EXHIBIT 5

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

May 31, 2013

Commissioner William White
D.C. Department of Insurance, Securities and Banking
810 First Street, NE, Suite 700
Washington, DC 20002

Dear Commissioner White:

Today, CareFirst has filed rates (through its Group Hospitalization and Medical Services, Inc. affiliate and CareFirst BlueChoice subsidiary) in response to regulations promulgated under the Affordable Care Act (ACA) and the District of Columbia. This letter supplements the actuarial memoranda required in health insurance rate filing procedures, and provides a brief perspective on the impact of proposed rates on our non-grandfathered Individual Under Age 65 and Small Group members.

As per the request of the Department of Insurance, Securities and Banking ("DISB") and the D.C. Health Benefit Exchange, the filed rates assume that the Individual and Small Group risk pools are combined – a mandate that significantly impacts premiums. The filed rates contain an average 35 percent increase for current Individual members and a twelve percent increase for current Small Group customers. We will file a supplemental report next week that puts in perspective the rationale for these filed rates and the expected impact on our non-grandfathered Individual Under Age 65 members and Small Group members.

Actuarial models suggest that an average rate increase of 60 percent or more may be needed to achieve financial break-even in providing nearly 8,000 ACA-eligible (non-grandfathered) Individual CareFirst members with benefits that comply with all ACA and D.C. Exchange requirements. However, the lower 35 percent rate increase request we have filed is driven out of our concern for the impact on our current subscribers and in fulfillment of our not-for-profit mission. As you are aware, CareFirst's current, pre-ACA premium rates in the Individual market are already substantially inadequate, resulting in significant financial losses that we are currently incurring - most particularly due to the losses we absorb as the only offeror to members in the high risk D.C. Open Enrollment Program.

We expect to continue to incur substantial losses on these newly filed rates despite the filed increases. In our filing, we expect that Open Enrollment members, who have an average medical risk profile that is three times worse than the average medically underwritten member, will be dispersed among all the carriers participating on the D.C. Exchange. If it turns out that an overwhelming proportion of Open Enrollment members remain with CareFirst, our Individual market losses could exceed $10 million in 2014 alone. While we are prepared to absorb some losses in the short term, such losses are unsustainable over the long term and rates would need to increase substantially in future years to enable us to simply cover costs.

While a portion of the average 35 percent increase in rates is attributable to a number of factors such as the greater projected illness level in the new ACA risk pool, guaranteed issue requirements, and various other technical actuarial and rating rules required under ACA, the majority of the increase is the result of policy decisions made by the DC Exchange Board: Combining the previously medically underwritten and open enrollment Individual pool with the guaranteed issue Small Group pool has a severe adverse rate effect on individuals seeking coverage. Prior to reinsurance recoveries, about 25 percent of the 35 percent increase is the result of merging the Individual and Small Group risk pools. These rates also reflect an estimated 7 percent increase for medical trend – a lower trend than the past several years. For this reason, we have repeatedly advised against the full and immediate merger of the Individual and Small Group markets. Nevertheless, this is what the DC Exchange requires.

We also reiterate our concern that closing the off-Exchange marketplace for small employer groups will decrease employer and individual choice as well as affordability. We continue to believe that the policy decision to transition to a closed (i.e., on-Exchange only) market should come only after thoughtful consideration of the actual experience emerging from the dramatic changes that will result from ACA and District rules.

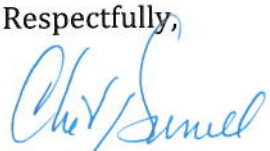
Beyond the costs associated with the Exchange Board's policy decisions, Individual premiums will be impacted by the age of the member as well as their plan design and family status. The 35 percent average that has been filed embodies a wide range of rate impacts which range from small decreases (for a few) to increases of 150 percent or more for others. In general, younger members will be the most adversely impacted. These are the very people most needed in the new ACA risk pool to moderate and stabilize premiums going forward.

CareFirst strongly supports the key objective of ACA – to help many thousands of people gain access to health care through Medicaid expansion or subsidies through the District's Health Benefits Exchange. Unfortunately, as our filing shows, the reality is that our compliance with ACA and District rules will cause many current CareFirst members to experience dramatic increases in premiums and out-of-pocket expenses, and to have far fewer choices in health plans. Relatively few (less than 1 in 7) of our current members are likely to qualify for meaningful subsidies. As a result, most will feel the full brunt of the increases, and we expect substantial subscriber dissatisfaction. This will be described more fully in the to-be-submitted report. We are deeply concerned about these impacts on our existing members in the District and regret the filings we are required to make today.

We further hope that the public disclosure of the rate filings of each of the carriers is done in a manner that allows for meaningful comparison - by product and metal level - across carriers of the actual proposed premiums. This will help to avoid the significant confusion experienced in other jurisdictions where such comparisons were rendered impossible in an understandable way.

As a not-for-profit insurer, we are committed to our mission of offering access to affordable, quality health plans. To this end, we have filed rates on which we expect to lose substantial sums in an attempt to mitigate even higher increases than those we have filed. An analysis will be forwarded within a week to your attention that seeks to explain more fully why and how we see the combined effect of ACA and DC requirements impacting rates in such dramatic fashion.

Respectfully,



Chet Burrell
President and CEO
CareFirst BlueCross BlueShield

Attachment

CareFirst

Report Accompanying CareFirst Coverage Plan and Rate Filings in the District of Columbia Pursuant to the Affordable Care Act –

May 31, 2013

CareFirst, Inc.

Submitted June 11, 2013

Report Accompanying CareFirst Coverage Plan and Rate Filings
in the District of Columbia Pursuant to the Affordable Care Act
May 31, 2013

Introduction

On May 31, 2013, CareFirst filed proposed rates and coverage plans for individual and small group subscribers in the District of Columbia, in response to regulations promulgated under the Affordable Care Act (ACA) and District of Columbia law. This report provides additional analysis on how these new ACA plans and rates are likely to impact current and future subscribers.

The Affordable Care Act seeks to improve the affordability and accessibility of health insurance by expanding Medicaid, reforming the individual and group market, offering qualified health plans via state health insurance marketplaces, and making qualified health plans affordable through premium and cost-sharing subsidies. The ACA's guaranteed issue provisions require carriers to accept every employer and individual in the District of Columbia that applies for coverage, regardless of health status. The ACA – and policy decisions of the DC Exchange Board and 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, CareFirst 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. There are approximately 42,000 uninsured individuals under age 65 in DC. Today, CareFirst provides coverage to approximately 10,700 DC residents under age 65 who buy policies directly (not as part of an employer group). The company also provides coverage to another 2,500 individual purchasers through the DC Open Enrollment program – the District's high-risk pool – for those who were denied coverage by carriers due to their higher illness levels.

Additionally, CareFirst provides coverage to over 76,000 members through 4,300 DC small employers (those under 50 employees in size), and is the largest health insurance carrier in the region in the individual under age 65 market segment as well as in the small group market in DC.

The CareFirst filing made on May 31, 2013, strictly conforms to ACA rules and requirements. Actuarial models suggest that an average rate increase of 60 percent or more would be needed to achieve financial break-even in providing 7,800 ACA-eligible individual CareFirst members with benefits that comply with all ACA and DC Exchange requirements. The 35 percent average rate increase actually requested by CareFirst is driven out of concern for the impact on our current subscribers and in fulfillment of our not-for-profit mission. As you are aware, CareFirst's current, pre-ACA premium rates in the individual market are already substantially inadequate, resulting in significant financial losses that we are currently incurring, most particularly in the high risk DC Open Enrollment Program. Our losses for this small population were $7M in 2012 alone.

We are deeply concerned with the impact that ACA and DC requirements will have on our existing subscribers who buy policies individually. Unfortunately, complying with ACA and District rules will cause many current CareFirst members to experience dramatic increases in premiums and out-of-pocket expenses, and have fewer choices in health plans. As a result, we expect substantial subscriber dissatisfaction as described in this report.

Faced with this situation, we have filed rates on which we expect there is a high likelihood that we will lose substantial sums in an attempt to mitigate even higher rate increases than those we have filed. The remainder of this report seeks to explain more fully why and how we see the combined effect of ACA and DC requirements impacting rates in such dramatic fashion.

Overview of Plans and Prices Filed on May 31, 2013

CareFirst has filed 15 plan designs for the individual under age 65 market on the DC Health Benefits Exchange. The filing includes offerings by both CareFirst operating affiliates licensed in the District – Group Hospitalization and Medical Services, Inc. (GHMSI) and CareFirst BlueChoice, Inc. (BC) – on all metal levels (Platinum, Gold, Silver and Bronze). A summary of these proposed plan designs and a guide to plan features are shown in Exhibit 1 on pages 15-17 of this report. A comparison of key plan features across metal levels is summarized in Exhibit 2 below.

