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

July 14, 2016

Hon. Stephen C. Taylor
Commissioner
Department of Insurance, Securities and Banking
810 First Street NE, Suite 701
Washington, D 20002

Dear Commissioner Taylor,

Group Hospitalization and Medical Services, Inc.'s ("GHMSI" or the "company") response to the questions posed in the June 14, 2016 DISB Order (the "Order") is enclosed.

This letter provides a larger view of the issues posed by the Order, places these issues in historical and legal context and expresses the company's position on the issues.

We start with the straightforward observation that the company's certificate holders ("subscribers") rightfully expect when they make their payments to the company for health care coverage that these payments will be fully used for their benefit. Indeed, the federal law that established the company in 1939 – that constitutes its Congressional Charter – explicitly requires that this be done. GHMSI is the only Blue Cross Blue Shield plan in the U.S. chartered by Congress. The Charter clearly states:

> *"Said corporation shall not be conducted for profit, but shall be conducted for the benefit of the aforesaid certificate holders."*

The most recent amendment to the Charter enacted by Congress in late 2015, reinforces and clarifies this core purpose of the company – and speaks directly to the issue of how "excessive" surplus is to be handled:

> *"The surplus of the corporation is for the benefit and protection of all of its certificate holders and shall be available for the satisfaction of all obligations of the corporation regardless of the jurisdiction in which such surplus originated or such obligations arise. The corporation shall not divide, attribute, distribute, or reduce its surplus pursuant to any statute, regulation, or order of any jurisdiction without the express agreement of the District of Columbia, Maryland, and Virginia—(1) that the entire surplus of the corporation is excessive; and (2) to any plan for reduction or distribution of surplus."*[1]

[1] Section 747(b) of the Financial Services and General Government Appropriations Act, 2016, enacted as part of the Act of December 18, 2015, Publ. L. No. 114-113, 129 Stat. 2242, states "[t]he amendments made by subsection (a) shall apply with respect to the surplus of Group Hospitalization and Medical Services, Inc. for any year after 2011.

In plain, clear terms, GHMSI's federal Charter has prescribed from the beginning, and continuously thereafter, that the company exists for the benefit of its subscribers. This means exactly what it says.

To go to the heart of the matter, the company holds surplus to assure that its promise to protect its subscribers by covering the costs of their health care services – come what may – will be fulfilled and that neither a single large event, such as an epidemic, nor a series of smaller events will undermine this promise or cause it to be unfulfilled. For example, should a threat like the Zika or Ebola viruses ever materialize on a large scale, the company must be able to fulfill its obligations to its subscribers to pay their claims.

The surplus is built up in two ways: first, by the retention and set aside of earnings each year from subscriber premium payments and second, by the additional investment income earned on the amounts set aside. Since the company is non-profit and operates essentially near cost (earnings average less than 2 percent per year), it takes many years to build up surplus. The surplus could be depleted very quickly, however, by an epidemic or series of other lesser events.

Additionally, since the advent of the Affordable Care Act, there are strict federal rules that limit how much a health insurance company can retain in earnings on health care coverage plans. Hence, surplus funds – once established – are precious resources, not easily replenished.

Further, GHMSI's federal Charter plainly provides that the surplus must be held as a common pool of funds that is available to protect all subscribers, regardless of the jurisdiction in which they live. It forbids the company from dividing or attributing a portion of the surplus or assigning a portion to a particular jurisdiction. This is in keeping with long established practice and policy in the health insurance field.

In the event that one jurisdiction (e.g., the District) were to conclude that surplus is too large, the federal Charter requires that all three jurisdictions reach agreement about whether the company holds too much total surplus and on any plan to remedy any excess.

Thus, the Charter establishes a clear framework within which the company must operate that governs its purpose, the scope of its operations and the use of the funds it obtains from its subscribers. Simply stated, the company exists to serve its subscribers and to "be there" for them under any set of circumstances.

With this said, as a general matter, it would be entirely appropriate for a regulator to determine whether the company – or any insurance company – holds too much surplus (i.e., holds more than what it needs to fulfill its promise to its subscribers). It is also appropriate for a regulator to determine whether it holds too little. In fact, the concern that an insurer holds too little surplus has historically been the most common focus of regulators and one need not look far to see the consequences of too little surplus when times are tough. GHMSI itself faced near bankruptcy in the early 1990s when its surplus was depleted. No government entity stepped in to save it. Fellow Blue Cross Blue Shield plans came to the rescue – an event the company hopes never needs to be repeated.

Determining the right level of surplus needed is a complicated question requiring qualified independent actuarial experts to provide advice and recommendations. This is not unlike the kind of technical expertise needed in determining whether a bridge can withstand different traffic loads in all weather conditions or how much capital banks must hold in reserve to protect against potential adverse economic events. In each of these cases, expert opinions are critical because the cost of getting it wrong may be catastrophic.

The company's surplus has been repeatedly and extensively studied with well over a dozen formal studies in the past decade by a range of expert, independent actuarial firms engaged by the company as well as by the company's regulators in the District, Maryland and Virginia – the three jurisdictions in which it operates.

