service areas.

A list of organizations benefitting from CareFirst's community giving in GHMSI's service areas in 2013 follows on the next page. The list is not exhaustive.

Organizations Benefitting From CareFirst Community Giving in GHMSI's Service Area in 2013

Abramson Scholarship Foundation
Advocates For Youth
Alexandria Neighborhood Health Services
American Cancer Society
American Diabetes Association
American Heart Association
Arlington Free Clinic
Asian American LEAD
A-SPAN
Boys & Girls Clubs of Greater Washington
Bread for the City
Breast Care for Washington
Bright Beginnings
Capital Breast Care Center
Child and Family Network Centers
Child Center and Adult Services
City Year Washington, DC
College Success Foundation-District of Columbia
Columbia Lighthouse for the Blind
Common Good City Farm
Community Clinic, Inc.
Community Foundation for the National Capital Region
Community Preservation and Development Corporation
DC Campaign to Prevent Teen Pregnancy
DC Central Kitchen
DC Chamber of Commerce
DC Public Education Fund
Dialogue on Diversity
District of Columbia Cancer Consortium
Doctors Community Hospital Foundation
Everybody Wins! DC
Florence Crittenton Services of Greater Washington
Food & Friends
Friends of Fort Dupont Ice Arena
George Mason University
George Washington University
Girl Scout Council of the Nation's Capital
Girls on the Run-DC
Goodwill Greater Washington
Grader Baden Medical Services
Hispanic Scholarship Fund
Holy Cross Hospital
Inova Health Care Services
Jeanie Schmidt Free Clinic
John F. Kennedy Center for Performing Arts
Joseph's House
Kids Smiles
La Clinica del Pueblo
Latin American Youth Center
Leadership Arlington
Leadership Greater Washington
Leadership Prince George's
Leukemia & Lymphoma Society
Lisner-Louise-Dickson-Hurt Home
March of Dimes
Marymount University
Mary's Center for Maternal & Child Care
MedStar Georgetown University Hospital
Mercy Health Clinic
Metro Teen AIDS
My Sister's Place
N Street Village
Neediest Kids
Northern Virginia Health Services Coalition
Northern Virginia Urban League
NOVA ScriptsCentral
NovaSalud
Planned Parenthood
Primary Care Coalition of Montgomery County
Providence Health Foundation
Ron Brown Scholar Fund
Samaritan Inns
Sibley Memorial Hospital Foundation
Smithsonian Anacostia Community Museum
St. Ann's Center for Children, Youth and Families
Sudden Infant Death Services of the Mid-Atlantic
Teen and Young Adult Health Connection
United Community Against Poverty
United Way of the National Capital Area
Unity Health Care
Urban Alliance
Us Helping Us

Organizations Benefitting From CareFirst Community Giving in GHMSI's Service Area in 2013

Continued

Virginia Hospital Center Foundation
Washington Area Women's Foundation
Washington Hospital Center Foundation
Washington Regional Association of Grantmakers
Washington Tennis & Education Foundation
Whitman-Walker Health
Women's Center
YMCA of Metropolitan Washington
YWCA of the National Capital Area

EXHIBIT 2

Report by
Group Hospitalization and Medical Services, Inc. (GHMSI)
on the Impact of the Affordable Care Act on GHMSI's Surplus

June 10, 2014

Introduction and Summary

The Affordable Care Act (ACA) has dramatically changed the market rules under which Group Hospitalization and Medical Services, Inc. d/b/a CareFirst BlueCross BlueShield ("GHMSI") and its HMO subsidiary CareFirst BlueChoice, Inc. ("BlueChoice") must operate.[1] Because of these sweeping changes, GHMSI believes that its surplus level is likely to fall in future years. The real concern should not be whether GHMSI's surplus is too high at present, but whether GHMSI will be able to maintain surplus levels that are adequate to ensure that it remains financially sound in the future.

Under the new market rules created by the ACA and uncertainties regarding the medical costs of new members in the new plans, it is more likely than ever before that an insurer such as GHMSI will face rate inadequacies due to misjudging the nature of the risk pool of covered members. Once rates become inadequate, the ACA will make it harder than ever before to increase those rates to an adequate level for future years, and very unlikely that a carrier would recover past losses. The ACA's rules and programs result in the following realities:

- ***First***, premium rates are rising because the requirement of guaranteed availability of coverage means that individuals who purchase insurance will be on average sicker and older than previous insureds. There is, however, great uncertainty regarding what rates will be adequate to cover the increased medical costs related to the new demographic profile of our subscribers and members. State level regulatory decisions, such as the merger of the DC individual and small group markets into a single rating pool, have increased this uncertainty. There is a significant chance that GHMSI's rates are already inadequate.

- ***Second***, the medical loss ratio (MLR) rules act as a one-way ratchet that allows for losses in some areas, but prevents any significant underwriting gains in others. Specifically, the MLR rules break up the experience of GHMSI and BlueChoice into 18 different rating cells, requiring the payment of rebates separately in each cell, and preventing the carriers from offsetting losses in one market against gains from another. If GHMSI's rates are in fact inadequate, the MLR rules will inhibit GHMSI from raising future rates to rebuild surplus, or from keeping any gains that may occur in individual market segments.

[1] BlueChoice is jointly owned by GHMSI and CareFirst of Maryland, Inc. (CFMI), and BlueChoice's surplus is a part of the consolidated surplus of CFMI and GHMSI. The surplus held by GHMSI, therefore, must meet the surplus needs not only of GHMSI, but also of BlueChoice in an amount proportional to its 49.999% ownership share.

- ***Third,*** there is great uncertainty regarding the federal risk adjustment and risk corridors programs. Risk adjustment has never been attempted on this scale before – the extent to which it will benefit or harm GHMSI is unknown. Under the risk corridors program, carriers share gains from exchange products with the federal government, and the federal government shares in any losses the carriers incur. There is a risk, however, that there will be more carriers with losses than carriers with gains and there may not be sufficient appropriated funds to cover the full needs of the program – in which case the protections intended by this feature of the ACA would not be fully available.

- ***Fourth,*** if rates are inadequate now, the new rate review rules, MLR rules, additional increases in medical costs from guaranteed issue, and market realities all make it less likely that GHMSI can "catch up" in future years for losses incurred in earlier years.

The combination of these ACA-driven realities could be devastating for the company. GHMSI is particularly concerned about a scenario in which:

(1) GHMSI's rates in one or more markets are inadequate, because GHMSI, in accordance with its not for profit mission, chose aggressive rating assumptions about the 2014 market, in hopes of reducing the price increases imposed upon members;

(2) In light of the many upward pressures on rates, including the phase-out of two federal risk mitigation programs, GHMSI is unable to obtain regulatory approval of rate increases in 2015 or other future years at a level that would allow it to implement adequate rate in those years;

(3) Even if rates in 2015 and later would be adequate as charged in a few market segments, the MLR rules require repayment of rebates in some of the 18 market segments in which GHMSI and BlueChoice operate, which would prevent GHMSI and BlueChoice from offsetting potentially significant losses in other markets; and

(4) The risk adjustment program requires GHMSI or BlueChoice to make payments to other carriers based on relative member health at the same time that the risk corridors program fails to offset losses in the insurance exchange products.

This scenario is a very real possibility. Should even some of these factors occur, GHMSI could suffer swift and deep losses that would threaten its surplus.

This Report is organized in the following Sections:

- Section I identifies the key ACA market changes that are expected to impact GHMSI's surplus, and provides a brief description of how those changes may alter GHMSI's rates, market position, and/or business operations.

- Section II discusses how these changes will affect GHMSI's ability to achieve rate adequacy, and how a failure to do so will cause GHMSI's surplus to fall.

- Section III addresses how these changes will limit GHMSI's ability to rebuild surplus, once lost, and how the changed market place rules make it likely that GHMSI's surplus will be much lower in future years even with adequate rates.

Section I
Key Market Changes Introduced By The Affordable Care Act.

The ACA seeks to improve the affordability and accessibility of health insurance by expanding Medicaid, reforming the individual and group health insurance markets, offering qualified health plans via state insurance marketplaces, requiring individuals to obtain health coverage, and making qualified health plans affordable through premium and cost-sharing subsidies. The ACA's guaranteed issue provisions require GHMSI and BlueChoice to accept every applying employer and individual within the carriers' service territory, regardless of health status. The ACA – and policy decisions of the DC Exchange Board and the Department of Insurance, Securities and Banking (DISB) – govern what health plans may be offered in the District, how they may be sold, and how they will be priced.

As a not-for-profit health plan, GHMSI strongly supports the key objective of ACA – to help many thousands of people gain access to health care through Medicaid expansion or subsidized qualified health plans offered through the District's Health Benefits Exchange, and the exchanges in Maryland and Virginia. Prior to 2014, there were approximately 42,000 uninsured individuals under age 65 in DC. Providing coverage for those individuals is an important goal. At the same time, it is important to recognize the significant disruption that the ACA is causing in GHMSI's marketplace and the very real risks that the company faces as a result.

Guaranteed Availability of Coverage, Regardless of Health Condition – A central element of the ACA requires that all persons seeking coverage be accepted by all carriers, regardless of health status. This is known as "Guaranteed Availability" or "Guaranteed Issue," and it involves a detailed set of rules regarding when and how plans may be offered. While this is a key legal provision for expanding insurance coverage, providing such coverage to previously uninsurable individuals will have costs. The uninsured population is expected to be significantly sicker than those who had insurance - which will lead to likely increased expenses for medical care and therefore higher insurance rates.