Exhibit 2: General Plan Characteristics by Metal Level
40 Year Old (Average Age Subscriber)

Plan Characteristics	Platinum (2 Plans)	Gold (4 Plans)	Silver (4 Plans)	Bronze (4 Plans)
2014 Monthly Premium	$371 - $457 Midpoint: $414	$277 - $367 Midpoint: $322	$238 - $295 Midpoint: $267	$166 - $232 Midpoint: $199
Deductible	$0 Deductible	$0 - $1,500	$1,300 - $2,500	$3,500 - $6,000
Out-of-Pocket Maximum	$1,800 - $2,000	$3,175 - $6,350	$5,500 - $6,350	$6,000 - $6,350
Cost-Sharing	• Low coinsurance levels of 0%-10%	• Coinsurance levels vary between 0%-30%	• Coinsurance levels vary between 20%-30%	• Coinsurance levels vary between 20%-30%
First-Dollar Coverage (services not subject to a deductible)	• Both plans have first dollar coverage (no deductible required for any service)	• First dollar coverage in most plans for a broad array of services	• First dollar coverage in some plans for specific services (i.e., PCP visits, urgent care and preferred generics)	• No first dollar coverage for most plans (all services are subject to a deductible first)
Integrated medical/drug deductibles	• No deductible for any plan	• Several plans have integrated medical/drug deductibles	• Most plans have integrated medical/drug deductibles	• All plans have integrated medical/drug deductibles
Network Choice	Each metal level offers at least 2 plan types (HMO Lock-In and PPO). Bronze, Silver and Gold metal levels also offer a Point of Service plan, where members can choose between accessing care from the HMO network with lower cost sharing or the broader PPO network with higher cost sharing.			
HSA	• No HSA plans	• No HSA plans	• HSA available for some	• HSA available for some

Hybrids of these plans were also filed that contain different member cost-sharing amounts (i.e., deductibles, coinsurance and/or copayments) for different income levels on the Silver metal level as required under ACA rules. Special plan versions for American Indians and other special offerings as required by Federal law and rule are included.

We have also filed 54 proposed plan designs for DC's Small Business Health Options Program (SHOP) Exchange. Here, too, hybrids have been filed as required by ACA.

Since ACA disruption in the small group market (employers with under 50 employees) will not be as great as in the individual under 65 market, the thrust of the discussion that follows relates to the individual market segment since it will experience the brunt of the ACA impact.

Characteristics of CareFirst's Current Members and Products in the Individual Under Age 65 Market Segment in DC

Nearly 80 percent of CareFirst current individual under age 65 subscribers were either previously uninsured or lost group coverage before joining CareFirst. Only 5 percent of individual subscribers in DC are age 25 or younger; one-quarter are 50-64 years of age. Seven out of eight DC members (87 percent) are enrolled as single subscribers while only one in eight (13 percent) are covered by family or subscriber/spouse policies.

On average, those covered remain in the pool for just over three years and, when they discontinue their coverage, about one-quarter of them become uninsured. The primary reason given is that they can no longer afford the premiums.

Of the members enrolled with CareFirst:

- 24 percent recently took a new job that does not offer health insurance
- 23 percent recently became self-employed
- 15 percent recently became unemployed
- 14 percent moved from another individual carrier that raised its rates
- 13 percent accepted a new job and chose not to take the health insurance offered

Thus, the individuals currently served by CareFirst are typically experiencing some form of transitional status and are extremely price sensitive. The income distribution of this population is, however, more skewed to the mid-upper end of the income scale than is the uninsured population in DC in general as shown in Exhibit 3 below.

Exhibit 3: Subsidy Eligibility of Uninsured and CareFirst's Under Age 65 Individually Insured in DC

Federal Poverty Level (FPL)	Uninsured		CareFirst ACA Impacted Population	
	Population	Distribution	Population	Distribution
Under 200%	28,000	66%	2,200	28%
200%-250%	3,000	7%	800	10%
250%-300%	1,000	3%	400	5%
300%-400%	3,000	7%	800	10%
400%+	7,000	17%	3,600	47%
TOTAL	42,000	100%	7,800	100%

CareFirst's individual members most commonly purchase plans with deductibles of $1,200-$2,700 and annual out-of-pocket limits of $2,800-$3,200. Only six percent of members are enrolled in a plan with a deductible above $3,000. Enrollment is heavily skewed toward PPO designs, with approximately 70 percent of members having PPO plans while only 30 percent have HMO plans. Enrollment is also skewed toward plans with copayments (58 percent) rather than coinsurance (42 percent). The most popular plans have separate copayment-based prescription drug benefits (not integrated with the medical drug deductible). Typically, comprehensive maternity is not a covered benefit in these plans.

In contrast, CareFirst's 1,800 non-grandfathered open enrollment members today have HMO benefits with very low cost-sharing – $0 deductible, $10 PCP and $20 specialist copays, and a $2,500 out-of-pocket maximum.

Proposed ACA Plans for the Individual Market in DC

Each newly filed CareFirst plan proposed for the individual market in DC fully conforms to the highly prescribed plan design and coverage requirements set forth in the ACA and as further elaborated in Federal rules and regulations that have been promulgated to implement the ACA to date.

All 2014 filings are for new plans (not modifications of existing plans) because of the materiality of the changes that ACA requires. This includes changes in the scope of covered services, the types and levels of cost sharing compared to current offerings, and the methodology for premium rating. There are additional District-driven changes to rates resulting from the merger of the individual and small group risk pools. Finally, all filed plans are guaranteed issue as required by ACA, and not medically underwritten.

Changes in Risk Pool – The Key Driver Behind Filed Premium Rates

CareFirst's rate filing is largely based on assumptions about the morbidity – or illness level – of the people in the risk pool upon which the proposed premium rates are based. The individual current pool is largely comprised of healthy people who successfully passed medical underwriting review before they were accepted for coverage. We believe the morbidity level of a new individual pool including the open enrollment population will be nearly double the relatively favorable medically underwritten risk pool currently in place.

Having said this, the vast majority of the increase is the result of policy decisions made by the DC Exchange Board and City Council. Combining the previously separate underwritten and open enrollment individual pool with the guaranteed issue small group pool has a severe adverse effect on individuals seeking coverage as the morbidity of small group members is nearly double that of individual medically underwritten members.

More information follows about how these changes to the risk pool drive rates higher.

The effect of increased morbidity

One contributor to the rise in morbidity of the new risk pool is the introduction of people to the pool who are anticipated to have illness levels that are one-and-a-half to three times the current medically underwritten risk pool. We believe these new entrants will often be sicker and have more complications when they seek medical care. As a result, their care is likely to cost much more when they obtain coverage.

We also expect that some of these new entrants will be eligible for premium subsidies and out-of-pocket cost sharing reductions under ACA. The relationship among poor health, lower income and degree of workforce participation has been well established in a number of studies and was a key reason for the Affordable Care Act. CareFirst's own actuarial experience and data from independent analyses also suggests the lower the entrant's income, the greater the likely illness level.

For the purposes of the filing, CareFirst has projected that its enrollment could grow from 7,800 individual non-grandfathered members to 13,400 members with many of these new members generating claims costs that are significantly higher than that of current medically underwritten non-grandfathered members. That is, these new members would look more like those we currently insure in the small group market. In fact, by combining the far larger small group risk pool with the individual risk pool, the overall morbidity approximates that of small group. Of course, estimates of future enrollment and illness levels are uncertain, but a number of known factors influence our thinking.

- First, people now covered by the DC Open Enrollment HMO will become part of the risk pool in 2014. We have detailed knowledge of the costs and illness characteristics of this population since CareFirst has been the exclusive carrier for this Program since 2007. All open enrollment enrollees are CareFirst members and CareFirst bears the financial risk of insuring this population. Our filing reflects an expectation that open enrollment members, who on average have a medical risk profile that is nearly three times worse than the average medically underwritten member, will be dispersed among all of the carriers participating on the DC Exchange. If, instead, it turns out that more than half the open enrollment members remain with CareFirst, our individual market losses could exceed $10 million in 2014 alone.

- Second, while there will likely be an effort by the District to enroll younger, healthier people into the pool, we believe the new entrants will have risk characteristics and claim cost levels more characteristic of the guaranteed issue small group market in DC. We have significant historical experience with this population, and have reflected this in our rate filing.

We also project that over 5,000 new entrants into the individual segment will have been previously uninsured, underinsured or insured by an employer group and will have illness levels nearly double the current individual medically underwritten members. This is based on experience with the applicant flow we receive today in the individual market as well as knowledge of the risk pool characteristics of the small group market in DC.

To put this in clearer perspective, the average per member per month (pmpm) health care cost of a currently underwritten individual member is approximately $195 pmpm based on 2012 data, while small group members had a care cost of $370 pmpm. We assumed a cost of approximately $380 pmpm for the 3,800 new entrants who are expected to come from those uninsured with incomes over 200 percent FPL since they should reflect an already established community average in a guaranteed issue environment.