Not a single one of these studies has concluded that the company holds too much surplus. Indeed, the dominant theme of these studies has been that the company holds *too little* surplus when compared to an ideal range of surplus needed to safeguard against the risks the company faces.

In accord with all of these formal studies, the DISB's own most recent expert actuarial consultant held that the company did not have too much surplus in 2011 – the same year that is the subject of the DISB's Order.

Nevertheless, despite overwhelming expert opinion to the contrary, the previous Acting DISB Commissioner independently decided that the company held too much surplus in 2011 and determined that a portion of this alleged excess (21%) was attributable to the District. This is the genesis of the $56.2 million sought in the current Order that now upholds the previously Acting Commissioner's decision.

Both the former Acting Commissioner's and the current Commissioner's Orders were issued under a District law, enacted in 2009, that conflicts with the federal Charter of the company. This local law, which was enacted at the urging of DC Appleseed, introduced the idea of a broader obligation on the part of the company to the community in general – namely, that the company has an obligation to undertake "community health reinvestment" to the "maximum extent feasible".

The District law requires that the company strive to meet the health care needs of the community beyond those of its subscribers – and to do so with subscriber money. In other words, it requires GHMSI to spend down subscriber funds set aside in surplus for their benefit and protection so that other public health needs of the non-subscriber community can be better met. This places a great additional burden on subscribers who are already burdened by the high cost of health care coverage – a burden Congress never intended, as reflected in its clear articulation that the company is to be *conducted for the benefit of the aforesaid certificate holders*.

The requirements of the District law are also accompanied by the idea that the company's surplus can be divided into parts – that is, that a portion of the surplus can be "attributed" to the District alone and that the funds in surplus – those in "excess" – can be used for District-only purposes, even though those funds were built up by subscribers in all three jurisdictions for the protection of subscribers in all three jurisdictions. In fact, actuaries who have reviewed this concept in District law of "attributing" surplus have pointed out that it is invalid to divide or attribute surplus in the case of a health insurance company operating in multiple jurisdictions. Certainly the federal Charter is clear in forbidding it.

Nevertheless, it was pursuant to this District law that Acting Commissioner McPherson concluded in his December 30, 2014 Order that GHMSI's surplus position was excessive and that the portion of this alleged "excess" attributable to the District was $56.2 million. The June 14 Order adopts this conclusion. It also offers the view that the contributions that the company has voluntarily made to the community with subscriber funds cannot be counted as "community health reinvestments" – even though this was clearly their intent and effect and despite the fact they were drawn from funds in surplus.

The Order has far-reaching implications. Over 88 percent of the company's members live in Maryland, Virginia and other jurisdictions, while less than 12 percent live in the District of Columbia. In other words, the legal framework created by District law requires that the common pool of surplus funded by all subscribers – the vast majority of whom are *not* District residents – are subject to being drawn off for *non-subscribers*, at the District's sole discretion.

Thus, District law provides a powerful motivation to find "excess" because it enables the District to tap into a substantial source of funds for purposes – however worthy – that are other than for the benefit of subscribers. All that is necessary for this to happen is for the Commissioner of the DISB to declare that an excessive surplus exists, "attribute" a portion to the District, and then approve a plan for disposition of the alleged excess for the benefit of the District's larger community. This is, in effect, a government

taking of property that is rightfully owned by subscribers, the vast majority of whom do not reside in the District of Columbia.

In the case of the surplus review conducted for 2011, this is exactly what has happened – leaving the only remaining question as to exactly how the alleged excess attributable to the District is to be spent. For this, the Commissioner seeks public comment, which, no doubt, will be bountifully forthcoming.

Once the 2009 District law was enacted and the DISB undertook surplus review proceedings in accordance with it, the other two jurisdictions – Maryland and Virginia – reacted strongly. Both States passed protective legislation and heightened their vigilance to guard the company's surplus. Their States' insurance regulators issued protective orders. Indeed, the company is currently under active orders from both Maryland and Virginia *not* to distribute any surplus funds pursuant to a District order without their approval. For the very year that is the subject of the DISB Order (2011), Maryland ordered the company to strive to increase its surplus in direct contradiction to the DISB Orders.

The Congress acted as well. The 2015 amendment to the Charter arose out of Congressional concern with actions either taken or intended by the District under its local law that were believed by the Congress to be inconsistent with the original intent of the Charter.

The central question now is which framework applies – the one set up by Congress or the one established by the District? There is only one possible answer: the framework established by Congress as embodied in federal law (the Charter) applies.

We believe that previous and current DISB orders holding that the company has excess surplus have no merit and are based on serious analytical errors that contradict the advice of the numerous experts who have reviewed the matter. We do not seek here to add to the arguments we have previously made regarding these errors. Rather, we seek to speak further to the central issues that now must be addressed.

The following five statements are true:

First, the company has only one surplus. A portion of it cannot be attributed to the District alone. It must remain available for the protection and benefit of all subscribers in all jurisdictions. This is federal law clearly set forth in the Charter. The federal law applies to all years, including 2011.