In 2013, the Society of Actuaries studied the likely increases in claims costs that would result from the new guaranteed issue rules. The Society predicted that 2014 medical claims costs in the individual market are likely to increase by an average of 51.9% in the District of Columbia (the 9th highest increase in the nation), 66.6% in Maryland (the 4th highest increase), and 28.4%

in Virginia. *See* **Exhibit 17,** *Cost of the Future Newly Insured under the Affordable Care Act (ACA)* (Mar. 2013).[2]

Essential Health Benefits And Other Mandated Benefits – The ACA sets minimum standards for the benefits that all non-grandfathered individual and small group insurance plans must provide. A number of these changes went into effect in September 2010, including elimination of annual and lifetime policy limits and coverage for preventive services without cost-sharing. Effective January 1, 2014, all such plans must also include a set of "essential health benefits," which require benefits in ten specified categories of coverage. *See* 42 U.S.C. §§ 300gg-6. The exact benefits are different for each State (including the District of Columbia), because the Department of Health and Human Services (HHS) requested that each State select the package of essential benefits that it wished to use. *See* 45 C.F.R. § 156.100 *et seq*.

As a result of these changes, individual and small group insurance plans are more generous, but also more costly. GHMSI calculates that the 2010 and 2014 benefit changes have had a pricing impact that ranges from 4%, for the small group market, to 17-18%, for individual PPO products:

	Individual Under 65	Small Group
2010 Benefit Enrichments	11%	1%
2014 Essential Health Benefits	HMO: 2% PPO: 5%-6%	3%
Total Impact	HMO: 13% PPO: 17-18%	4%

New Rating Rules Will Benefit Some And Raise Costs For Others – Under the ACA, premium rates cannot be varied by more than three to one on account of age. 42 U.S.C. § 300gg. In other words, the oldest subscriber will not pay more than three times the premium of the youngest subscriber, if they live in the same region and have the same smoking status. The ACA also prohibits rating on the basis of gender.[3] *Id.* Coupled with the addition of maternity benefits, these changes to the rating rules increase the costs of insurance for younger, healthy males, while decreasing those costs for women of child-bearing age and older subscribers.

The question is whether enough younger and healthier members will buy the new products, or whether they may stay out of the marketplace because of the substantial rate increases. A carrier that does not have enough younger and healthier members in its "risk pool"

[2] A citation to "Exhibit ___" in this Report refers to the appropriately numbered Exhibit filed by GHMSI with its Prehearing Brief in advance of the June 25, 2014 hearing before the D.C. Department of Insurance, Securities, and Banking regarding GHMSI's surplus.

[3] The District of Columbia enacted these rating rules early, in 2011. Virginia and Maryland, in which GHMSI also operates, did not fully adopt the new rules until January 1, 2014.

for rating purposes will have to charge dramatically higher rates to offset the medical expenses that it incurs.

The Individual Mandate – Beginning in 2014, all individuals who are required to file a tax return must obtain health insurance coverage or face a tax penalty. Individuals can obtain a hardship exemption if the cost of insurance would exceed 8 percent of their income. The penalty amount is the greater of a set dollar minimum or a percentage of income. For 2014, these amounts are relatively small – the penalty would be the greater of 1% of income or $95 per adult and $47.50 per child. *See* 26 U.S.C. § 5000A(c). For an individual making 251% of the federal poverty level ($28,840/year), the penalty would be only $288 in 2014.

As discussed above, GHMSI is concerned that younger and healthier individuals, who are facing the highest premium increases, may choose to pay the penalty rather than purchase coverage. For example, a Harvard University survey of young Americans in December 2013 found that less than one-third of uninsured "millenials" planned to enroll in coverage.[4] If younger and healthier members do not enroll with GHMSI and BlueChoice, rates will spiral upward – and if GHMSI cannot obtain the rate increases needed to offset the increased costs, GHMSI's surplus quickly will fall.

Plan Standardization – All individual and small group plans are standardized by their actuarial value into one of four metal levels. A plan's actuarial value (AV) reflects the portion of medical expenses paid by the carrier, as opposed to the portion paid by the subscriber through cost-sharing such as co-pays, deductibles, or co-insurance. The metal levels are bronze (60%), silver (70%), gold (80%) and platinum (90%). *See* 42 U.S.C. § 18022. Because of the standardization of plans and benefits, consumers may focus on prices to the exclusion of other factors – significantly increasing enrollment in the lower priced carriers.[5]

As discussed in Section II, GHMSI is one of the lower priced carriers in its individual and small group markets, and expects substantial enrollment increases. This increased enrollment necessarily means greater expected claims costs, and surplus must actually increase in dollar terms or fall as a percent of RBC-ACL.

Enhanced Rate Review – The Affordable Care Act sets additional requirements for rate reviews, including public reporting on rate increases to HHS and on carrier and government websites. Since 2011, state regulators and HHS have applied special attention to any rate increases above 10%. *See* 45 C.F.R. § 154.200. In 2013, many carriers filed double-digit

---

[4] *See* Harvard University Institute of Politics, *Survey of Young Americans' Attitude Toward Politics and Public Service* (24th Ed., Dec. 4, 2013), available at http://www.iop.harvard.edu/majority-disapprove-health-care-law-believe-their-costs-will-rise-and-quality-will-fall.

[5] Consumers who purchase bronze plans also may experience some "cost sharing shock," because the cost-sharing levels are very significant, with the consumer on average bearing a full 40% of expected medical costs and with large deductibles that require consumers to pay for significant amounts of healthcare themselves before receiving full benefit of their bronze coverage. GHMSI addressed this and other types of consumer shocks related to the ACA in its May 31, 2013 Report to the DISB. *See* **Exhibit 5,** *Report Accompanying CareFirst Coverage Plan and Rate Filings in the District of Columbia Pursuant to the Affordable Care Act* (May 31, 2013).

increases in their 2014 rates, to reflect the higher claims costs that were expected for the new guaranteed issue products.[6] Regulators cut back significantly on those rates in some cases – and some carriers have withdrawn from individual and/or small group insurance markets as a result.[7]

GHMSI's rates have long been closely reviewed in the District of Columbia and Maryland, and GHMSI purposely moderated its 2014 rate increases (as discussed below), so that it obtained approval of its 2014 rates without trouble. However, given the many factors acting to drive insurance rates upward in the coming years, GHMSI has a long-term concern that the enhanced review process and publicity surrounding insurance rates may increase the difficulty of obtaining adequate rates in the future.

Medical Loss Ratio Rules – Starting in 2011, a carrier must pay rebates if its non-medical costs exceed 15% in the large group or 20% in the small group and individual markets. This calculation is performed separately for each market, jurisdiction, and carrier. *See* 45 C.F.R. § 158.210. In other words, GHMSI must pay a rebate to small group policyholders in the District of Columbia if its non-medical costs for those small group products exceed 20%, and must separately determine whether it would be required to pay a rebate in the Maryland or Virginia markets. This requires 18 separate calculations for GHMSI and BlueChoice - each of which operates in the individual, small group, and large group markets in DC, Maryland, and Virginia.

The MLR rules will place significant constraints on GHMSI's ability to rebuild surplus once it is lost. First, the MLR rules place a cap on how much surplus could be generated in any year, regardless of a carrier's financial condition. Any funds that would go into surplus must come out of the 15 to 20 percent allocated for non-medical costs, along with employee salaries, broker commissions, equipment, administration, and other such expenses. *See* 45 C.F.R. § 158.221(b). GHMSI cannot simply increase its rates at will to rebuild surplus that was lost in a previous year. The MLR rules prevent rates from rising significantly above medical claims costs. While this is generally good for consumers, it limits GHMSI's ability to recover from unexpected losses or when medical costs are greater than were anticipated.

Second, GHMSI cannot offset losses in one market or jurisdiction with profits from another. The market fragmentation required under the MLR rules operates as a one-way ratchet: GHMSI will have to pay rebates in market segments where its non-medical costs exceed the MLR percentage limit even if GHMSI has underwriting losses in other market segments and jurisdictions; those losses cannot be used as offsets. That minimizes the likelihood that a carrier's rates would significantly exceed medical cost increases overall and makes it more likely that losses would not be recovered.

---

[6] In some instances, new products were not subjected to the enhanced rate review procedures. GHMSI believes that regulators in DC, Maryland and Virginia gave equal scrutiny to 2014 rates regardless of whether the individual products could be characterized as new or renewal plans.

[7] *See, e.g., Aetna Withdraws from Health Insurance Exchanges in 3 States*, CBS Atlanta (Aug. 6, 2013), http://atlanta.cbslocal.com/2013/08/06/aetna-withdraws-from-health-insurance-exchanges-in-3-states/ (discussing withdrawals in Maryland, Georgia, and Connecticut).

Insurance Exchanges – The development of the insurance exchanges constitutes a significant shift in how insurance products are marketed and sold. In the District of Columbia, all individual and small group insurance products *must* be sold through the insurance exchange and the individual and small risk group rating pools have been merged. If and when the exchanges work as planned, consumers will gain a new tool to shop for coverage. Carriers, however, lose significant control over the marketing, sale, and even servicing of their products, and are dependent upon the exchanges to accurately and efficiently perform many key customer service functions (such as changes to plan selections, changes in enrollment, calculation of premium, determination of subsidies). If the exchanges do not work as planned, carriers may suffer damage to their own brands, as consumers are not likely to distinguish between poor performance by carriers and poor performance by an exchange.