Taken as a whole, CareFirst assumes that the overall mix in the new combined pool will be similar to what is shown below in Exhibit 4. This mix will produce close to a 40 percent (on average) increase in the level of morbidity to the individual risk pool. The key driver of the increase in morbidity is the District's decision to merge the individual risk pool with the small group risk pool. Not only do small groups have nearly twice the morbidity of individual medically underwritten members, but we expect to have almost five times as many small group members as individuals in 2014. The morbidity of the merged pool could yet be even higher if there is a flight of underwritten individuals and a heavier emphasis on subsidized members.

Exhibit 4: Projected Risk Pool Characteristics

Projected 2014 CareFirst Individual Under 65 Market	Risk Score	12/31/2014 Projected Members (000s)	% of Total DC Risk Pool	Allowed Claims PMPM
1. **Current Non-Grandfathered Individual Medically Underwritten Members**	0.75	6.5	8%	$ 194
2. **Current Non-Grandfathered Non-Medically Underwritten Members** *Non-Grandfathered Open Enrollement HMO, HIPAA, and Group Conversion members.*	2.47	1.1	1%	$ 642
Non-Grandfathered Individuals Under 65 Subtotal	1.00	7.6	10%	$ 260
3. **Grandfathered Individual Members Choosing to Purchase on Individual Exchange** *Individual members including Medically Underwritten, HIPAA, Group Conversion, PPO Open Enrollment.*	2.39	0.4	1%	$ 622
4. **New Entrants with Incomes > 200% FPL Choosing to Purchase on Individual Exchange** *Risk profile that resembles the current Small Group market; may qualify for some subsidy through the Exchange.*	1.45	3.8	5%	$ 377
5. **New Entrants from Employer Groups Choosing to Purchase on Individual Exchange** *Individuals with risk levels comparable to those in the Small and Large Group markets.*	1.37	1.6	2%	$ 356
Grandfathered and New Entrants Individuals Under 65 Subtotal	1.50	5.8	8%	$ 390
Total Projected CareFirst 2014 Individual <65 Market	**1.22**	**13.4**	**17%**	**$ 316**
Projected 2014 CareFirst Small Group Market				
6. **Small Group Market** *Groups under 50 employees On and Off the Exchange (Grandfathered and Non-Grandfathered).*	1.42	63.6	83%	$ 369
Total Projected CareFirst 2014 DC Risk Market	1.38	77.0	100%	$ 360

Directly stated, our concern is that if the healthier members already covered by CareFirst do not stay in the pool in large numbers due to large premium increases and greater cost sharing in the new ACA coverage plans, or others who are at least as healthy are not attracted into the pool, the morbidity level in the pool will rise even more than it has already as a result of combining individuals and small groups into a single risk pool. CareFirst's analysis indicates that there is a greater probability that the morbidity of the individuals who actually come into the merged pool is likely to be 50 percent higher than the current (2013) non-grandfathered individual pool.

It is obvious that premium rates will depend on the mix of individuals and groups who enter the new merged pool. If there is a significantly lower representation of existing CareFirst underwritten individual members or new healthy entrants, and a significantly higher mix of open enrollment members or subsidy-eligible members, the results change adversely. There is no way to know in advance what the actual mix will be.

The ACA specifies a number of other changes in premium rate development and scope of covered services that impact pricing. It adds fees, taxes and assessments that must be included in premiums which, together with essential health benefits, add about six percent to premium rates. Exhibit 5 below details how the District's merger of the individual and small group risk pools coupled with these ACA-required changes cause a hypothetical $230 pmpm individual premium rate in 2013 to become a $310 pmpm premium rate in 2014 – an increase of 35 percent.

Exhibit 5: Model of ACA Impact on CareFirst DC Individual Under Age 65 Rates Across Entire Risk Pool

		% Change 2013-2014
2013 Average Rate (Hypothetical)	**$ 230**	
Merged Individual and Small Group Risk Pools	$ 62	27%
Rate Adequacy Adjustment*	$ 23	10%
Medical Cost Trend (7%)	$ 14	6%
ACA Fees & Essential Health Benefits	$ 13	6%
Reinsurance Recoveries	$ (32)	-14%
2014 Rate	**$ 310**	35%

*To bring to break-even from current losses

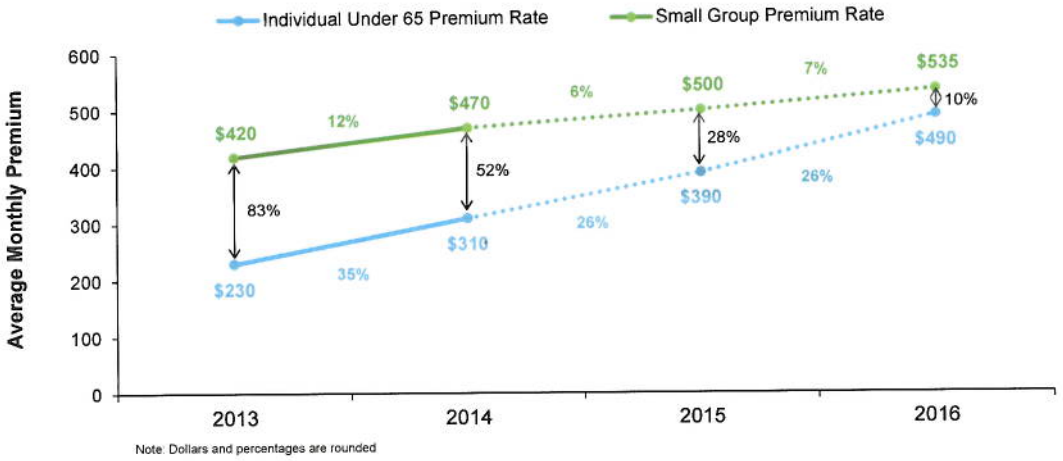
The effect of combining the individual and small group market

As is clear, a majority of the 35 percent proposed average rate increase for individual under 65 members is the result of merging the individual and small group risk pools. The proposed rates also reflect an estimated 7 percent increase for medical trend which, in part, is driven by the anticipated sicker population to be served. For this reason, we have repeatedly advised against the full and immediate merger of the individual and small group markets. Nevertheless, this is what District law now requires.

As a result of the single risk pool for individuals and small groups, individual premium rates will move closer to small group rates over time. Given that medical care costs per member per month used in the rate filings are substantially the same, disparities in future average rates will be solely due to differences in administrative expenses, contribution to reserve, propensity for groups to buy higher metal level products than individuals, and federal reinsurance reimbursements in the individual segment (which apply at progressively lower levels in 2014-2016).

In this regard, it is worth noting that the May 31 rate filing moves individual rates to an average of $310 pmpm in 2014 from $230 pmpm in the first quarter of 2013 as shown in Exhibit 6 on the next page. The average first quarter 2014 small group rate in the current filing is $470 pmpm compared to $420 pmpm in the first quarter of 2013. The dollar amount and percent rate increase for the individual segment is significantly larger than for small groups as the gap between the individual and small group rates narrows. Over time, the rates will be far more comparable. The impact of District law and ACA policy will be adverse for people who have bought plans individually if they are not subsidy-eligible.

Exhibit 6: Average Individual Under 65 and Small Group Premium Rates: 2013-2016



Note: Dollars and percentages are rounded

Proposed Filing Holds Five Types of "Shocks" for CareFirst Individual Subscribers in DC

As a result of the mandated ACA filings, many existing subscribers will see significant differences in the new offerings compared to current offerings. Exhibit 7 shows the current top products (and premium rates) that are most commonly purchased by individual CareFirst customers today and that account for nearly 80 percent of overall current individual under 65 enrollment that is not in grandfathered plans. The "shocks" that will be felt by these subscribers are outlined below.

Exhibit 7: Today's Most Popular CareFirst Non-Grandfathered Products Mapped to Most Similar 2014 Plan (DC)

Today's Product	% CareFirst Enrollment in DC	2013 Premium (Age 40)	Actuarial Value* & Metal Level	Most Similar 2014 Product	Premium for Most Similar 2014 Plan (Age 40)	Percent Change in Premium**	Actuarial Value & Metal Level
BlueChoice HMO Open Enrollment ($0 Deductible)	25%	$239	.88 Platinum	HealthyBlue Platinum $0	$371	+55%	.88 Platinum
BluePreferred HSA $2,700	20%	$135	.71 Silver	BluePreferred HSA Bronze $3,500	$232	+72%	.62 Bronze
HealthyBlue 2.0 $1,500	11%	$208	.81 Gold	HealthyBlue Gold $1,500	$327	+57%	.80 Gold
BluePreferred $1,200	8%	$169	.79 Gold	BluePreferred HSA Silver $1,500	$295	+75%	.68 Silver
BluePreferred $500	5%	$343	.84 Gold	BluePreferred Gold $500	$367	+7%	.79 Gold
HealthyBlue 2.0 $2,500	4%	$189	.76 Gold	BlueChoice Plus Silver $2,500	$260	+38%	.70 Silver
BluePreferred $750	3%	$324	.81 Gold	BluePreferred Gold $500	$367	+13%	.79 Gold
BluePreferred Saver $2,500	3%	$200	.67 Silver	BluePreferred HSA Bronze $3,500	$232	+16%	.62 Bronze

First, many individuals will experience "rate shock."