Second, if the District believes that the surplus the company holds is excessive in any year – including 2011 – it cannot, by unilateral action, order a reduction of the alleged excess surplus without the approval of the other jurisdictions. The District has not obtained or even sought this approval. Indeed, the two other interested jurisdictions have acted to block any attempt by the District to reduce the company's surplus without their express approval.

We may debate what the term "coordination" with another jurisdiction means under District law, but the Charter is crystal clear that agreement is needed among the three jurisdictions to declare excess and to distribute such excess. This has not occurred and the company now faces contradictory orders from the jurisdictions – a circumstance that the Congressional Charter's command was specifically designed to avoid. As Maryland Insurance Commissioner Redmer observed in his July 11, 2016 Statement, "That conflicting orders between the jurisdictions exist highlights the fact that, to date, no coordination has taken place between the District and the other jurisdictions." Further, the company is commanded by its federal Charter not to obey an order to reduce or distribute its surplus unless all three jurisdictions agree.

Third, the reference in the 2015 amendment to the Congressional Charter, regarding the applicability of the newly added subsection "for any year after 2011" does not give the District free rein to unilaterally do what it wants with regard to 2011 surplus. There is no "2011 surplus." There is only current (2016) or future surplus. Any reduction in current or future surplus must first be approved by the other jurisdictions. This, too, is federal law. The District has not acted in a manner required by this law.

Fourth, a premium rate freeze as a tool to reduce surplus or to punish the company for failure to produce a plan to reduce surplus to the Commissioner's satisfaction is impermissible. Less-than-adequate rates deplete present or future surplus, which in turn requires the agreement of the other jurisdictions – something that has been neither sought nor given.

Fifth, if the DISB orders the distribution of $56.2 million in subscriber funds to support community health reinvestment in the District, it will violate federal law under the Charter because such an order is not for the benefit of the subscribers whose payments built the surplus and for whose protection it is intended. And, because such an order constitutes an unconstitutional taking of private property without compensation by the government, the DISB should refrain from entering a final order that will trigger that serious constitutional question.

There simply cannot be two competing frameworks under which the company operates – one established by the District and the other by federal law. The best way for this to be resolved is for the District to rescind its June 14 Order and to work with the other jurisdictions toward consensus on the surplus position of the company as provided for in the company's Congressional Charter.

Sincerely,

Chet Burrell
President & CEO

Cc: Commissioner Jacqueline Cunningham
Virginia Bureau of Insurance

Commissioner Al Redmer
Maryland Insurance Administration

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF INSURANCE, SECURITIES AND BANKING

IN THE MATTER OF	)	
Surplus Review and Determination for Group Hospitalization and Medical Services, Inc.	)	Order No.: 14-MIE-012

GHMSI COMMENTS IN RESPONSE TO
DISB'S ORDER OF JUNE 14, 2016

Group Hospitalization and Medical Services, Inc. ("GHMSI"), submits the following comments, in response to the June 14, 2016 Order ("the June 14 Order") issued by the Department of Insurance, Securities and Banking ("DISB"). DISB has far exceeded the bounds of its own statute, has ignored the express instructions of Congress set out in GHMSI's federal Charter, and is in direct conflict with Maryland and Virginia, which are rightly concerned that their residents will be forced to subsidize reinvestment in the District. GHMSI suggests that the only legal and prudent course for DISB at this time is to rescind the June 14, 2016 Order, coordinate with Maryland and Virginia to reach agreement on any differences among the jurisdictions regarding GHMSI's surplus, as is required by law, and correct the defects in Acting Commissioner McPherson's decision issued on December 30, 2014 (the "December 2014 Order").

GHMSI has previously detailed how the proposed course of action taken by DISB in this proceeding is contrary to the Medical Insurance Empowerment Amendment Act ("MIEAA"),

and will not repeat those arguments here.[1] In making this submission, GHMSI expressly incorporates all of its prior submissions and filings in connection with the December 2014 Order and the June 14 Order. GHMSI does not waive any argument previously made. In this memorandum, Section I details how the proposed course of action taken by DISB is contrary to the terms set by Congress in GHMSI's federal Charter. Section II addresses other issues relating to DISB's proposed, but not yet disclosed, plan.

I. DISB's Proposed Course of Action Violates Federal Law.

A. DISB Cannot Proceed Without The Agreement Of Maryland and Virginia.

The GHMSI Charter expressly requires DISB to obtain approval of Maryland and Virginia before it may order GHMSI to reduce its present or any future surplus. In December 2015, Congress enacted and the President signed the Consolidated Appropriations Act of 2016, which added the following new section to GHMSI's Congressional Charter:

> SEC. 11. The surplus of the corporation is for the benefit and protection of all of its certificate holders and shall be available for the satisfaction of all obligations of the corporation regardless of the jurisdiction in which such surplus originated or such obligations arise. The corporation shall not divide, attribute, distribute, or reduce its surplus pursuant to any statute, regulation, or order of any jurisdiction without the express agreement of the District of Columbia, Maryland, and Virginia—(1) that the entire surplus of the corporation is excessive; and (2) to any plan for reduction or distribution of surplus.