GHMSI and BlueChoice each participate in three very different exchanges, in DC, Maryland, and Virginia. All three have had their own operational problems and issues. Without pointing the finger at any one exchange, GHMSI and BlueChoice have experienced improperly calculated rates and subsidy amounts, incomplete and inaccurate enrollment information transmitted by exchanges, exchanges that have not permitted policyholders to complete enrollment, exchanges that do not permit policyholders to add children or make other policy changes, multiple enrollments by the same individual, irate consumers presenting issues that can only be addressed by the exchanges, incorrect information provided to members by exchange customer service representatives, and many other issues. Given the troubled roll-out of the insurance exchanges in all jurisdictions, GHMSI has spent significant resources (and expects to continue doing so) in an effort to minimize disruption for its customers.

GHMSI is concerned that its CareFirst BlueCross BlueShield and CareFirst BlueChoice brands are already suffering impacts from the roll-out of the exchanges. Customer service call volumes in early 2014 exceeded call volumes before open enrollment by as much as 500%. Weekly call volumes for the three CareFirst carriers (CFMI, GHMSI, and BlueChoice) have ranged from less than 12,000 calls in late September 2013, before open enrollment, to nearly 60,000 in late January 2014.[8] As of the final week of March (which was the end of open enrollment, subject to some limited exceptions), weekly customer call volumes were still nearly triple their pre-open enrollment rate (more than 32,000 calls). Even though CareFirst added and trained more than 400 additional customer service representatives before and during the open enrollment period, call wait times have spiked, and customer service representatives are frequently unable to assist potential exchange enrollees with issues that only the exchanges can address.[9] If CareFirst had not already incurred millions of dollars in expenses to replace its

[8] CareFirst, Inc. is the parent company of GHMSI and CareFirst of Maryland, Inc. (CFMI). Many functions, such as customer service, are integrated and provided to members of all three carriers in the CareFirst family – GHMSI, CFMI, and BlueChoice. As used here, the term "CareFirst" refers to all three carriers, combined.

[9] GHMSI often cannot help individuals with issues that can only be addressed by the exchange. GHMSI cannot, for example, enroll individuals or complete enrollments, and would not know whether an individual has enrolled in an exchange unless and until the exchange sends the appropriate information. GHMSI also cannot modify enrollment information, add dependents, or permit individuals to change plans when enrolled through an exchange. Should the exchange fail to address such issues in a timely

customer service telephone systems in 2012 and 2013, it would not have even been *possible* to handle this volume of calls, even with greatly extended wait times.

On April 1, the Board of the Maryland Health Benefit Exchange voted to abandon its exchange, and to retain Deloitte Consulting, LLP to implement the exchange technology used in Connecticut. GHMSI and BlueChoice will therefore be required to start again in Maryland with a new exchange with new technical requirements, and to implement this new exchange before 2015 open enrollment begins this Fall.

Federal Subsidies Administered By Exchanges – The ACA provides for two new subsidies for low-income persons who purchase insurance through the exchanges – the advance premium tax credit (APTC) and the cost sharing reduction (CSR) subsidy. The APTC is available to individuals with incomes below 400% of the federal poverty level (FPL). Each exchange is required to correctly calculate the amount of APTC to which a policyholder is entitled, and the federal government should remit the amount of the credit directly to carriers. The premium charged to the policyholder is reduced by the amount of the subsidy. *See* 45 C.F.R. § 156.460. The CSR is available to policyholders who make less than 250% FPL. This additional subsidy comes in the form of reduced deductibles, co-insurance, co-pays or out-of-pocket maximums. Individuals receiving the CSR subsidy are enrolled in a plan with reduced cost sharing and the federal government pays a subsidy directly to carriers on a monthly basis. *See* 45 CFR §§ 156.410, 156.420 & 156.430.

Ultimately, the subsidies should be positive for carriers. At the same time, however, carriers are dependent upon both the Exchange and the federal government to accurately determine and pay a significant portion of the premium dollars needed to pay medical claims. During this implementation phase in particular, carriers are at risk of delays in payment or of changes to the subsidy rules mid-stream by regulators or legislators. The Maryland Exchange initially miscalculated its members' subsidies, for example, and the federal process for reconciliation and review of subsidy payments is still being implemented.

These uncertainties will continue for the indefinite future. Carriers and Exchanges are now beginning the cycle for the 2015 plan year. In Fall 2014, this cycle will include numerous new requirements for members, and multiple mandated letters to members from both Exchanges and carriers – because subsidy amounts and eligibility must be set for 2015, and members must either renew their plans or select new ones. GHMSI expects significant member confusion throughout this new process.

Federal regulations require the Exchanges to re-determine 2015 subsidy amounts by November 15, 2014, to provide 30 days' notice to the subsidized individuals regarding the initial re-determination, and then make a final determination of 2015 subsidy. *See* 45 C.F.R. § 155.335. At the same time, State and federal laws require carriers to provide members with notices of renewal and notices of premium increases, but those notices are not coordinated with the Exchange communications. For example, while GHMSI and BlueChoice must provide at least 45 days' notice before renewing members into 2015 plans at 2015 premiums, subsidies for those

---

way, the affected individuals frequently seek recourse to GHMSI, and the increased call volumes experienced by GHMSI and the other CareFirst carriers is a direct result of such problems.

plans will not yet be re-determined when this notice is provided.[10] Worse, it now appears that the Exchanges will be unable to make all of the redeterminations within the required deadlines, and the rules may be modified by HHS with very little notice. GHMSI is concerned that members will receive a group of potentially conflicting notices and bills with differing premium and or subsidy amounts, which may engender further consumer confusion. GHMSI expects to continue to expend significant customer service, IT and other resources as these issues are worked through.

The "3R's" – Reinsurance, Risk Corridors, and Risk Adjustment. The ACA includes three different "risk mitigation" schemes. They are intended to even out premium costs between carriers in the marketplace and to smooth the transition into the new, higher guaranteed issue rates. They are funded through significant new taxes on insurance products. A brief summary of each of these programs is provided at **Exhibit 8**.

Two of these programs – reinsurance and risk corridors - are temporary and designed to even out carrier experience in the marketplace during a three year period. From 2014 to 2016, the federal government, or states acting on the federal government's behalf, will operate a transitional reinsurance program. Carriers and self-insured plans are assessed fees on a per-capita basis to pay for the program, and the program funds phase down over a 3-year period: $10B in 2014; $6B in 2015; $4B in 2016 nationally. When claims for a member exceed an attachment point (proposed to be $45,000 for 2014 and increasing thereafter), carriers can receive reinsurance payments up to a maximum cap (when claims for the individual reach $250,000). The payments partially offset the carrier's costs above $45,000 for the sickest members. When the pool of funds is exhausted in any given year, however, no further reinsurance payments will be made. *See* **Exhibit 8**, at 7-8.

Under the "risk corridors" program a carrier shares gains and losses on products sold through the exchange with the federal government. HHS will make a payment to a carrier who's incurred allowable costs for a benefit year are greater than 103% of the expected target amount, and carriers must make a payment to HHS if their allowable costs for a benefit year are less than 97% of its target amount. The amount of such payments will depend upon the amounts of the gains or losses. The risk corridors program will be in effect for 2014, 2015, and 2016, and provides carriers with some protection against large losses on the new insurance exchanges.[11] *See* **Exhibit 8**, at 9-10.

---

[10] *See* proposed 45 C.F.R. § 148.122 (requiring a specified federal notice of renewal for exchange members, without premium information); Va. Code § 38.2-3407.15 (requiring carriers to provide notice of renewal to members in the individual market 75 days before renewal, with premium amounts and plan change information); COMAR 31.10.01.03(S) & 31.12.02.06(I) (Maryland regulations requiring notice of premium increase 45 days before renewal). In DC, the approved insurance contracts for GHMSI and BlueChoice require 45 days' notice before any premium increase.

[11] There have been efforts in Congress to repeal or curtail the risk corridors and reinsurance programs, by legislators who have referred to them as a "bail out" of the insurance industry. In fact, the funds that would be received from those programs are passed to consumers – the approved 2014 rates assume that the transitional reinsurance and risk corridor programs are in place. Should those programs be terminated early or modified in response to these challenges, 2015 and later rates would need to reflect the lack of or modifications to those programs.

Because of these two programs, an individual carrier's rates will not fully reflect the carrier's medical claims experience until 2017. The rate increases in 2014, therefore, were only the first year of a multi-year transition period. Were GHMSI's rates to be inadequate in 2014, any increase to bring them back to adequacy would necessarily be on top of increases needed to offset the phase-out of these transitional programs. As discussed in Section II in greater detail, GHMSI cannot maintain its surplus without adequate rates.

The risk corridors program poses a significant and unique risk to GHMSI. GHMSI filed its 2014 rates with the assumption that the federal government would share in losses (and profits) in the amounts specified in statute and regulation. The risk corridors program, however, has no specific federal funding. If there are more carriers with losses than carriers with gains, the federal government may be required to pay out more than it takes in.