Under ACA, our proposed premium prices for new individual plans offered on the Exchange will apply to existing subscribers as well as new subscribers who come through the Exchange.

As already noted, CareFirst currently serves approximately 7,800 individual members in DC who will be impacted in 2014 by the new ACA plan and premium filings. These are under age 65 members who are not in grandfathered plans.

In order to conform to ACA rules and account for the risk pool dynamics described above, **the average filed premium for the new individual plans is approximately 35 percent higher than average rates in place today** in the individual market based upon projected enrollment, closely reflecting the rise in the illness level in the pool as well as the merging of the individual and small group risk pools as discussed previously.

These new, higher premiums will be a harsh blow to people who are already struggling with existing premium levels – the vast majority of whom will not receive Federal premium subsidies. But, this is the direct consequence of the application of ACA and District rules and requirements.

CareFirst serves another 5,300 individual members in DC – including 700 PPO open enrollment members – who are, today, in grandfathered plans that are shielded from these premium rate shocks. However, if these members seek coverage outside of the grandfathered pool, they will then expose themselves to these substantially higher premiums. We note that the grandfathered pool is closed to new entrants and will certainly experience future rate increases of its own due to the aging of those in this closed pool.

We would stress again that in filing new ACA plans and rates, the company seeks only to mitigate – not eliminate – its financial losses through the transition period 2014-2016. Indeed, we think – as noted above – that there is a substantial risk that we have underestimated the costs to come and could very well find ourselves with a material financial loss on these offerings, despite the risk protections included in ACA for carriers during the 2014-2016 transition period. Our surplus position in GHMSI (for the protection of policyholders) is already well below the optimal range. We expect it to decline even further – perhaps steeply – with the premium increases filed.

Second, there will be major "cost-sharing shock" for current members due to the far higher deductibles, coinsurance and out-of-pocket limits required in these plans.

Most CareFirst individual products sold today equate to Silver, Gold, or Platinum level plans under ACA rules. In sharp contrast, we project that about 75 percent of all future enrollment will likely be on the Bronze and Silver metal levels and 5 percent will be in the Catastrophic plan. Only 15 percent will enroll in Gold plans, and 5 percent will choose Platinum plans since the filed premium rates of the plans on these richer Gold and Platinum levels are simply beyond the financial reach of the vast majority of buyers.

In order to conform to very specific ACA driven actuarial value requirements, the new Bronze level plans carry $3,500 to $6,000 deductibles with prescription drug costs included in these large deductibles. Most of these plans also carry coinsurance at 20 or 30 percent rather than the modest copayments in more common use today. They also generally carry the highest out-of-pocket maximum limits allowed by ACA rules ($6,350 per individual) in order to keep deductible and/or coinsurance levels from being even higher. This results from the interaction between the actuarial value calculation requirements in Federal rules and the new, higher premium levels.

Most members will view this markedly higher cost sharing as significant decrease in coverage and increase in liability. The combined impact of premiums exceeding $4,000 per year and out-of-pocket maximums exceeding $6,300 per year will be seen as unaffordable and devastating by many. As referenced earlier, Exhibit 1 shows a summary view of May 31 plan filings by metal level.

Third, there will be "choice shock" for our individual existing subscribers since the number of plans available for choice will be limited.

Today, CareFirst members in DC have a choice of 21 plan designs with varying deductible and monthly premiums. As a result of ACA requirements, the number of plan designs has been reduced to 15 (i.e., only a few choices on each metal level). This will leave existing members with fewer choices of plan designs that fit their needs. If, as expected, members' plan selection is concentrated on the Bronze and Silver levels, they will only have 8 plans from which to choose.

Of course, other carrier choices will be available on the DC Exchange, but even here, there is likely to be a high degree of plan "homogenization" and standardization by metal level since all carriers are subject to the same ACA requirements. This may leave little differentiation in plan designs on each metal level.

The net effect, we believe, is that existing individual subscribers will see this very negatively: fewer plan choices with higher premiums and greater out of pocket costs. This will inevitably produce a scramble to find the lowest possible price across all carrier offerings – a price built almost wholly on assumptions that may or may not prove adequate.

Fourth, there will be "compulsion shock" since every current individual member not in a grandfathered plan will be required to switch to one of these new plans whether they want to or not.

Market research suggests that a vast majority of Americans believe they can stay in their existing coverage if they like it. This is simply not true. Every individual not in a grandfathered plan will be required by the ACA to move to a new ACA-driven plan at the renewal date of their current plan after January 1, 2014. As noted above, 7,800 CareFirst members will need to change plans.

These consumers will be forced out of their current coverage and will face an extremely unattractive choice:

- seek a price as close as possible to the premium price they are currently paying (which may not be achievable), but face substantial deterioration in coverage through far higher out-of-pocket expenses, or;
- seek coverage more comparable to what they currently have and be forced to pay far more for it.

Members will be extremely dissatisfied with paying more to receive less.

Fifth, there will be "subsidy shock" for the vast majority of individuals who will not qualify for meaningful help – through subsidies – with their new high premiums.

We estimate that one-quarter of current CareFirst individual members may be eligible for some level of subsidy on the District's Exchange, but that these subsidies will not be substantial enough to truly lessen the blow on the higher premium pricing they will face. Exhibit 8 (on the next page) shows the impact of subsidies on premiums for an average age 40 male member at different income levels.

Exhibit 8: Impact of Premium and Cost Sharing Subsidies by Income Level for BlueChoice Plus Silver $2,500 Deductible

$260 Monthly Premium[1]
$2,500 Annual Deductible
$6,350 Out-of-pocket Maximum

*Analysis assumes CareFirst's BlueChoice Silver $2,000 is the second lowest cost Silver plan with a premium rate of **$242 pmpm***

Federal Poverty Level	Annual Income[2]	Member Premium Cap as % of Income[3]	Unsubsidized Premium	Premium Tax Credit	Monthly Member Premium After Tax Credit[4]	% Change in Premium After Tax Credit	Annual Deductible After Subsidy	Out-of-pocket Maximum After Subsidy
200%-250%	$25,900	7.18% = $155	$260	$87	**$173**	-33%	$1,600	$5,200
250%-300%	$31,600	8.78% = $231	$260	$11	**$249**	-4%	$2,500	$6,350
300%-400%	$40,200	9.50% = $318	$260	$0	**$260**	-	$2,500	$6,350
400%+	$46,000	N/A	$260	N/A	**$260**	-	$2,500	$6,350

200%-250% FPL are eligible for both premium and cost sharing subsidies

[1] 40 year old non-smoker
[2] Annual income is based on the midpoint of the FPL range (225%, 275%, 350%)
[3] The premium cap percentage is defined by ACA on a sliding scale as a function of FPL. It is calculated based on the premium for the second lowest cost Silver plan in the market.
[4] Because the monthly premium for the BlueChoice Plus Silver $2,500 Deductible plan is $18 more than the second lowest cost Silver plan ($260 vs. $242), this difference is the responsibility of the member, irrespective of subsidy amount

This means that the overwhelming majority of existing individual members will feel the full brunt of the new required premium price levels. This will cause a scramble for alternative coverage or an impulse to simply drop coverage altogether because the tax penalty for no coverage is much more affordable than paying more for less coverage.

Thus, we are concerned that the actual impact of ACA on existing non-grandfathered individual members may cause some to choose to drop health care coverage altogether. If many of CareFirst's members classified as "good risk" (i.e., healthy) today drop coverage entirely or otherwise leave CareFirst coverage, the risk pool on which the rates are based will worsen, making the already much higher ACA rates quickly inadequate.

In short, we know from our own research and from the research of others that people with existing individual coverage simply do not expect the three things that are quickly coming that will impact them the most:

- the forced change in coverage plan,
- the high cost of premiums, and
- the high degree of out-of-pocket expense in the plan designs to be offered.

This will not go down easily. We expect it to cause a maelstrom of complaints and anger among our existing individual subscribers.

Beyond this, current product portfolios such as our HealthyBlue family of products that encourage – among other things – preventive services, a healthy lifestyle, use of generic drugs, a strong relationship with a primary care provider and care coordination when illness strikes – will be relegated to the high cost Gold and Platinum metal levels in which few will enroll. This is the direct result of ACA rules.

HealthyBlue has been the top selling product in the individual market across all carriers in the last two years. The nearly 1,400 individual members in DC now enrolled in the HealthyBlue product – who see it as a design for the future (as do we) – will likely be forced out of it by its new price. Among the new plans in our filing, HealthyBlue appears only twice: once at the Gold level and once at the Platinum level due to Federal actuarial value rules. ACA rules effectively price the HealthyBlue plans beyond the reach of all but the few more affluent subscribers. Indeed, some of the highest ACA driven rate increases will be among those currently enrolled in HealthyBlue.