Financial Services and General Government Appropriations Act, 2016 § 747, *enacted as part of* Consolidated Appropriations Act of 2016 (emphasis added) ("the Charter Amendment"). This

[1]GHMSI previously outlined the defects in the December 2014 Order at length. When he issued the December 2014 Order, former Acting Commissioner Chester McPherson: (1) failed to coordinate with Maryland and Virginia, as the MIEAA requires; (2) ignored the opinion of his own expert, Rector & Associates, and the overwhelming evidence in the record when he rejected the well-established 98% confidence level; and (3) ignored every actuarial opinion and the evidence when he determined that GHMSI should manage surplus to a single target point, despite the fact that surplus is organic and fluctuates constantly, and cannot be predicted with precision from one year to the next. The finding that GHMSI's surplus was excessive was based entirely on these errors, and would not have been made without them.

amendment imposes the same requirement that was already required by the MIEAA in D.C. Code § 31-5506(e), but now does so as a matter of federal law.[2]

The Charter Amendment applies to any decision by DISB to reduce GHMSI surplus after 2011. *Id.* (stating that the amendment "shall apply with respect to the surplus of Group Hospitalization and Medical Services, Inc. for any year after 2011."). This means that the Charter Amendment applies to any apportionment, reduction, or distribution of the surplus that GHMSI holds *today* or in the future, and the surplus held by GHMSI *today* cannot be apportioned, reduced, or distributed unless Maryland, the District and Virginia all agree both that GHMSI's present surplus is excessive *and* as to the details of any plan for reduction or distribution. To the extent that any jurisdiction wants to "attribute" surplus to itself out of GHMSI's present surplus, it cannot do so unless all three jurisdictions agree. The District has no authority to act alone.[3]

[2] As GHMSI has stated before, the MIEAA required DISB to reach agreement with Maryland and Virginia even before the federal government amended the GHMSI Charter, in response to the December 2014 Order. "Coordination" means more than simply accepting, and then disregarding, written testimony. Coordination "envisions more than unilateral action." *MAMSI Life & Health Ins. Co. v. Wu*, 411 Md. 166, 203 n.10 (Md. 2008). To "coordinate," parties must "harmonize, work together, or bring into a common action, effort or condition," *Network Commerce, Inc. v. Microsoft Corp.*, 260 F. Supp. 2d 1034, 1041 (D. Wash. 2003), *aff'd* 422 F.3d 1353 (Fed. Cir. 2005)—that is, "work together properly and well" in order "to cause (two or more things) to not conflict with or contradict each other." *Merriam-Webster Online Dictionary, available at* http://www.merriam-webster.com/dictionary/coordinate. DISB's assertion in the June 14 Order, that it may "coordinate" simply by accepting written testimony and then determining for itself the interests of Marylanders and Virginians is simply wrong. DISB's unilateral actions are leading to the very intra-jurisdictional conflict that the "coordination" language in MIEAA was designed to avoid. In all events, however, federal law now makes clear that the DISB must obtain the agreement of Maryland and Virginia before unilaterally taking any action with regard to any surplus of GHMSI.

[3] Indeed, any contrary interpretation of DISB's authority would raise serious constitutional questions under the Fifth Amendment and the Supremacy and Commerce Clauses. The fundamental flaw in DISB's position is that it allows DISB to reduce a fictional surplus allocated by DISB to GHMSI while still retaining the whole surplus for the protection of DC subscribers of GHMSI, all at the expense of CareFirst subscribers in Maryland and Virginia. Congress avoided the constitutional issues by making clear in the Charter Amendment that any surplus was to be considered as a whole for all of GHMSI and

DISB cannot avoid the Charter Amendment by now ordering a reduction of a fictional "2011 surplus." GHMSI's surplus at a given point in time reflects the assets of the company *at that time*. There are no assets set aside as "2011 surplus," as opposed to GHMSI's surplus today. There is no "2011 surplus" that could be distributed, and no "2011 surplus" that could be reduced. GHMSI can reduce only its *present* (2016) or future surplus. By making it clear that the Charter Amendment would apply to any surplus after 2011, Congress chose not to interfere with the *review* of GHMSI's 2011 surplus by the Commissioner, which unilaterally found surplus to be excessive and unilaterally sought to apportion surplus (despite the MIEAA's requirement of coordination). However, to the extent that DISB now seeks to impose a remedy reducing GHMSI's present surplus, Congress has made clear that Maryland and Virginia must agree to any such reduction, and that those States may do so only after a finding that GHMSI's present surplus is excessive and based upon a distribution plan accepted by all three jurisdictions. No such agreement has been obtained. DISB's decision to proceed unilaterally violates federal law, as well as the MIEAA.

This point is obvious if one considers the mechanics of how GHMSI would reduce its surplus. There are only two ways in which GHMSI can reduce surplus to the benefit of its subscribers as required by its federal Charter. If GHMSI moderated future rates, the result would be a reduction in GHMSI's *future* surplus. If GHMSI distributed funds today to subscribers, GHMSI would reduce its *present* surplus. In either case, any order by DISB would compel reduction or distribution of GHMSI's surplus in a year after 2011. If DISB proceeds to order a reduction in GHMSI's surplus without the concurrence of Maryland and Virginia, it is violating

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that the regulators in the three jurisdictions, DC, Maryland and Virginia, had to agree on any reduction in the surplus because all three are affected by any such action.

federal law as well as the MIEAA. The MIEAA cannot override the federal Charter of GHMSI, and the Charter prohibits the unilateral action proposed by DISB.