On March 11, 2014, HHS issued proposed regulations governing 2015 benefit and payment parameters under the 3R's. In the preamble, HHS stated an intention to implement the risk corridors program "in a budget neutral manner, and may make future adjustments, either upward or downward to this program (for example, as discussed below, we may modify the ceiling on allowable administrative costs) to the extent necessary to achieve this goal." Proposed Rule, *Notice of Benefit and Payment Parameters for 2015*, 79 Fed. Reg. 13744, 13787 (Mar. 11, 2014). There is a substantial risk that there will be more carriers who lose money in the exchanges in 2014 and 2015 than there are carriers who make profits. In that event, if the program were modified to be "budget neutral," the government would not take the full share of losses that it should take under the ACA. GHMSI's 2014 rates were filed with the assumption that the risk corridors program would work as set forth in statute, and would not be limited to "budget neutrality." If that assumption is not correct, its rates could be inadequate for that reason alone.

HHS published its final regulations on May 27. *See* Final Rule, *Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond*, 79 Fed. Reg. 30240 (May 27, 2014). In the final version, HHS appears to change course, but still notes a significant caveat regarding whether or not insurers may receive full payment. HHS states, in the preamble to the final rule, that "[i]n the unlikely event of a shortfall for the 2015 program year, HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers. In that event, HHS will use other sources of funding for the risk corridors payments, ***subject to the availability of appropriations***." *Id.* at 30260 (emphasis added). No funds have been appropriated directly for the risk corridors program, and HHS has not specifically identified other funds that may be used for the purposes of making payments under the program. Thus, while the apparent change in direction is welcome, significant uncertainty remains.

The third program, "risk adjustment," is a permanent program that applies to the individual and small group markets. The risk adjustment program will require a transfer of funds from carriers that attract low-risk, healthier members to carriers that attract higher-risk, sicker members. The intention is to partially equalize rates between carriers – so that carriers with sicker individuals will not be forced to charge ever higher and uncompetitive rates based on their sicker risk pools. The methodology of the program is untested. Risk adjustment has never been

performed on the scale required by the ACA, and it heavily depends upon data regarding the health or sickness of members in each carrier's risk pool. That data does not presently exist, and it is not clear how accurate this program will be. *See* **Exhibit 18**, *Financial Reporting Implications Under the Affordable Care Act*, American Academy of Actuaries, at 3-7 (June 2013) (discussing uncertainties in the risk adjustment program). Thus, while there may be a long term benefit, the program presents significant short term risks and it imposes significant implementation costs and challenges that GHMSI must overcome.

Extended Timelines For Filing Rates – The ACA, and the "3R's" in particular, significantly limits the ability of a carrier to respond to changed market conditions in its rate filings. Individual and small group rates for a calendar year must be filed in May and June of the year before. For example, in Maryland and Virginia, the product filings for the 2015 calendar year must be filed by May 1, 2014. At the same time, the 3R's require financial adjustments that cannot be completed until *after* a year of coverage has ended. The financial adjustments attributable to the 2015 calendar year will not be complete until mid-way through 2016. The last slide on **Exhibit 8** maps out this timeline for 2013 through 2015.

As a result, the 2015 rates must be filed in early 2014, before there will be any significant experience with the 2014 rates. The *2016* rates will then be filed in early 2015, before risk adjustment and other financial modifications are complete for the *2014* calendar year. It will take a carrier more than two years to fully respond, in its rates, to changes in market conditions in the individual or small group markets.

Section II
GHMSI Must Maintain Adequate Rates In Order To Maintain Surplus

GHMSI fully supports the goals of the ACA and is committed to providing quality, fully compliant coverage to all of its members. However, the new ACA rules significantly constrain GHMSI's ability to respond to changed market conditions or to vary the terms on which it provides coverage, and take significant control away from the company with respect to marketing and selling its insurance products. Due to this confluence of factors, GHMSI expects that its surplus will significantly decline in future years as a percentage of RBC-ACL. The reason for this is simple – the ACA is increasing the cost of coverage, while imposing hurdles that will make it difficult for GHMSI's rates to rise in tandem with those increasing costs.

A. GHMSI Manages Surplus Through Its Rates, As Shown By GHMSI's Rate Moderation In 2011 and 2012.

GHMSI manages its surplus through the rate-setting process. To increase its surplus during a given year, GHMSI must increase its rates. It is only through such a rate increase that GHMSI could generate additional revenues (above expenses) that could be taken into surplus at the end of the year.[12]

[12] While GHMSI also receives income from investments, which may contribute to surplus, GHMSI's investments are subject to statutory requirements and are prudently managed, and returns in a given year are not within GHMSI's control. GHMSI cannot prudently "increase" its investment returns in response to declining surplus levels.

To decrease its surplus, by contrast, GHMSI would reduce premium increases or lower its rates. GHMSI took this approach in 2011 and 2012. At year-end 2010, GHMSI's surplus was 1098% RBC-ACL. Throughout 2011 and 2012, GHMSI reduced premium increases or reduced rates outright. As a result, GHMSI's surplus fell by 100 basis points in 2011, to 998% RBC-ACL, and by an additional 77 basis points in 2012, to 921% RBC-ACL. GHMSI estimates that it provided roughly $27 million in rate moderation in 2011 and 2012, while its surplus fell by 177% RBC-ACL over the same period. *See* **Exhibit 9**, *Financial Impact of DC Individual and Small Group Pricing Decisions*. As a matter of law, such rate reductions constitute "community health reinvestments." *See* DC Code § 31-3501(1A).

As these recent events show, GHMSI's ability to create or even to maintain surplus is highly dependent upon whether GHMSI is able to charge adequate rates for its products. If GHMSI's rates are not adequate, its surplus levels can quickly fall.

B. The ACA's Guaranteed Issue Rules, Additional Benefits, And Additional Taxes And Fees Require Substantial Premium Increases.

As discussed above, the ACA has caused substantial premium increases in the individual and small group markets. Based on the increased medical costs for guaranteed issue coverage alone, the American Society of Actuaries predicted that 2014 medical claims costs in the individual market are likely to increase by an average of 51.9% for the District of Columbia and 66.6% for Maryland. *See* **Exhibit 17**, at 7-8. As discussed in Section I, *supra*, the additional benefits required by ACA also add from 5% to 20% to the cost of products, when compared to pre-ACA plan designs. These are *average* increases. Due to the changes in rating rules, premium increases for some individuals or groups are much larger.

In addition, the ACA imposes significant new taxes and fees that are built into rates. Users of the federal exchange in Virginia are assessed an FFE fee of 3.5% of premium; DC policyholders will be assessed a fee to fund the District's exchange in an amount that is currently set at 1% of premium, but may be adjusted in the future;[13] all policyholders pay a portion of fees to fund administration of the transitional reinsurance program and the permanent risk adjustment program; carriers pay a new "patient centered outcome research institute" fee and a new federal health insurance tax. This new federal health insurance tax, referred to as a "health insurance provider's fee," may by itself add as much as $6 per member per month to rates. *See* **Exhibit 18**, at 10-17 (discussing applicable taxes and fees).

These rate increases are not limited to 2014. They will not reach their apex in 2014, because 2014 rates are somewhat mitigated by the transitional reinsurance and risk corridors programs. Those programs will end in 2016 and, by design, the full impact of the ACA's rate changes will not be felt until 2017.

[13] *See* D.C. Act 20-329 (May 22, 2014). The assessment for 2014, which will cost GHMSI approximately $7.7 million, does not take place until mid-year, based on a bill enacted in May. This means that GHMSI was not able to build the cost of the 2014 assessment into its 2014 rates.

Further, there are many unknowns that may cause larger increases in the future. Carriers may have underestimated the true costs of guaranteed issue claims; in some places regulators may be found to have "pushed" rates lower than was appropriate; and the risk adjustment program may not work, or may only partially work, in transferring risks between carriers. It is not possible, at this time, to predict the full impact of these changes and uncertainties on future rate filings.

C. GHMSI's 2014 Rate Filings Sought To Minimize The Increases Needed In The First Year Of The ACA.

Despite these risks, GHMSI took an aggressive position in 2014, seeking to protect its members from rate increases that were larger than necessary. GHMSI did so in fulfillment of its not-for-profit mission, seeking to provide accessible and affordable coverage. This approach, however, makes it more likely that GHMSI's surplus will drop.

GHMSI's 2014 DC Rate Filings. GHMSI sought an average rate increase of 35% for its 2014 individual and small group market rates; even though some actuarial models suggested that an average increase of 60% or more would be needed to break even in 2014. *See, e.g.,* **Exhibit 17**, at 7-8. The precise factors that went into GHMSI's 2014 DC rate filings are discussed in detail in **Exhibit 5**, *Report Accompanying CareFirst Coverage Plan and Rate Filings in the District of Columbia* (May 31, 2013), which was filed with DISB at the time.