Examples of ACA Coverage and Rate Impacts

Perhaps the clearest way to see the impact of ACA on individual subscribers is to show how it applies in a real world situation as illustrated in Exhibit 7 noted previously.

If a 40 year old male selects the plan that is most similar to what he has today, his rate increase in 2014 could range from seven percent to 75 percent depending on his choice and the product he is coming from. As a result of ACA rating rules, rate variations could be even wider depending on family size and the ages of family members. This pattern will shock and anger recipients of large rate increases.

It is certainly true, when put in perspective, that the 7,800 CareFirst members in DC impacted by our May 31 filings represent only a small portion of the entire population of individuals in the District who are targeted by ACA for coverage. If two-thirds of the 42,000 currently uninsured individuals in the District receive coverage through Medicaid and one-sixth are able to receive subsidies on the Exchange and, therefore, obtain access to healthcare coverage, it could be argued that the larger societal purpose of ACA has been served.

However, for many of the 7,800 individual CareFirst members who will feel the brunt of the "Five Shocks" listed above, this is small comfort. They did everything right, secured and paid for health insurance on their own and now will be hit in varying degrees by the shocks above.

Beyond the immediate impacts, we would offer a number of additional thoughts for policymakers as the District moves through the 2014-2016 transition period that ACA envisions. These are briefly outlined below.

The high out-of-pocket expenses in the new plans will almost certainly discourage access to care.

If, as expected, the most commonly chosen plans by individual subscribers will be Bronze and Silver because of the premium savings relative to higher-level plans on the Gold and Platinum levels, the substantial out-of-pocket expenses and high out-of-pocket maximums will be felt by subscribers who buy such coverage.

We know from experience that even far more modest cost sharing – well below what is in these new ACA plan designs – discourages access to needed services and has long-term consequences when health care breakdowns occur. The integration of pharmacy claims into the larger deductibles required at the Silver and Bronze levels will discourage the taking of needed medications – a serious problem that we are already dealing with even at the far lower cost sharing levels today.

Additionally, people with one or more chronic diseases who take multiple medications are particularly vulnerable to the reset of deductibles each year. The treatment of their chronic diseases goes on, but every year a new round of major out-of-pocket expense reasserts itself. We worry that this will cause discontinuity in needed services and care gaps that later express themselves in more costly breakdowns.

Uncompensated care and bad debt will likely remain high.

As people use their benefits, they will be surprised to discover the impact of 20-30% coinsurance and high out-of-pocket maximums ($6,350 per year per individual and $12,700 per family) on their personal finances. The high deductibles and coinsurance found in ACA-compliant plans – particularly Bronze and Silver plans – may cause consumers to slowly or partially pay providers. Providers will likely experience an increase in uncompensated care and bad debt.

We believe the new high premium levels will also create arrears or defaults in premium payments. Under ACA rules, we are required to pend (hold) payments to providers while premium collection efforts continue for up to 90 days. If payment is then not received, providers will not be paid.

Substantial premium rate increases for the individual market will likely go on for three years.

The impacts caused by ACA will not be felt in 2014 alone. We expect the price shocks to continue into 2015 and 2016. Even with a 35 percent average increase in premium price levels in 2014, sharp premium increases will almost certainly continue. While ACA includes risk mitigation rules in an attempt to address the expected market disruption, these are mostly just short-term deferrals of cost that must ultimately be included in premium rates. For example, the Federal Reinsurance Program is projected to moderate rates by 14 percent in 2014 below where they would otherwise be. But, this reinsurance is dramatically reduced in 2015 and 2016, and is phased out by 2017. As it phases out, the costs borne by the reinsurance protection must be included in premiums.

As noted previously, Exhibit 6 (on page 6) forecasts a continuing sharp increase in individual rates relative to small group rates as the gap between the two closes as a result of merging the risk pools. This will leave individual rates nearly 10 percent below small group rates at the end of 2016 since the portion of all costs covered by plan designs selected by members in the individual market will likely be lower than in the small group market. This derives from the fact that small groups are more likely to maintain coverage at the Gold and Platinum levels while individuals are more likely to concentrate their coverage at the Silver and Bronze levels where more of total cost is borne by the member.

Assuming that premium costs in the individual market were to be approximately 90 percent of those in the small group market by 2016 as shown in Exhibit 6, individual rates in 2016 would need to be – on average – more than double 2013 individual rates.

We recognize that it is the intent of ACA to counteract the tendencies above through the functioning of highly complex risk adjustment, risk corridor and reinsurance features. Since there is no experience with these yet and since the reinsurance and risk corridor features will phase out completely by the end of 2016, we have taken their effects into account to the extent this is possible.

Moreover, if DISB chooses to reduce our proposed rates, then future increases in rates will need to be that much larger since it would be necessary to implement pricing "corrections" and "catch-ups" (upward adjustments) in subsequent years to bring rates into conformity with actual costs. This would create rolling, large and continuing rate "shocks" that will likely be difficult for the nonsubsidized subscriber to absorb. In the process, it will create serious continuing losses for CareFirst.

In the end, given the course ACA has set for the country coupled with District law, once the 2014-2016 transition period is completed, it is likely that individual medically underwritten subscriber premium rates will look much more like small group premium rates. Currently, small group premium rates are nearly double individual rates. With its filing on May 31, CareFirst individual subscriber rates moved to within fifty percent of small group rates.

Loss of Incentives for Wellness and Health Improvement

One of the most profound long term incentives for people to live a healthier lifestyle is to give them a financial reward when they do so. One way to do this is to give a premium "break" to individuals who actually improve their health or maintain a healthy status. This is the equivalent of a safe driver credit.

One of the problems with a pooled, guaranteed issue approach is that it does not permit the rewarding of individuals for better behavior as directly as may be needed. That is, an individual who is healthy or works to become healthy will always be charged the community-wide pooled rate. Longer term, we believe that a credit against the rate or some other similar approach will need to be included in the ACA framework in order to reward healthy lifestyles more strongly.

Small Group Rates Much Less Impacted

Since the small group market in DC has been guaranteed issue for many years, the average rate impacts are more modest in this segment in comparison. The average filed increase in the small group market segment in DC is about twelve percent – four percent of which is for new ACA taxes, fees and assessments. The rest is for the anticipated overall rise in medical care costs. Nonetheless, we expect wide variation in the rate increase (or decrease) levels for each specific small group as a result of historical small group underwriting practices coupled with ACA-required member level rating and District-mandated single risk pool.

Summary and Conclusion

The degree of change that will come with the advent of the ACA cannot be overstated. It will be seen and felt most in the individual market segment. ACA's worthy goals and highly specific requirements will help many – particularly those previously uninsured who will now be covered by Medicaid or eligible for subsidies to help them with their premiums and out-of-pocket expenses for coverage obtained on the DC Exchange.

But, for thousands of existing subscribers of CareFirst who have bought policies as individuals, there will be a different reality. For many, the costs of coverage will dramatically rise as will out-of-pocket expenses incurred in seeking health care services. For those not subsidy-eligible (the majority), the new law, quite simply, will mean paying far more for less coverage after out-of-pocket expenses are considered because few will be eligible for enough in subsidies to materially ease the blow.

For the chronically ill on multiple medications, the turn of each year will bring new exposure to large expenses in the form of deductibles, coinsurance and other copayments. Rather than enhanced access through better coverage, many of these people will have diminished access due to the financial burden of these new plans.

The ACA and the rules that implement it are remarkable in the degree of specificity they contain and the scale of their impact. They quite literally commandeer insurers and compel the changes in plans and prices outlined above. The resulting ACA impact on those already with coverage will be very different than on those seeking it for the first time and entitled to either Medicaid or subsidies.

We are deeply concerned about these impacts on our individual subscribers, many of whom struggle today to meet their required premium payments and make their out-of-pocket expenses. We say this with full recognition that there is little the District can do to change ACA's essential framework or the highly specific rules and requirements of the ACA.

Boiled down to its essence, the premium rates CareFirst has filed for individual subscribers in the District reflect the intended (by ACA) movement toward an overall community average cost that all must pay when all risks and all illness levels are incorporated. This moves away from the carefully selected risk pool of today in the individual market and eliminates the favorable rates that are based on it. In the District, this is further exacerbated by merging the individual and small group risk pools since today's small group costs and rates are nearly double those of underwritten individuals.

In the end, this will inevitably result in individual premium rates and small group premium rates in the District that are very similar. ACA requires these segments to be governed by the same coverage and pricing rules. Moreover, the District law change mandating the combination of the individual and small group risk pools over time further shrinks any remaining differences. The guaranteed issue, single community pool requirements has resulted in uniform average per member per month medical costs for the individual and small group segments, resulting in multi-year higher increases to individual rates relative to small group rates.