B. DISB Cannot Use Subscriber Funds to Benefit Non-Subscribers.

Question (f) in the June 2014 Order asks whether distribution of funds to policyholders would be community reinvestment. In fact, if a distribution or reduction of surplus were authorized and appropriate, DISB would not be able to distribute funds to persons *other* than subscribers. Any Order requiring GHMSI to distribute funds within the District to persons other than GHMSI subscribers would violate GHMSI's federal charter. DISB has no authority to transfer GHMSI surplus funds to non-subscribers. Both the long-standing provisions of the GHMSI Charter *and* the recent Charter Amendment forbid it.

II. DISB Cannot Ignore GHMSI's Substantial Community Reinvestment And Its Substantial Loss of Surplus Since 2011.

The June 14 Order categorically rejects each and every grant, contribution, rate reduction, and other act of community reinvestment undertaken by GHMSI in the District of Columbia since 2011. The Order claims that none of these actions, each of which benefitted the District community at GHMSI's expense, constitute a reduction of "excess surplus," even though GHMSI lost $37 million dollars in the District from 2012 to 2014 (even after including investment gains attributable to the District) and GHMSI's total surplus for all jurisdictions fell by $30 million dollars. Community reinvestment undertaken by GHMSI in the District *at a loss* must be credited to a reduction of any finding of "excess surplus."

A. Any Plan For Dedication Of Excess Surplus Must Account For Surplus Reductions That Already Have Occurred.

In Question (c), the June 14 Order asks "[w]hether the amount of excess surplus to be dedicated should be offset by any reduction in surplus between December 31, 2011 and

December 31, 2015." June 14 Order at 20. Under the MIEAA, any remedial plan must consider GHMSI's present surplus and must ensure that GHMSI's surplus remains above the level required for "financial soundness." Equally important, under the MIEAA, the "surplus" that must be examined for this purpose is the surplus attributable to the District of Columbia, to ensure that the District is not appropriating surplus dollars that DISB itself apportioned to Maryland and Virginia.

The MIEAA makes clear that DISB must determine the level of surplus required for "financial soundness and efficiency," and that GHMSI cannot be required to engage in community reinvestment if surplus falls below that level. *See* D.C. Code §§ 31-3501.01 & 31-3506(e)(2). DISB stated this in the December 2014 Order itself:

> [T]he Commissioner interprets section 31-3506(e)(2) as requiring him to determine the level of surplus that maximizes GHMSI's community health reinvestment without undermining GHMSI's financial soundness and efficiency. Stated differently, ***the Act requires the Commissioner to determine the amount of surplus that is large enough to be consistent with financial soundness and efficiency***, but no larger.

December 2014 Order at 5 (emphasis added). To the extent that GHMSI has reduced its surplus since the end of 2011, any remedial plan must take such reductions into account.

The "surplus" at issue with respect to any remedial plan is at most the portion of surplus that has been attributed to the District of Columbia, not GHMSI's surplus as a whole. The MIEAA requires DISB to "review the portion of the surplus of the corporation that is attributable to the District" and determine "whether the surplus of the corporation attributable to the District is excessive." D.C. Code § 31-3506(e) & (f); *see also* D.C. Code § 31-3506(h) (authorizing DISB to hire consultants "[w]hen determining what surplus is attributable to the District and whether the surplus is excessive").

Since DISB created an artificial "District-specific" surplus as of year-end 2011 (which DISB did in the December 2014 Order), DISB now must track that surplus from year-to-year going forward, to determine whether this District-only surplus has grown or shrunk based upon the results of business in the District. DISB must do this in order to ensure that the District does not drain away surplus generated by Maryland and Virginia subscribers. The MIEAA does not authorize distribution of surplus allocated to Maryland and Virginia for "community reinvestment" in the District. Neither Maryland nor Virginia has sought to reduce the surplus attributable to their jurisdictions, and the MIEAA does not allow DISB to do so.

In Questions (c) and (d), the June 14 Order asked whether a dedication of surplus to community health reinvestment under MIEAA "could be modified pursuant to future reviews of GHMSI's surplus," and whether any dedication of surplus "should be suspended or modified in the event that adverse conditions reduce GHMSI's surplus." June 14 Order at 19-20. The answer to both of these questions is plainly "yes." If GHMSI's present surplus attributed to the District has fallen below the level that DISB itself finds necessary for financial soundness, then there is by definition *no longer any excess surplus to distribute*.