This increase is primarily driven by expected medical costs that will result from the transition to a guaranteed-issue market and (for the individual market) by the regulatory decision to combine the individual and small group risk pools in the District of Columbia. **Exhibit 5**, at 5-6 (identifying each of the projected risk pool characteristics). In DC, it is expected that new entrants into the individual market will have illness levels that are, on average, one and one-half to three times that of medically underwritten individuals. *Id.*

GHMSI significantly moderated the rate increases that it sought out of concern that the impact upon its subscribers would be too adverse. *Id.* at 8; *see also cover letter from GHMSI CEO C. Burrell*, at **Exhibit 5**. GHMSI took this approach despite the fact that its pre-ACA premium rates in the DC individual market were already substantially inadequate, resulting in significant financial losses, particularly in the high risk DC Open Enrollment Program. In 2013, GHMSI incurred losses of $14 million from its sales in the individual health insurance market, including $3 million in losses in the District of Columbia market. BlueChoice, owned 49.999% by GHMSI, incurred an $18 million loss in the individual market in all jurisdictions, and a $7 million loss in the District.[14]

GHMSI's 2014 Maryland Rate Filings. In Maryland, GHMSI initially filed 2014 individual market rates that were 53% higher, on average, than 2013 rates. GHMSI refiled those rates on April 12, 2013, lowering the average increase to 25%, again in fulfillment of its not-for-profit mission. *See* **Exhibit 4**, *Letter to Commissioner Goldsmith from Chester Burrell of April*

[14] If its share of BlueChoice's losses is included, the total 2013 individual market losses for GHMSI therefore would be $23 million for all jurisdictions and $6.2 million in the District.

11, 2013. The original filing was based on GHMSI's expectation that there would be a 53% increase in illness level and related costs, primarily as a result of implementing guaranteed issue plans and incorporating the very sick individuals in Maryland's high risk pool into the market. *Id.* GHMSI's subsequent filing assumes a more optimistic, but also less likely, scenario. *Id.*

Experience in 2014 - The experience of GHMSI and BlueChoice through the first quarter of 2014 supports GHMSI's ongoing concerns regarding rate adequacy. As of March 31, 2014, GHMSI had a consolidated first quarter underwriting loss of 1.5% ($12.6 million), with an underwriting loss of 12.6% ($5.7 million) in the individual under-65 health insurance market. BlueChoice had a 0.7% ($4.5 million) consolidated first quarter underwriting gain, with a 21.4% ($10.5 million) underwriting loss in the individual under-65 health insurance market. These results are still preliminary – there were significant enrollment fluctuations throughout the first quarter, many new enrollees joined only at the end of the quarter, and further adjustments may be made due to uncertainties in ACA accounting. These early results, however, demonstrate that GHMSI's concerns are well founded.

D. GHMSI's Ability To "Catch Up" Inadequate Rates Or To Build Future Surplus Will Be Greatly Constrained.

If GHMSI's rates do become inadequate at any point, GHMSI's ability to "catch up" to rate adequacy in future years, and its ability to recover any lost surplus, will be greatly constrained. There will be a need for future rate increases to cover costs of coverage, even when rates are adequate, and bringing rates up to adequacy would require increases beyond those additional costs; and the MLR rules limit the extent to which GHMSI could build surplus through rate increases. These factors make it very unlikely that GHMSI could increase rates to the level required to cover the increased costs *and* build surplus.

GHMSI Expects Further Rate Increases Through 2017. As discussed above, the phase-out of the transitional reinsurance and risk corridors programs will cause rate increases in 2015, 2016 and 2017, because those two programs were designed to hold rates down during the transitional period. To the extent that GHMSI must increase premium to "catch up" its rates to an adequate level or to build surplus, it would have to do so against a background context of rising rates.

GHMSI Likely Will Be Unable To Increase Premium To Make Up Losses From A Previous Year. As discussed in Section I, the introduction of new, sick individuals to the individual and small group risk pools is a primary driver of the expected rate increases. If GHMSI's (or BlueChoice's) 2014 rates are inadequate – as they may be for the reasons discussed in Section II.C – the company would have to raise rates even further in 2015 and 2016 simply to ensure that rate adequacy is achieved. GHMSI would be required to make significant rate increases multiple years in a row, in a competitive marketplace. These facts make it that much more likely that GHMSI's rates would continue to be inadequate in coming years and that GHMSI's surplus will be significantly reduced as a result.

The Medical Loss Ratio ("MLR") Rules Make Inadequate Rates More Likely And Prevent GHMSI From "Recapturing" Surplus In Future Years. As discussed in Section I, the

MLR rules make it much more difficult for a carrier to "rebuild" surplus once it is lost. GHMSI must pay rebates if its non-medical costs exceed 15% in the large group or 20% in the small group and individual markets, regardless of its surplus position. 45 C.F.R. § 158.220. Any funds that would go into surplus must come out of the 15 to 20 percent allocated for non-medical costs, along with employee salaries, broker commissions, equipment, administration, and other such expenses. Even if directed to do so by DISB or another regulator, GHMSI may be prevented by federal law from increasing its rates to rebuild surplus that was lost in a previous year, because the MLR rules prevent rates from rising significantly above medical claims costs.

These effects are exacerbated by the requirement that GHMSI and BlueChoice must calculate medical loss ratios and pay any rebates utilizing 18 separate calculations, one for each carrier (GHMSI, BlueChoice), jurisdiction (MD, DC, VA), and market segment (individual, small group, large group). GHMSI or BlueChoice will have to pay rebates in market segments where their non-medical costs exceed the MLR percentage limit even if the carriers have underwriting losses in other market segments, minimizing the likelihood that either carrier's rates would significantly exceed the cost of medical claims and making it more likely that losses would not be recovered.

Section III
Even With Adequate Rates, ACA Likely Will Reduce GHMSI's Surplus As A Percentage Of RBC-ACL

Even assuming that GHMSI has and maintains adequate rates, the ACA changes will likely reduce its surplus. GHMSI expects increased enrollment as a result of the ACA, and that increased enrollment will lower surplus as a percentage of RBC-ACL, because the RBC-ACL formula expressly includes expected future medical costs as a component, and a larger enrollment will lead to larger future costs. GHMSI cannot count on market segments other than the individual and small group markets to make up lost revenues or significantly increase surplus, because the large group and self-insured markets are extremely competitive. Implementation of the ACA has and will continue to impose incredible expenses on GHMSI, which will reduce funds otherwise available for surplus. For all of these reasons, GHMSI's surplus is likely to trend downward even if rates are adequate.

GHMSI's Filed Rates Are Low In Comparison To Those Of Other Carriers, And Will Likely Lead To Increased Enrollment and Reduced RBC. A comparison of 2014 filed rates by carriers participating on the DC Exchange indicates that, for most products and metal tiers, GHMSI's filed rates are lower than those of others in the marketplace. The differences are particularly significant on the lower (bronze and silver) tiers, which are expected to be most attractive to new market entrants. The likely result will be an increase in GHMSI's enrollment and revenue. This is not a bad result for GHMSI as a provider of health insurance, so long as GHMSI's rates are adequate, but the expansion of enrollment will reduce GHMSI's surplus levels as a percentage of risk-based capital.

An increase in enrollment will require a larger surplus in dollar terms just to maintain a stable level of RBC-ACL, because a larger enrollment causes a larger pool of potential medical

claims that must be paid out. RBC-ACL is a measure of financial risk, and the increased potential claims liability creates a larger financial risk. The increased enrollment will require GHMSI to, in effect, "run to stay in place" – GHMSI must build additional surplus in dollar terms simply to keep its RBC-ACL levels constant. However, for the reasons stated in Section II, it is unlikely that GHMSI would be able to increase premiums enough to contribute to surplus during 2014 through 2017. It is more likely that GHMSI's surplus will drop as a percentage of RBC-ACL.

In fact, preliminary enrollment numbers for the first quarter of 2014 show increased enrollment in the individual market, most dramatically for the HMO plans offered by BlueChoice. As of May 1, 2014, GHMSI's individual market enrollment had increased by nearly 8% since the end of 2013 (from 52,013 enrollees to 56,036 enrollees), while BlueChoice's individual market enrollment increased by about 256% between the end of 2013 (35,746 enrollees) and May 1, 2014 (127,388 enrollees).[15] These numbers do not include some late enrollees who received an extension of time at the end of the open enrollment period and who had not yet paid as of May 1.

GHMSI's Other Market Segments Are Competitive And Cannot Be Counted On To Increase Surplus. GHMSI has little pricing flexibility in the large group insured or self-insured markets. Those markets are highly competitive, and GHMSI must offer highly competitive rates and reduced administrative fees simply to retain existing business. GHMSI cannot increase large group rates or increase administrative fees merely because it wishes to build surplus; the end result of non-competitive prices in those markets would be a significant loss of membership and related revenue. Losses of large numbers of members in the self-insured or large group market segments would be financially inefficient – GHMSI's fixed administrative and technology costs would then be spread over a smaller pool of members and would impose even heavier burdens on the individual and small group markets.

The Affordable Care Act Has Imposed Incredible Additional Expenses On GHMSI, And Likely Will Continue To Do So. CareFirst and GHMSI spent well in excess of $100 million in 2013 alone on costs associated with implementation of the Affordable Care Act. These ongoing implementation costs will continue for many years, and many millions of dollars, more. These costs are in addition to other significant regulatory mandates, such as tightening privacy rules under HIPAA and complicated new medical coding rules mandated by ICD-10 coding, which will be required in 2015. In 2014 alone, CareFirst expects to spend more than $43 million that is directly attributable to ACA implementation costs.