Unfortunately, the anticipated "disruption" of the ACA and the DC-specific changes will fall most heavily on existing individual subscribers who have done the "right thing" by securing their own coverage before any subsidies were available.

Within the limits of the ACA-District framework, CareFirst seeks to ameliorate as much of the pain as possible for our individual subscribers consistent with the financial soundness an insurer must have and to find a pathway forward with the DISB and other District and Federal decision makers that best achieves the overall goals of ACA with as much fairness as possible to these existing individual subscribers. As a not-for-profit insurer, we seek – at most – only to cover costs and not to produce a financial gain from the changes wrought by ACA and the District. We believe the rates we have filed are more likely to produce losses.

Given its rules, ACA's goal of achieving more broadly accessible coverage may become more and more heavily dependent on subsidies to more people in order to make affordable the far higher premium price levels and out-of-pocket expense levels ACA requires. CareFirst is concerned about these impacts on our individual subscribers and recognizes the District is, in many instances, bound by the requirements of ACA. As we proceed into this new era, CareFirst remains dedicated to the best interests of its subscribers and the fulfillment of its charter as a not-for-profit organization conducted for the benefit of its certificate-holders.

In the end, health care costs must be better controlled. CareFirst is at the forefront of lowering health care costs through quality improvement. As demonstrated by the recent announcement of the 2012 results of our Patient Centered Medical Home program – the centerpiece of our Total Care and Cost Improvement Programs (TCCI) program – through our work in partnership with providers and their patients (our members), we are dedicated to successfully restraining the rise in the underlying health care costs that drive premiums.

Therefore, while we made the May 31 filing in accordance with ACA requirements, we remain deeply concerned over its impact on our existing individual subscribers – whatever greater good ACA may do for society in general.

Despite our concerns, CareFirst remains fully committed to partnering with the DC government to expand access to health insurance while maintaining affordability, and making the transition period as seamless as possible for our members.

Exhibit 1: Proposed Individual Filed Premium Rates Effective 1/1/14 in DC – Age 40

Platinum

$371/month

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

$457/month

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

$325/month

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
$367/month

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

$277/month

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

$327/month

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 (Tiers 3-5):
$0/$0/$45/$200/$200;
Out-of-pocket maximum: $3,250
Wellness Incentive

Silver

$238/month

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
$295/month

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

$242/month

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

$260/month

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

$232/month

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

$172/month

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

$203/month

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

$166/month

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

$72/month [age 27]

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 DC, effective 1/1/14 for individual age 40. Benefits listed are for in-network services only. Out-of-network services have greater cost sharing or may not be covered at all.

Exhibit 1 (continued): Guide to Plan Features

Example:	**BluePreferred HSA Bronze $3,500**	
Product Description	**(.62 AV)**	Actuarial value
Interpretation	PPO; $3,500 deductible;	Plan type; annual deductible
	$30 PCP/$40 Specialist	Copayment for office visit
	20% after deductible;	Member share coinsurance up to out-of-pocket maximum
	No first dollar coverage;	Services fully covered before deductible
	Integrated Rx: 20%/20%/30%/50%/50%	Member share coinsurance by tier for Rx
	Out-of-pocket maximum: $6,350	Maximum financial exposure of member

Coinsurance: The percentage of the medical or prescription drug costs the individual is required to pay through their insurance plan. A coinsurance of 20% means CareFirst will cover the remaining 80% of the bill. Typically, if there is a deductible, the individual must meet the full deductible first before they will start to pay coinsurance.

Copayment: A fixed dollar amount (usually under $50) an individual must pay when health care services are received. This is the individual's portion of the overall expense for the medical service. For example, a visit to a primary care doctor might require a copayment of $30, and a visit to a specialist might require a copayment of $40. CareFirst would pay amounts above this.

HMO Lock-In: A type of health plan where the individual is restricted to accessing care through doctors in the BlueChoice network (a network of over 28,000 providers of all types). If an individual chooses to seek care from a doctor that is not in the BlueChoice network, they will not be covered; in essence, they are "locked in" to the BlueChoice network. The BlueChoice network is slightly smaller than the CareFirst PPO network, made up of over 35,000 providers.

Wellness Incentive: A feature of the HealthyBlue plans in which an individual may be rewarded for taking steps to improve their health and earn a financial reward for doing so.

Integrated Medical and Rx Deductible: A plan with one deductible that an individual must pay prior to receiving any coverage for medical or prescription drugs. For example, BluePreferred HSA Bronze $3500 has an integrated medical and drug deductible where the individual must pay a $3500 deductible before their coverage begins for any medical or drug services.

First Dollar Coverage: This means that medical and/or prescription drug services are covered prior to the individual having to meet any deductible. For example, a plan with first dollar coverage for primary care doctor visits means that the individual will be covered even before meeting the deductible. Plans with no first dollar coverage means that the deductible must be met first before any medical or prescription coverage begins.

Point of Service: A type of health plan where individuals have a choice to either access care through doctors in the BlueChoice network and pay lower deductibles/copays/coinsurances or visit a doctor in the larger PPO network and pay higher deductibles/copays/coinsurances. The individual may decide this at the point they seek a service – hence, the term "Point of Service."

PPO (BluePreferred): A type of health plan in which individuals have access to the CareFirst network of PPO providers and pay in-network deductibles/copays/coinsurances. These plans will typically have higher premiums than Point of Service and HMO Lock-In plans due to the broad network access.

Exhibit 1 (continued): Guide to Plan Features

Out-of-Pocket Maximum: The maximum dollar amount an individual will be required pay in medical and drug coinsurance, copays, and/or deductibles in a calendar year. Once the out-of-pocket maximum is met, CareFirst will cover 100% of all remaining covered services and the individual will have no further expenses (other than their health plan premium).

Tiered Prescription Drug Coverage: Prescription drugs covered under an individual's health plan are classified under 5 tiers and shown as Tier 1/Tier 2/Tier 3/Tier 4/Tier 5. The percentages that appear (e.g., 20%/20%/30%/50%/50%) show the portion of drug cost that is paid by the member. This example means that the individual will pay 20% coinsurance for Tier 1 and Tier 2 prescription drugs (preferred and non-preferred generics), 30% coinsurance for Tier 3 (preferred brand), and 50% for Tier 4 (non-preferred brand) and Tier 5 (specialty).

- **Tier 1 Preferred Generics:** These are typically the least expensive generic drugs. They have proven to be the most therapeutically effective drugs at the lowest cost. Preferred generics make up 80% of all generic drugs. An individual's copayment or coinsurance is the lowest at Tier 1.
- **Tier 2 Non-Preferred Generics:** These are higher cost generic drugs and make up the remaining 20% of all generic drugs. An individual's copayment or coinsurance may be higher than Tier 1.
- **Tier 3 Preferred Brand:** Brand drugs that have no generic alternative. These drugs are generally more expensive than generic drugs and therefore, an individual's copayment or coinsurance is higher compared to Tier 1 and 2.
- **Tier 4 Non-Preferred Brand:** Brand drugs that have a generic alternative. Individuals are encouraged to select the generic alternative rather than the brand and therefore, an individual's copayment or coinsurance is higher than that for preferred brand drugs.
- **Tier 5 Specialty Drugs:** These are typically more expensive drugs needed for specific medical conditions that have no alternative available. Examples include self-administered injectable drugs or oral chemotherapy drugs. An individual's copayment or coinsurance is the most expensive for Tier 5 drugs. Generally, individuals who take these drugs will meet their out-of-pocket maximum more quickly.

Separate Prescription Drug Deductible: Some plans require a separate deductible for prescription drug coverage – generally a lower amount than the medical deductible – that an individual must meet first before drug coverage begins.

EXHIBIT 6

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

July 1, 2013

Hon. Therese M. Goldsmith
Maryland Insurance Commissioner
200 Saint Paul Place, Suite 2700
Baltimore, MD 21202

Dear Commissioner Goldsmith:

I write on behalf of CareFirst of Maryland, Inc. ("CFMI") and Group Hospitalization and Medical Services, Inc. ("GHMSI" and collectively "the Companies"), and pursuant to the Consent Order between the Maryland Insurance Administration and CFMI and GHMSI dated September 14, 2012, No. MIA-2012-09-006 ("the Consent Order").

In accordance with paragraph C of the Consent Order, the Companies have reviewed the appropriateness of their approved surplus ranges, and they provide the following information with respect to the surplus of CFMI and GHMSI:

- CFMI's surplus at Year-End 2012 was 682% of Risk-Based Capital - Authorized Control Level ("RBC-ACL"), up marginally from the 679% RBC-ACL reported for Year-End 2011. While RBC-ACL levels improved for a fifth consecutive year, CFMI remains far below the bottom of the Board-approved approved target range of 1050-1350 percent of RBC-ACL.

- GHMSI's surplus at Year-End 2012 was 921 percent RBC-ACL, down from the 998 percent RBC-ACL from Year-End 2011 and below the bottom of the Board - approved target surplus range of 1000-1300 percent RBC-ACL.