GHMSI has lost money on its business in the District since 2011. From 2012 to 2014, GHMSI incurred $62 million in underwriting losses on its District business. Underwriting losses are an expenditure made by GHMSI for the benefit of its subscribers regardless of what GHMSI originally proposed in its rate filings, and surplus is reduced as a result of such losses to the same extent. Even adding back an attributed portion of investment gains, the surplus attributed to the District in the December 2014 Order fell by $37 million between the end of 2011 and year-end 2014, from the $202 million attributed in the December 2014 Order to $165 million. *See* GHMSI March 16, 2015 Plan, at Ex. 1. During this same period, GHMSI's overall surplus only

fell by $30 million, meaning that Maryland and Virginia had positive results to offset some of the losses in the District. *Id.* Unless the District intends to seize and distribute surplus that *DISB itself* attributed to Maryland and Virginia, or to force GHMSI's District-attributed surplus below the level that *DISB itself* determined was required for financial soundness, then DISB must account for these losses before ordering any distributions of "excess" surplus.

GHMSI has already performed this analysis. The portion of surplus attributed to the District *by DISB itself* has fallen far below 721% RBC ("risk based capital"), using the same RBC calculations used to examine GHMSI's surplus as a whole, but with the inputs to those calculations based on District-specific business rather than GHMSI's entire financial statement. *See* GHMSI's March 16, 2015 Plan at Ex. 1 (concluding that the surplus attributed to the District in the December 2014 Order had fallen to 569% RBC by year-end 2014). Even under the flawed logic of the December 2014 Order, it would not be consistent with "financial soundness" to require additional reductions of the surplus attributed to the District by DISB. Nothing in the MIEAA authorizes DISB to force GHMSI's surplus *today* below the level required for financial soundness based upon a finding that GHMSI's surplus was once excessive four and a half years ago.

Most importantly, while GHMSI addresses in this and the following sections the requirements of the MIEAA and a remedial plan under that Act as ordered by DISB, the Charter Amendment makes clear that the artificial distinctions drawn by DISB under the MIEAA are not valid and must yield to the Charter as amended. *There is no separate surplus for the District of Columbia, for Maryland or for Virginia.* At any time, there is only one surplus; the surplus of GHMSI, and that surplus, as the Charter Amendment provides, is for the benefit of all three

jurisdictions. Hence, all three jurisdictions must agree on any distribution of GHMSI's surplus, if one even exists.[4]

B. GHMSI Has Already Reduced The "Excess Surplus" By Providing Community Giving Between 2011 And 2014.

In Question (g), the June 14 Order asks "[w]hether there were any negative contributions to surplus made by GHMSI that should be taken into account for the plan." June 14 Order at 20. GHMSI made negative contributions to surplus through many means, not just its rate filings, which are discussed in § II.C, below. GHMSI also made negative contributions to its surplus through direct community giving and other reinvestment in years when GHMSI incurred surplus losses.

During 2012 to 2014, GHMSI provided $11 million in direct community giving in the District, while GHMSI's total surplus fell by $30 million and the surplus attributed to the District in the December 2014 Order actually fell by $37 million:

- In 2012, GHMSI engaged in $3.9 million in direct community giving, GHMSI's total surplus fell by $23 million, and the surplus attributed to the District in the December 2014 Order also fell by $23 million.

- In 2013, GHMSI engaged in $3.4 million in direct community giving, GHMSI's total surplus fell by $6 million, and the surplus attributed to the District in the December 2014 Order fell by $3 million.

- In 2014, GHMSI engaged in $3.7 million in direct community giving, GHMSI's total surplus fell by $1 million, but the surplus attributed to the District in the December 2014 Order fell by $11 million.

See GHMSI's March 16, 2015 Plan at Exs. 1 & 2.

[4] To the extent that the MIEAA purports to require allocation of any GHMSI surplus among the three jurisdictions and attribution of a portion to the District, the Act is not only unrealistic and unworkable, it violates federal law and must yield to the unitary approach of the federal Charter. While the DISB may not have the power to question the constitutionality of the MIEAA, *see, e.g., Stackhouse v. D.C. Dep't of Employment Servs.,* 111 A.3d 636, 639 (D.C. 2015), DISB certainly has an obligation to avoid an unconstitutional interpretation or implementation of the Act.

None of these grants was made out of "premium dollars." During this same period of time, GHMSI incurred $62 million in underwriting losses in the District and GHMSI's premiums failed to cover even the company's operating costs. In each year, GHMSI engaged in community giving that (a) was direct community health reinvestment to the District, (b) was not covered by any income received from District business, and (c) therefore directly reduced GHMSI's year-end surplus for the year in which the giving occurred. Giving by GHMSI that reduces its surplus constitutes a reduction in the "excess surplus" found in the December 2014 Order.

As stated above, there is no pool of funds labeled "excess 2011 surplus" from which community giving can be drawn. If GHMSI engages in community giving at the same time that it incurs underwriting losses, it *only* can do so by drawing down its surplus.