Moreover, after the health insurance exchanges in each of GHMSI's jurisdictions "stumbled" following the October 1 start of open enrollment, CareFirst and GHMSI now will likely spend millions more in unexpected costs to mitigate the risks that consumers will not be able to use the health insurance exchanges as intended. The exchanges are an enormous and complicated technical enterprise being implemented for the very first time, on a very aggressive time scale, and requiring extensive coordination between the Department of Health and Human

[15] The individual market enrollment for BlueChoice now exceeds that of GHMSI, and it is expected that the surplus requirements for GHMSI arising from GHMSI's ownership of BlueChoice are similarly likely to grow.

Services, the Department of Labor, the Internal Revenue Service, the Office of Personnel Management, State insurance departments, and State health exchanges.

The unreadiness of the exchanges is forcing the company to implement numerous *ad hoc* solutions to problems such as implementation and administration of premium tax credits and cost sharing reductions, temporary enrollments and re-enrollments of members, and shifting payment deadlines, each of which generates additional expense and risk for GHMSI. In particular, as discussed above, Maryland is starting over with a new exchange for 2015, requiring a new implementation by GHMSI and BlueChoice on a very short time line.

Section IV
Conclusion

All of the above dynamics contribute to an environment in which (a) it is more likely than ever before that an insurer such as GHMSI will fail to secure adequate rates and (b) once rates are inadequate it will be harder than ever before to increase those rates to an adequate level. These market pressures must be combined with the additional downward pressures specific to GHMSI −namely, that (c) GHMSI, in an effort to benefit its subscribers in this transition period, has sought rate increases well below what the actuarial models suggest are necessary, and (d) GHMSI's RBC level is likely to drop on account of increased enrollment. With all of these factors, GHMSI faces a scenario where the company is facing unprecedented risks and the likelihood of a downward RBC spiral. It is unlikely that GHMSI will have significant opportunities to replace that lost surplus.

EXHIBIT 3

Milliman

District of Columbia

Department of Insurance, Securities and Banking

Public Hearing to Review the Surplus and Community Health Reinvestment of Group Hospitalization and Medical Services, Inc. April 29, 2014

Pre-Filed Testimony of Phyllis Doran, F.S.A., M.A.A.A.

Introduction and Background

I, Phyllis Doran, am a consulting actuary with Milliman and am presenting this testimony at the request of our client, CareFirst, Inc. I am a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries, and I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinions contained herein. I have been employed by Milliman as a Consulting Actuary working with health insurance plans for over 30 years. I have served as a board member and a vice president of the Society of Actuaries.

Milliman is among the world's largest independent actuarial and consulting firms. We have an outstanding reputation, and we are widely recognized in the health care industry as the premier actuarial firm, with 270 fully qualified health actuaries. We have worked for the majority of Blue Cross and Blue Shield Plans and other health insurance companies and performed numerous surplus evaluations in addition to advising companies on surplus related issues.

I am one of the authors of the May 31, 2011 Milliman report titled *"Group Hospitalization and Medical Services, Inc.; Development of Optimal Surplus Target Range".* This report, carried out at the request of CareFirst generally and its Group Hospitalization and Medical Services, Inc. (GHMSI) affiliate specifically, presents the results of an analysis of surplus requirements for GHMSI. The purpose of our analysis was to address the need for statutory surplus for GHMSI, including its ownership share of CareFirst BlueChoice, and to quantify an optimal surplus target range within which we believe the company should strive to operate, under normal circumstances.

Results of Milliman 2011 Analysis

At the time of our 2011 study, the Affordable Care Act had been passed the previous year and many of its most significant provisions would not be implemented for two to three years. The uncertainty regarding the impact of health care reform was addressed in our report and in our conclusions: Based on our 2011 analysis of surplus requirements for GHMSI, we concluded that an appropriate target for GHMSI's surplus falls in the range of 1050% to 1300% of RBC-ACL[1], taking into account the impact of federal health care reforms that had been implemented at that time. We also estimated that the surplus target range for GHMSI could be expected to increase by 100% to 150% of RBC-ACL, if the potential for adverse selection due to the future impact of the health care exchanges and other health care reform provisions not yet implemented were taken into account.[2]

We stand by these conclusions, noting that they were based on information available to us at the time of our analysis in 2011.

Rector & Associates, Inc. December 9, 2013 Report

In 2013, Milliman had communications with Rector & Associates, Inc. and their associated actuarial consultants (to be referred to collectively as "R&A" for purposes of this discussion) in connection with a review being conducted by R&A for the D.C. Department of Insurance, Securities and Banking (DISB). At the request of R&A we carried out certain calculations, utilizing Milliman's models while substituting specific parameters and factors provided by R&A, and we provided the results of these calculations to R&A.

R&A produced a December 9, 2013 report titled *"Report to the D.C. Department of Insurance, Securities and Banking; Group Hospitalization and Medical Services, Inc.".* In this report, R&A concludes that GHMSI should strive for a target surplus of 958% RBC and that GHMSI's surplus should be measured against a Benchmark Range of 875% -1040% RBC.

Comments on R&A Report

We have reviewed the R&A report and, based on a reading of the report and as a result of the modeling calculations we performed for R&A, we are familiar with the basis for

[1] RBC-ACL refers to the Risk Based Capital Authorized Control Level, a key reference value for the National Association of Insurance Commissioners (NAIC) risk based capital formula and a commonly accepted measure of surplus levels for insurance organizations.

[2] See "*Group Hospitalization and Medical Services, Inc.; Development of Optimal Surplus Target Range*", Milliman, May 31, 2011, page 5 and page 8, for discussion of the significant uncertainty regarding the potential impact of health care reform on GHMSI surplus requirements.

most of the assumptions R&A selected. With regard to those assumptions, we offer the following comments and observations:

1) **Target Surplus Range** – R&A selected a range consisting of the target surplus level of 958% of RBC +/- approximately 82.5 basis points. The 82.5 basis point variation reflects the average year to year change in GHMSI's surplus RBC percentage during the 2004 to 2012 period (page 13 of R&A report).

We would suggest a wider range, in order to minimize the disruption caused by the likelihood of routinely falling outside of the range over a two-year period.

As a practical matter, a very long lead-time is required to detect the causes of financial variance, correct for them in premium rates, and then realize the actual premium revenue associated with such premium rate corrective actions; consequently, we can expect a correlation year to year in the surplus change. The historical correlation can be illustrated by comparing the average two-year change in the RBC ratio to the 82.5 basis point average of one-year values tabulated by R&A. The two-year average for the same period is greater: 96.7 vs. 82.5 basis points.

Further, there is a not-insignificant probability that the change in surplus ratio year by year will be greater than the calculated 82.5 basis point average of such changes over the past few years. If surplus were at the target level in a given year, the potential for a change in excess of 82.5 basis points in the following year, plus the likelihood that the change for the subsequent year will be in the same direction, creates a high likelihood of routinely falling outside of the range over a two-year period. We note that over the 2004 to 2012 period analyzed by R&A the two-year change in the RBC ratio exceeded 82.5 basis points 4 times out of 7. If the period from 2000 to 2012 is considered, the result is 7 times out of 11.

Such a high frequency of this occurrence would be needlessly disruptive. We would suggest a wider range, such as twice the calculated average of 82.5 basis points.

2) **Health RBC Formula** – R&A asserts that *". . . the RBC formula was constructed with a high degree of conservatism embedded into the formula"* (found on page 13 of its report). We have seen no evidence in historical documents or practice that this assertion is correct.

It should also be noted that the District of Columbia has strengthened its RBC formula in the recent past, increasing the Company Action Level from 200% to 250% when certain adverse financial conditions are present (the so-called Trend Test).

3) **Medical Loss Ratio Rebate Requirements** – R&A states that it has not included the effect of medical loss ratio (MLR) rebate requirements that were

enacted by health care reform, arguing that doing so is unnecessary and would complicate the analysis. While the magnitude of the impact of the MLR rebates may be expected to be low under many scenarios, we believe it is nevertheless important to assess this impact based on GHMSI's business characteristics by reflecting it in the modeling.

This issue is important to recognize because the rebate requirements serve to directly limit surplus accumulation and recovery. In the past, if a health plan experienced adverse financial results in one segment of business, there was often potential for gains in another segment, helping to offset financial losses. Under the MLR rebate requirements now in effect, the potential for such offsetting gains in another segment has been minimized or eliminated, increasing the chance of net underwriting losses for the company as a whole and limiting the company's ability to accumulate surplus when necessary.

R&A indicates that trend and catastrophic losses between lines of business and regions are closely correlated, making it unlikely that one region or line of business could experience favorable results while other regions or lines of business experience unfavorable results. However, there are factors specific to particular lines of business -- including adverse selection, competition, and degree of regulatory restrictions on rates -- that will likely produce varying results across segments of business. This is particularly true under health care reform. While we agree that the modeling of this impact adds complexity, and that any such modeling will have its limitations, we believe that an attempt should be made to recognize its potential effect on surplus requirements.

4) **Trend and Rating Projections** – In describing Milliman's approach to reflecting expected trend variability, R&A states that Milliman ". . . assumed that trends are independent from one year to the next" (page 22). In fact, Milliman assumed that each ***loss cycle's*** trend is independent of prior periods, and that each year's ***trend within a loss cycle*** is the same (i.e., it is treated as being fully dependent). This approach was incorporated as a simplification of the more complicated calculation that R&A suggested, reflecting year to year correlation. Our approach produces results very similar to those produced by the correlation approach suggested by R&A.