- On December 3, 2012, the Boards of CareFirst, Inc. ("CareFirst"), GHMSI, and CFMI reviewed and approved CareFirst's three-year financial plan for the years 2013 through 2015, including the financial plans for CFMI and GHMSI. As part of this annual review, the Boards reviewed the target surplus ranges for GHMSI and CFMI, as well as the expected final 2012 surplus and the projected 2013 surplus for each entity. The Boards also approved the 2013 surplus ranges and projections as part of their approval of the Companies' financial plans. The 2013 target ranges are the same as those used in 2012 – 1050-1350 percent of RBC-ACL for CFMI and 1000-1300 percent RBC-ACL for GHMSI.

- In June 2013, CFMI and GHMSI each obtained a report from Milliman, supplementing the full, actuarial surplus analysis performed by Milliman in 2011. Milliman's reports are attached. In its reports, Milliman considered developments affecting CFMI and GHMSI subsequent to its 2011 studies and concluded that it would not expect the CFMI or GHMSI surplus target ranges to vary materially from the respective ranges reported in its 2011 studies. Milliman, in particular, noted the uncertainties caused by federal health care reform with respect to product pricing, new risk adjustment mechanisms, medical loss ratio and rating constraints, and other uncertainties that relate to the major market changes beginning in 2014. Milliman did not recommend a change to the target surplus ranges for either CFMI or GHMSI at this time. The Companies concur in this approach.

- In addition to the reports that are attached to this letter, CFMI and GHMSI have engaged Milliman to perform a full, actuarial surplus analysis to update its 2011 studies. It is expected that Milliman will begin that analysis later this year.

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

Sincerely,

Chet Burrell
President and CEO

Enclosures

cc (by e-mail):
Van Lear Dorsey, Principal Counsel
Mark Chaney, Chief Financial Officer
Meryl Burgin, General Counsel

EXHIBIT 7

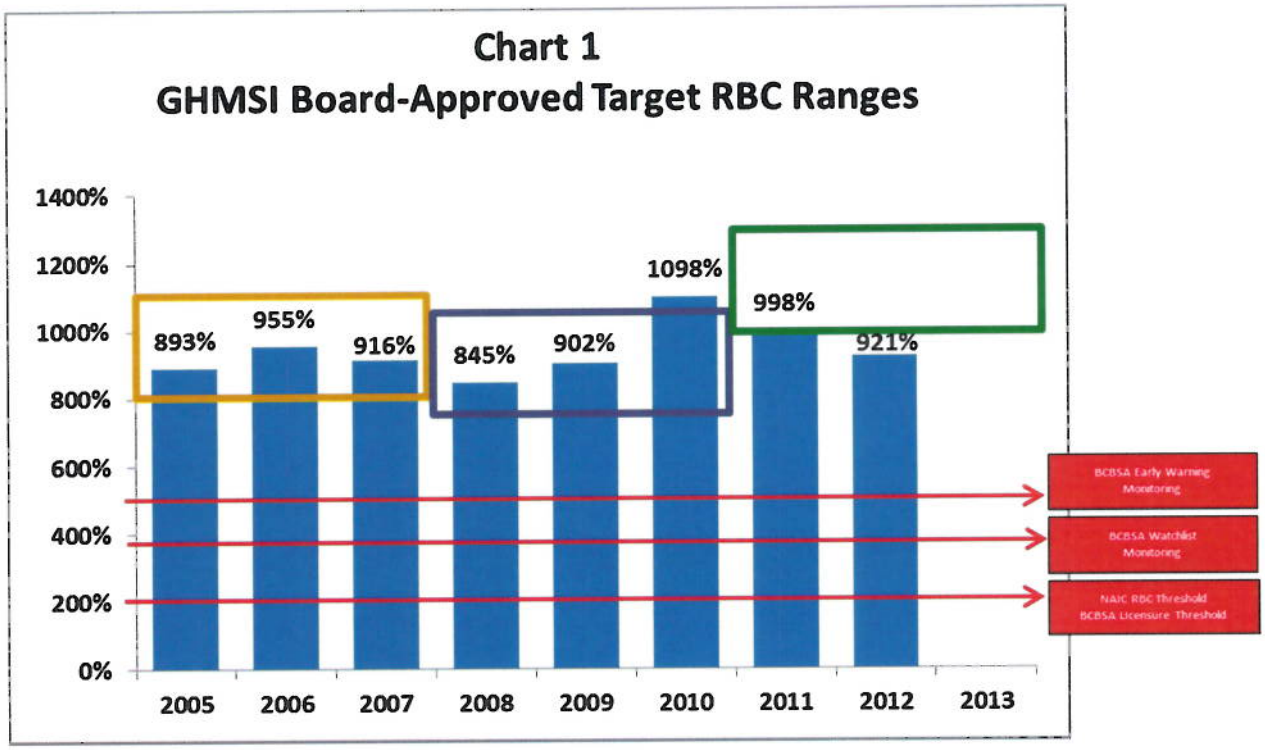
Report to the D.C. Department of Insurance, Securities and Banking Regarding GHMSI's Surplus at Year-End 2012

July 1, 2013

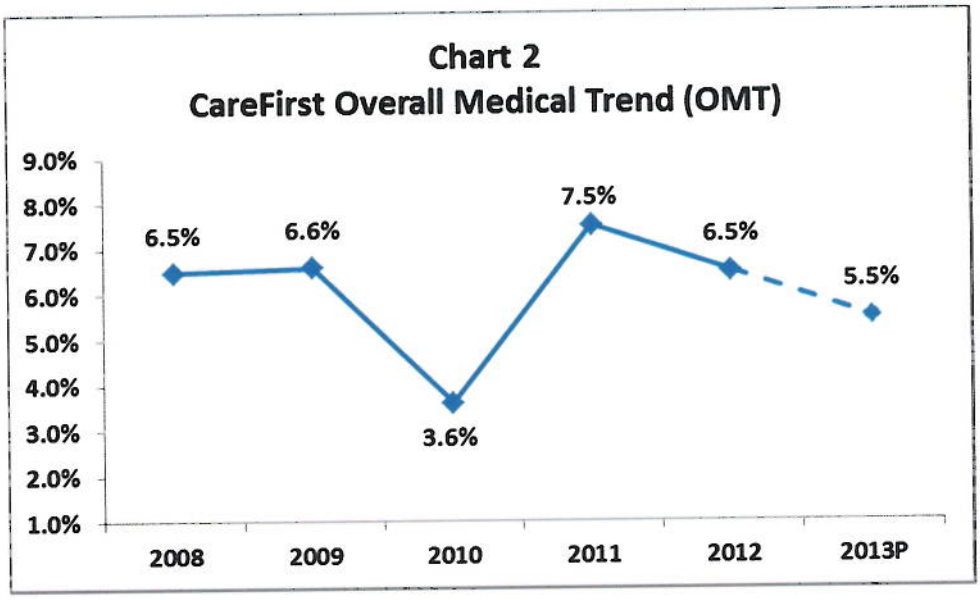
Group Hospitalization and Medical Services, Inc. ("GHMSI" or "Company") submits this report regarding its surplus at Year-End 2012 to the Commissioner of the Department of Insurance, Securities and Banking (the "DISB"), pursuant to 26A DCMR 4601.1. As outlined in greater detail below, GHMSI's 2012 surplus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

GHMSI's Current Surplus Level

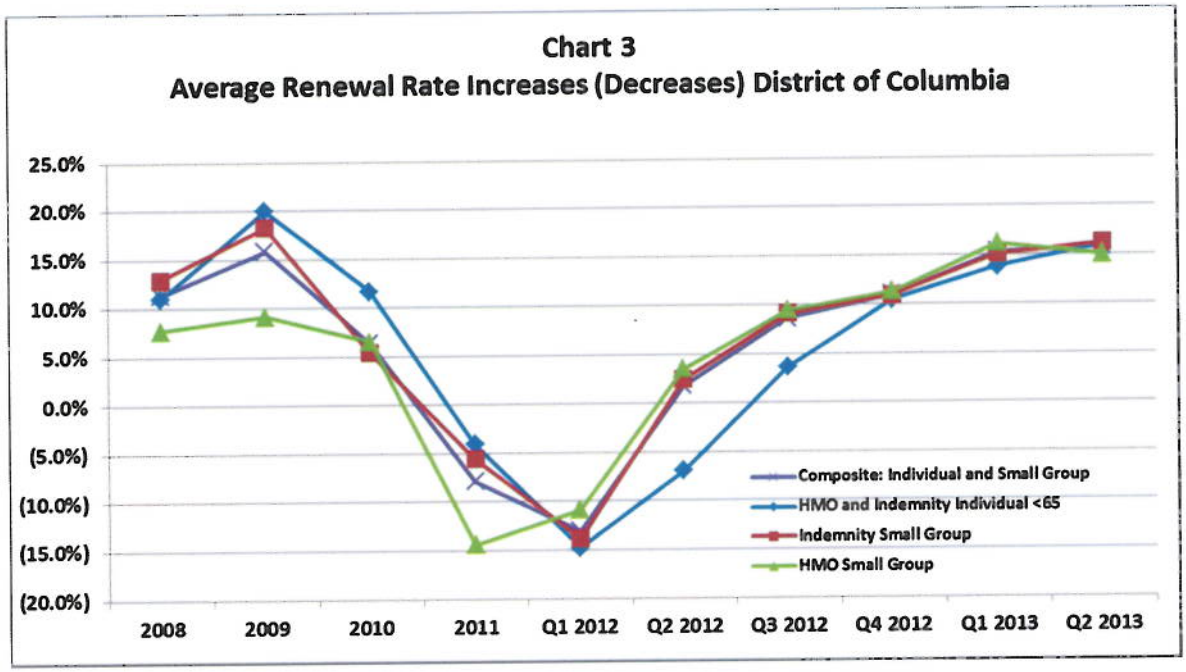
At Year-End 2012, GHMSI's surplus stood at 921 percent Risk-Based Capital-Authorized Control Level ("RBC-ACL") – a 77 point decline from the Company's 2011 Year-End RBC-ACL surplus of 998 percent. This reduction largely reflects actions taken by the Company, under Board-approved policy, to reduce or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