C. GHMSI's Rate Reductions Were Taken From "Excess Surplus."

Starting in 2011, GHMSI began taking specific steps to reduce rates in order to reduce its surplus. There was no mystery about why GHMSI was taking these steps – GHMSI specifically reported on these reductions to DISB and the market *at the time* and long before this proceeding. The reductions were specifically described to DISB *at the time* as a set of actions undertaken to reinvest in the community and to reduce GHMSI's surplus to the levels set by GHMSI board policy. As stated in GHMSI's June 1, 2011 filing with DISB, "[t]he Boards [of GHMSI and CareFirst, Inc.] have reviewed and adjusted surplus ranges as necessary" and "have overseen the filing of self-initiated premium rate reductions that carry out a policy of community health reinvestment." GHMSI Annual 2011 Report on Surplus at 10 (dated June 1, 2011, and attached as **Exhibit 1**). As GHMSI informed DISB:

> [t]his reduction/moderation in premium rates is a self-initiated set of coordinated actions that are designed to prevent any further accumulation of surplus, return surplus levels to the middle of the target range and return value directly to

> subscribers through lower rates. Indeed, we believe such actions are the very essence of 'community health reinvestment.'

*Id.*at 9.

In Question (g), the June 14 Order asks "[w]hether there were any negative contributions to surplus made by GHMSI that should be taken into account for the plan." June 14 Order at 20. As set forth in **Exhibit 2** (attached), GHMSI's small group and individual rate filings demonstrated a consistent and dedicated approach to rate moderation through the use of negative contributions to reserve, which resulted in a $42.44M reduction in surplus from 2011 through January 2014. Each small group rate filing for effective dates from May 1, 2011, through January 1, 2013, were filed with a negative contribution to reserve, which resulted in a total of $35.13M being reinvested through rate moderation.[5] Similarly, GHMSI included negative contributions to reserves in its individual rate filings from June 1, 2011, through January 1, 2014, which resulted in a reduction of surplus of $7.31M.[6]

[5]The following small group rate filings include a reduction in surplus as a negative contribution to reserve: CFAP-127044248 (effective May 1, 2011); CFAP-127118704 (effective August 1, 2011); CFAP-127350283 (effective November 1, 2011); CFAP-127388738 (effective January 1, 2012); CFAP-127779155 (effective April 1, 2012); CFAP-128093858 (effective July 1, 2012); CFAP CFAP-128355618 (effective October 1, 2012); and CFAP-128650978 (effective January 1, 2013). As part of the Proposed Rate Change Deviation and Pricing Pages included with these filings, GHMSI included two sets of rate changes: the "Required Rate Change" and "Proposed Rate Change." The Required Rate Change is the change necessary to achieve the "Contribution to Reserve" identified under the Company's proposed retention. In each filing, to demonstrate a negative contribution to reserve, GHMSI included either (1) an express negative Contribution to Reserve in the schedule, with an identical Required and Proposed Rate Change, or (2) a Proposed Rate Change that was less than the Required Rate Change, which resulted in a reduced retention and a negative Contribution to Reserve.

[6]From the period of 2011 through January 1, 2014, 24 of GHMSI's 27 individual (under 65) rate filings included a reduction in surplus as a negative contribution to reserve: CFAP-127049232, CFAP-127048531, and CFAP-127049176 (effective June 1, 2011); CFAP-127074098, CFAP-127074181 (effective July 1, 2011); CFAP-127159629, CFAP-127159563 (effective October 1, 2011); CFAP-127360767, CFAP-127360790 (effective January 1, 2012); CFAP-127812299, CFAP-127812318 (effective April 1, 2012); CFAP-128088866 (effective July 1, 2012); CFAP-128343804, CFAP-128343860 (effective October 1, 2012); CFAP-128659634, CFAP-128659635 (effective January 1, 2013); CFAP-128718533 (effective April 1, 2013); CFAP-128902801, CFAP-128905891 (effective July 1, 2013); CFAP-128905891 (effective October 1, 2013); and CFAP-12919773 (effective January 1, 2014). These filings also included negative contributions to reserve as described in Note 5.

GHMSI clearly explained these reductions to DISB as part of its January 1, 2012, rate filing:

> As of 12/31/10, the "Risk-Based Capital" (RBC) percentage for GHMSI was 1098%. In 2011, two independent actuarial consultants, Milliman and the Lewin Group, updated their recommended optimal RBC range to reflect the impact of federal healthcare reform. Based on their surplus evaluations, management filed with their respective regulators revised GHMSI RBC ranges of 1000% - 1300% (Board Approved). These ranges have increased significantly over the previous ranges that were set in 2008, which were 750%-1050%.
>
> For the 8/1/11 filing, prior to the approval of the new GHMSI RBC, the year-end RBC of 1098% was above the high end of the 2008 range. *Our Board RBC policy prescribes that we reduce rates to invest the surplus in our subscribers when we are above the high end of the range, which is why the Contribution to Reserve target was set negative for the 8/1 filing.*

GHMSI response to Objection 1, SERFF Tracking Number CFAP-127388738 (Oct. 13, 2011) (emphasis added). As further stated in the response, GHMSI's filing for rates effective January 1, 2012, was after board approval of new RBC ranges, which were higher than previous ranges. As a result, GHMSI would need to increase its surplus, but would do so gradually, while continuing to include a negative contribution to reserve through the use of filed rate changes that were less than the rate change necessary for a positive contribution to reserve.