The report also describes Milliman's trend miss assumption as "the projected period of time that GHMSI's actual trend differs from its anticipated trend before GHMSI makes adjustments to its trend assumption" (page 19). We wish to clarify that Milliman's assumption is that GHMSI does make changes prior to the end of this period, but due to rating cycle delays and imperfect information the changes do not fully compensate for the differences between actual and anticipated trends during the period.

5) **Premium Rate Restrictions** – R&A asserts that it is not appropriate to assume that regulators will restrict needed premium rate increases requested in premium

rate filings, especially in scenarios where GHMSI is in a financially difficult situation.

We agree that if the company is clearly in serious difficulty, the regulator will act accordingly. In the loss scenarios that form the basis for our modeling, however, severe financial difficulty does not manifest itself early in the cycle. The delay from the initial development of adverse financial experience patterns to the realization of any favorable impact of resulting corrective actions can and often does take two years or more. This is a consequence of normal lags in claims reporting, the potential for routine experience fluctuations and other changes that can mask emerging patterns, and the advance notice and, in some cases, regulatory review requirements that delay the realization of necessary premium increases. Restriction of premium rates below what is actuarially required, even when the company appears to be financially healthy, has the potential to exacerbate or even cause future financial difficulties.

6) **Provision for Catastrophic Events** – Milliman's analysis reflected a baseline provision plus a contingent provision for catastrophic events in all scenarios. R&A eliminated the baseline provision.

The selection of such assumptions requires a considerable degree of judgment. As noted by R&A, data to support such modeling for health insurers has not been captured or reported. Further, this provision is intended to encompass events that may not have recently occurred and therefore cannot be measured (e.g., extreme pandemics, natural disasters or terrorism events), or even events that may have not been envisioned – so-called "unknown unknowns" – perhaps resulting from the occurrence of multiple events simultaneously.

Catastrophic events could be truly devastating medically, operationally, and financially – to the community and to GHMSI. We believe it is critically important to ensure adequate provision for such events in surplus, for the benefit of these parties.

We also note that R&A makes multiple references to "charges" with respect to Milliman's provision for catastrophic events. For example: "a 2.5% charge in 7.5% of its modeling outcomes and a 7.5% charge in 2.5% of its modeling outcomes" (page 24). These values represent potential adverse financial outcomes that are tested in our modeling, and do not reflect charges to surplus.

7) **Provision for Unidentified Development and Growth** – In its development R&A appears to have considered the unidentified development component but not the unexpected growth component of this risk element.

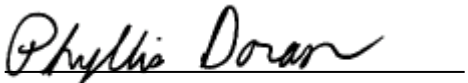
With regard to unidentified development expenses, the R&A report cites a 9% health insurance industry average annual growth rate in non-admitted assets attributable to electronic data processing (EDP) expenditures between 2003 and

2012 as the foundation for its assumption. This growth rate is substantially lower than the 20% experienced by GHMSI between 1998 and 2012.

R&A does not cite its data source or methodology for compiling this industry average statistic, but in our experience there is no sound basis for establishing such a value on an industry-wide average basis. Non-admitted assets are financial reporting items, the treatment of which may be handled differently by various companies based on their financial structures. For example, a company may lease or own EDP assets – if owned, the assets may be held within the entity or in an upstream or downstream subsidiary or affiliate. In addition, reporting practices for non-admitted assets often vary by state due to regulatory differences. Further, non-admitted assets attributable to EDP expenditures are only one of many types of development costs that may arise unexpectedly.

Unexpected surges in enrollment are also a significant component of this risk element – so called "surplus strain" from growth. This uncertainly has always existed, but is even more of a consideration with ACA marketplace and rating provisions in place.

Overall, we would expect that Rector's results would be closer to those in Milliman's 2011 report if these comments were incorporated by Rector; and, as indicated earlier, we continue to stand by the results produced in our 2011 study as representing an appropriate target surplus range for GHMSI based on information available to us at the time of the study.



Phyllis A. Doran, FSA, MAAA
Principal and Consulting Actuary

EXHIBIT 4

Chet Burrell
President and Chief Executive Officer

CareFirst BlueCross BlueShield
1501 S. Clinton Street, 17th Floor
Baltimore, MD 21224-5744
Tel: 410-605-2558
Fax: 410-781-7606
chet.burrell@carefirst.com

CareFirst BlueCross BlueShield

April 11, 2013

The Honorable Therese Goldsmith
Insurance Commissioner
Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, MD 21202

Dear Commissioner Goldsmith:

As mentioned in our letter and accompanying report to you earlier this week, CareFirst has evaluated ways to moderate the premium rate increases for individual subscribers we filed with the MIA on April 1, 2013. Our goal is to lessen the blow for the over 50,000 individuals currently subject to the new ACA premium rating and benefit coverage plan requirements that go into effect on January 1, 2014.

Specifically, we have developed an alternative scenario that assumes a lower level of illness among the new entrants in the new individual community rated pool than was assumed in the April 1 filing. Under this alternative scenario, we have assumed the rise in 2014 in the illness level in the individual pool would be 25 percent, not the 53 percent assumed in our April 1 filing.

This change causes the overall average premium rate increase in the individual market on January 1, 2014 to be about 25 percent – down from the approximate 55 percent increase in our April 1 filing. The amended filing reflecting this alternative scenario is being sent to your office separately. See Exhibit 1 which shows the impact of this on an average 42 year old.

When taking the long view over the three year period envisioned by the ACA for transition (2014-2016), we believe it is critically important to recognize that individual rates will ultimately move up and conform more closely to the rates in the guaranteed issue small group market in Maryland. Today, small group rates are twice individual rates and this gap will inevitably close materially. This is shown in Exhibit 2 attached.

So, while this amended filing enables lower starting premium rates in 2014, it will almost certainly mean that rates in 2015 and 2016 will have to rise by similar percentages (25 percent) in each of these two subsequent years assuming the characteristics of the pool eventually come

to closely match the small group pool over a three year period. But, this alternative lower starting point gives a chance to assess results as they emerge before subsequent changes are made.

On the other hand, if the new individual risk pool turns out to look more like that assumed in our original filing (i.e., the 53 percent increase in the illness level of the pool actually occurs in 2014), CareFirst will experience significant underwriting losses in the $40-45 million range before the impact of the ACA's risk adjusters and risk corridors are felt the following year (2015). These tempering ACA features could reduce such a loss to the $20-25 million range by the time all is known in mid to late 2015. If experience is better than assumed in our April 1 filing, this can be taken into account.

Since so much is based on assumption, we believe that starting with premium rates lower than those we filed on April 1 holds a better chance of attracting healthier and younger individuals and that this could have a large bearing on the subsequent characteristics of the risk pool.

It is certainly worth noting that actual experience could be worse than assumed in the April 1 filing. If the illness level in the new individual pool turns out to be 70 percent above the current level, then the losses will be in the $105-115 million range, or $35-40 million after the impact of risk corridors and risk adjusters.

Other observations about the process and timing of rates are of note as well. Since the reinsurance and risk corridor features in ACA will be phased out by the end of 2016, the financial risks to the company will increase as we go forward in time. Premium rates for 2015 will be set well before we know 2014 results, so steep losses in the first year of ACA could produce steep losses in the second and third years – with less protection – even if every aspect of the ACA risk adjusters, risk corridor and reinsurance framework were to work correctly.

It is worth keeping in mind that losses in the "25 percent" and "70 percent" scenarios would be incurred on less than five percent of our total enrollment, putting great pressure on obtaining positive results on the rest of our business – by no means a sure thing.

It must also be stressed that the more individual rates are below small group rates in 2014, the more likely are the prospects that the small group market will begin to atomize as groups decide to free their members to shop on the individual State Exchange. Should this dynamic gain strength in 2014 heading into 2015, it will be very difficult to plan a course through the ensuing swirl. And, if people leave groups in the first or second years of ACA on the belief that there is a price advantage only to find it evaporates in the third year, the discontent and disruption among subscribers could be widespread.

The risks, therefore, are very substantial. Nevertheless, we are so deeply concerned with the impact of our original filing on our individual subscribers that we seek to pursue the lower rates in the amended filing that we are submitting.

We would note that we have long subsidized rates for individual subscribers – particularly in recent years as premium rates have risen in response to the rise in health care costs. Our financial results in the under age 65 individual market over the past five years have been distinctly negative, with a cumulative underwriting loss of approximately $50 million in this segment during this period. We have always considered this to be a form of community health

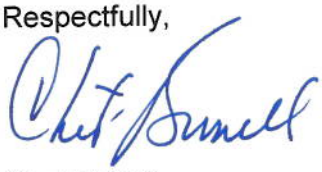
reinvestment in addition to the other forms of community giving we have undertaken in the last five years.

While the stakes are high, we believe that we must take this action on behalf of the community and subscribers we serve. This will likely reduce and put a strain on the Risk Based Capital (RBC) resources we hold for our subscribers' protection. Our RBC level is already below the optimal range, but we believe this is in the best interest of our subscribers and is the best use of this capacity under the circumstances.

We will monitor the emerging experience closely. We wish to work with you and other State policymakers to best serve the worthy goals of the ACA and fulfill our own statutorily given mission.