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



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



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

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

Determining the "Right" Level of GHMSI Surplus

1) The Challenge of Calculating Surplus

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

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

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

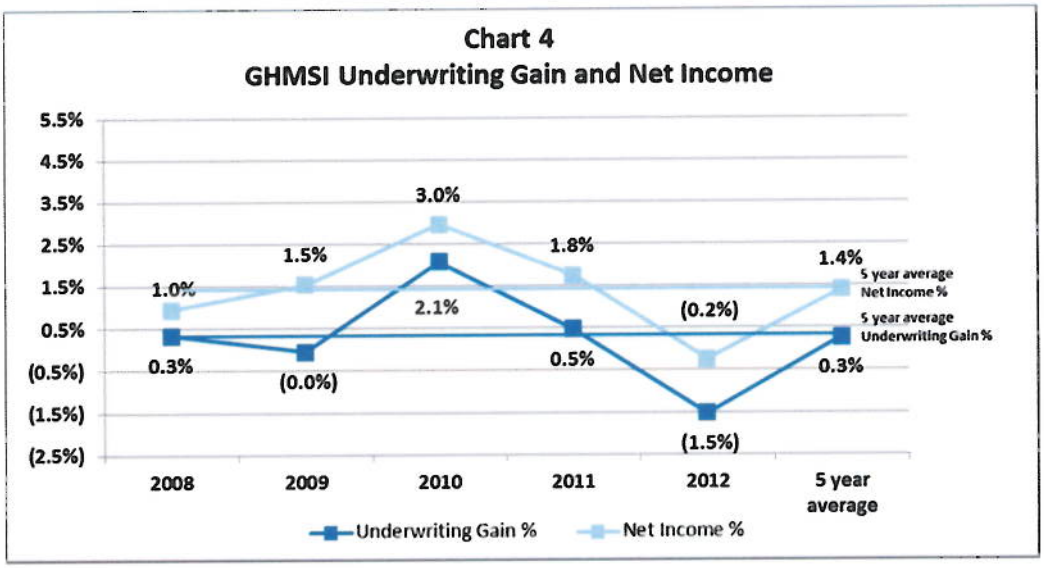
The actuarial experts engaged by GHMSI have recommended surplus ranges that achieve a "confidence level" between 95–98 percent certainty that the Company would not fall below the 200 percent RBC-ACL level adopted by the NAIC (and now embodied in District law) and between 90-95 percent certainty that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

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

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

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

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



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

Federal Health Care Reform Presents Significant New Uncertainties

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

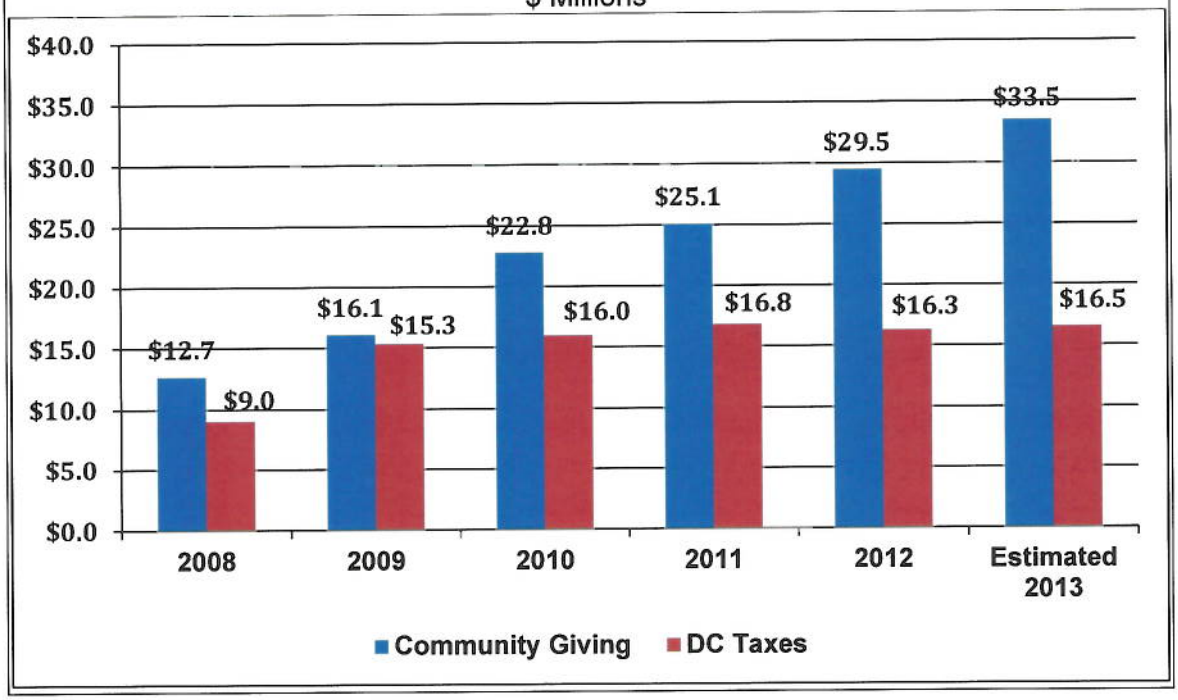
The DISB has since launched a second review of GHMSI's surplus. DISB engaged Rector & Associates, Inc. ("Rector"), the same firm that assisted the agency with the 2009-10 review, and Rector is expected to present a report to the DISB shortly.

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

4) GHMSI and CFMI Have Given Generously to the Community

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

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



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

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

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

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

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

Areas of Giving:

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

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

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

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

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

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

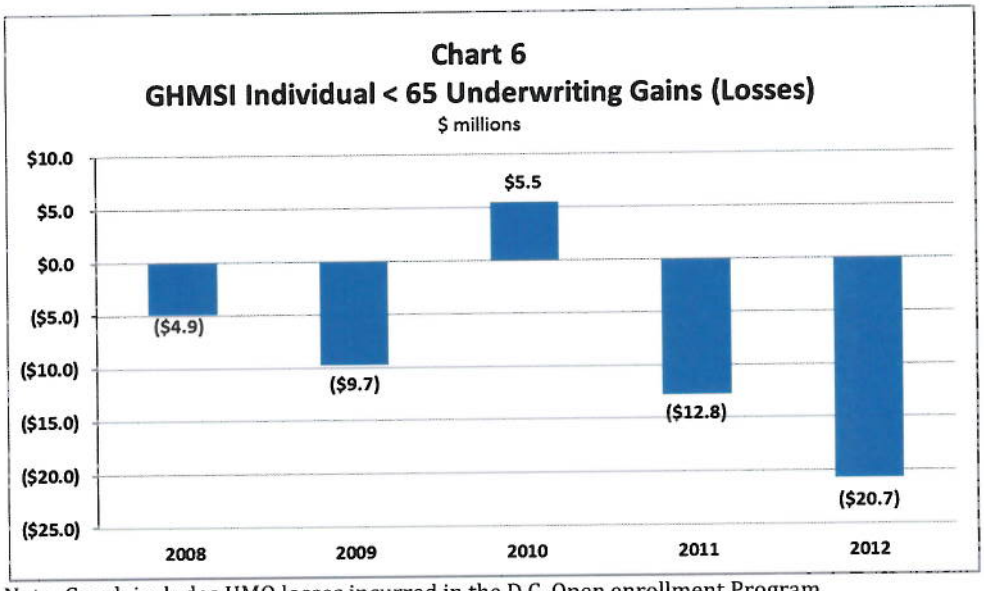
Community Health Reinvestment:

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

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

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

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



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

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

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

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

Conclusion:

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

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

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

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Enclosure:

1. Milliman, Inc. Letter re: GHMSI Surplus

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