We ask, therefore, that you accept our amended filing for individual under age 65 members as the basis for your review of our proposed premium rates for ACA coverage plans to take effect on January 1, 2014, instead of those filed on April 1. As noted, these amended rates are being transmitted to you.

Respectfully,



Chet Burrell
President and CEO
CareFirst BlueCross BlueShield

Exhibit 1: Amended Filing 4/11/13 – Proposed Individual Filed Premium Rates Effective 1/1/14 in Maryland – On/Off Exchange – Age 42

CareFirst

Platinum

$377/month [amended]
$493/month [4/1]

HealthyBlue Platinum $0 (.88 AV)
Point of Service
$0 deductible
$0 PCP/$30 Specialist; Hospital: $150 per day
Rx: $0/$0/$45/$100/$200
Out-of-pocket maximum: $2,000
Wellness Incentive

$421/month [amended]
$504/month [4/1]

BluePreferred Platinum $0 (.89 AV)
PPO
$0 deductible
$20 PCP/$30 Specialist
10% coinsurance after deductible;
Rx: 20%/20%/30%/50%/50%
Out-of-pocket maximum: $1,800

Gold

$299/month [amended]
$391/month [4/1]

BlueChoice Gold $0 (.79 AV)
HMO Lock-In
$0 deductible
$20 PCP/$30 Specialist
30% coinsurance
Rx: 20%/20%/30%/50%/50%
Out-of-pocket maximum: $6,350

Multi-state plan

$326/month [amended]
$391/month [4/1]

BluePreferred Gold $500 (.79 AV)
PPO
$500 deductible
$30 PCP/$40 Specialist
20% coinsurance after deductible
No first dollar coverage
Integrated Rx: 20%/20%/30%/50%/50%
Out-of-pocket maximum: $3,750

$267/month [amended]
$349/month [4/1]

BlueChoice Gold $1,000 (.78 AV)
HMO Lock-In
$1,000 deductible
$20 PCP/$30 Specialist
10% coinsurance after deductible
First dollar: PCP, urgent care, preferred generics
Integrated Rx (Tiers 2-5): 10/20%/30%/40%/40%;
Out-of-pocket maximum: $3,750

$324/month [amended]
$423/month [4/1]

HealthyBlue Gold $1,500 (.80 AV)
Point of Service
$1,500 deductible
$0 PCP/$40 Specialist
Hospital: $450 per day after deductible
First dollar: PCP, DXL, urgent care, ER, generics; Separate $400 Rx deductible (Tier 3-5): $0/$0/$45/$200/$200;
Out-of-pocket maximum: $3,250
Wellness Incentive

Silver

$234/month [amended]
$305/month [4/1]

BlueChoice HSA Silver $1,300 (.70 AV)
HMO Lock-In
$1,300 deductible
$30 PCP/$40 Specialist
20% coinsurance after deductible
No first dollar coverage
Integrated Rx: 20%/20%/30%/50%/50%
Out-of-pocket maximum: $6,350

Multi-state plan

$259/month [amended]
$311/month [4/1]

BluePreferred HSA Silver $1,500 (.68 AV)
PPO
$1,500 deductible
$30 PCP/$40 Specialist
30% coinsurance after deductible
No first dollar coverage
Integrated Rx: 20%/20%/30%/50%/50%
Out-of-pocket maximum: $5,500

$236/month [amended]
$308/month [4/1]

BlueChoice Silver $2,000 (.69 AV)
HMO Lock-In
$2,000 deductible
$30 PCP/$40 Specialist
20% coinsurance after deductible
First dollar: PCP, urgent care, preferred generics
Integrated Rx (Tiers 2-5): 10/20%/30%/40%/40%
Out-of-pocket maximum: $6,350

$244/month [amended]
$318/month [4/1]

BlueChoice Plus Silver $2,500 (.70 AV)
Point of Service
$2,500 deductible
$20 PCP/$40 Specialist
20% coinsurance after deductible
First dollar: PCP, urgent care preferred generics
$400 separate Rx: $10/20%30%/40%/40%
Out-of-pocket maximum: $6,350

Bronze

$198/month [amended]
$237/month [4/1]

BluePreferred HSA Bronze $3,500 (.62 AV)
PPO
$3,500 deductible
$30 PCP/$40 Specialist
20% coinsurance after deductible
No first dollar coverage
Integrated Rx: 20%/20%/30%/50%/50%
Out-of-pocket maximum: $6,350

$156/month [amended]
$204/month [4/1]

BlueChoice HSA Bronze $4,000 (.60 AV)
HMO Lock-In
$4,000 deductible
$30 PCP/$40 Specialist
30% coinsurance after deductible
No first dollar coverage
Integrated Rx: 20%/20%/30%/50%/50%
Out-of-pocket maximum: $6,350

$180/month [amended]
$235/month [4/1]

BlueChoice Plus Bronze $5,500 (.62 AV)
Point of Service
$5,500 deductible
$35 PCP/$45 Specialist
20% coinsurance after deductible
First dollar: PCP, urgent care preferred generics
Integrated Rx (Tiers 2-5): $10/20%/30%/40%/40%
Out-of-pocket maximum: $6,350

$150/month [amended]
$196/month [4/1]

BlueChoice HSA Bronze $6,000 (.58 AV)
HMO Lock-In
$6,000 deductible
$0 PCP/$0 Specialist
No charge after deductible
No first dollar coverage
Integrated Rx: No charge after deductible
Out-of-pocket maximum: $6,000

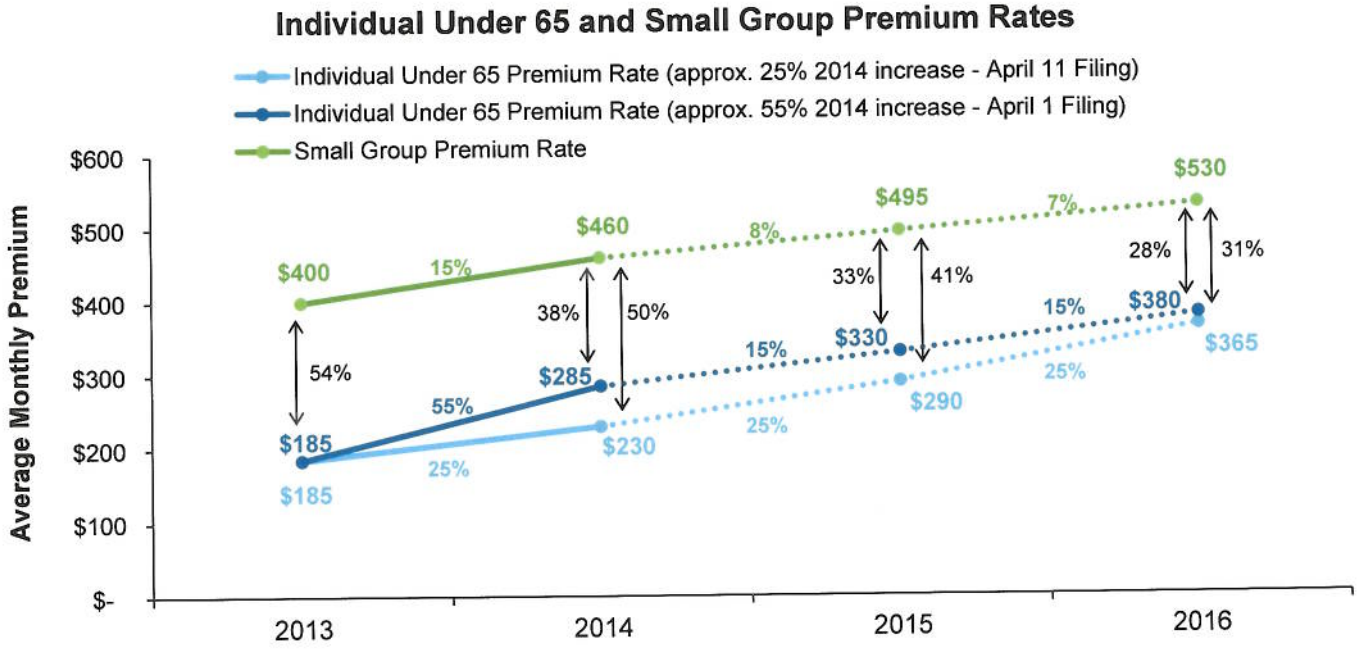
$96/month [amended]
$127/month (Age 25) [4/1]

BlueChoice Young Adult (.60 AV)
HMO Lock-In
$6,350 deductible
$0 PCP/$0 Specialist
0% coinsurance
Rx: No charge after deductible
First dollar: 3 office visits
Out-of-pocket maximum: $6,350
(Catastrophic Plan – available to under age 30 only)

NOTE: Filed premium rates for Maryland, effective 1/1/14 for individual age 42 non-smoker, living in the Baltimore metropolitan area. Benefits listed are for in-network services only. Out-of-network services have greater cost sharing or may not be covered at all.

Exhibit 2: Average Individual Under 65 and Small Group Premium Rates: 2013-2016

- Over time, the individual risk pool will look more like the guaranteed issue pool of the small group market in resulting in underlying pmpm allowed claims costs that converge.
- As a result, the differences in premium rates between the individual and small group markets will narrow.
- The remaining premium gap results from small groups typically buying benefit plans with less cost sharing than individuals.



NOTE: Premium rates and year-over-year growth rates are rounded.