GHMSI's rate moderation activities were also well communicated to the market, and circulated to the broker community as part of a CareFirst Sales Flash for rate effective May 1, 2011. In the Sales Flash, brokers, general and full-service producers were all told that:

> Consistent with its mission, CareFirst strives to set rates that make health coverage affordable for the maximum number of residents in the communities that we serve, while maintaining prudent financial stability. Health insurers nationally have seen health care spending decrease from levels projected in late 2009 and early 2010. As a result *CareFirst is moderating rates even in the face of the uncertainties posed by federal health care reform.*

CareFirst Sales Flash, March 8, 2011 (emphasis added) (attached as **Exhibit 3**).

To the extent that the June 14 Order speculates that rate moderation may have been motivated by market factors, such speculation is both unsupported in the record and irrelevant. Nothing in the definition of community health reinvestment hinges on GHMSI's intentions – it applies so long as GHMSI has made an expenditure that benefits its subscribers or the community. Here, however, GHMSI *intended* to moderate rates, continued its program of rate moderation for 2012 through 2014, and incurred $62 million in underwriting losses as a result. It defies logic to conclude that such rate reductions and moderation may be ignored.

D. GHMSI's Contributions To Healthy DC Were Taken from "Excess Surplus."

In 2012 through 2014, GHMSI was required to provide $5 million to the Healthy DC fund each year. These funds did not come from premium dollars – GHMSI's premium receipts in the District were insufficient to recover even its day to day operating expenses. There can be no reasonable dispute whether this $15 million contribution to Health DC constitutes a community reinvestment – "community health reinvestment" includes any "expenditures that promote and safeguard the public health or that benefit current or future subscribers." D.C. Code § 31-3501(1A).

It does not matter whether such expenditures are required under a statute or under a public-private partnership agreement – the definition of community health reinvestment applies to *any* expenditure within the scope of the definition, not merely to voluntary expenses. *Id.* The remedial provisions of the MIEAA similarly make no distinction between community reinvestments that are required by law and ones that are voluntary – either may reduce surplus and either must be properly considered in any plan to dedicate excess surplus.

Where GHMSI incurred $62 million in underwriting losses during the period of 2012 to 2014, it cannot reasonably be concluded that this $15 million contribution was included in or

paid out of received "premiums." It was not – GHMSI's surplus provides the only source for such payments. To the extent that these contributions caused a reduction in GHMSI's District-attributed surplus (which they did), they must be recognized as a reduction of excess surplus in any remedial plan.

E. GHMSI's Open Enrollment Losses Were Taken from "Excess Surplus."

In 2012, 2013 and 2014, GHMSI provided $24 million in subsidies for the District's open enrollment program ($7.5 million in 2012, $10.3 million in 2013, and 6.2 million in 2014). Again, there can be no reasonable dispute that such subsidies constitute community reinvestment – they are plainly expenditures of GHMSI "that benefit current or future subscribers." D.C. Code § 31-3501(1A). Nor can one reasonably argue that such subsidies were included in premium dollars, where the subsidies were specifically provided *because* premiums were inadequate to cover costs, and where GHMSI incurred $62 million in underwriting losses during the same period. As with the Healthy DC contributions, to the extent that GHMSI's District-attributed surplus was reduced by these subsidies, the subsidies must be recognized as a reduction of excess surplus in any remedial plan.

F. DISB Has No Authority To Develop And Then Approve Its Own Surplus Distribution Plan, Other Than Denying Rate Increases For 12 Months.

The MIEAA did not confer upon DISB the power to develop and then "approve" its own surplus distribution plan. The MIEAA sets forth a particular process that DISB must follow, identifies the precise determinations that DISB must make, and then specifies precise remedies that only apply after a finding of excessiveness. These remedies specifically provide only two alternatives: (1) a plan submitted by GHMSI or (2) a decision by DISB to deny premium increases for twelve months. *See* D.C. Code § 31-3506(i) (emphasis added). DISB's own

regulations refer only to the specific remedy of denying premium rate increases, and do not specify any other potential remedies that DISB may order. *See* D.C.M.R. 26-A4603.3.

The remedy provided in the MIEAA, to deny premium increases for twelve months, is precisely in line with the DISB's authority to review surplus annually, and its role in approving annual rates. After DISB freezes rates for twelve months, DISB may on the next surplus review continue to freeze rates if any excess surplus remains. This remedy provides a limited exception to the general requirement that rates must be adequate, and it is consistent with the requirement in the GHMSI Charter that GHMSI must be operated solely for the benefit of its subscribers.[7] DISB has no authority to replace the statutory remedy set out in the MIEAA with its own remedial plan.

CONCLUSION

For all of the foregoing reasons and those stated in prior submissions, GHMSI respectfully requests that DISB engage with Maryland and Virginia to achieve a joint resolution of the issues raised by this case as required by MIEAA and GHMSI's Federal Charter before issuing any remedial plan or final Order.

[7]However, the DISB must first obtain approval of Maryland and Virginia under the Charter before GHMSI's rate increases can be frozen, as the freezing of any rate increases will be used as a means to distribute excess surplus.

EXHIBIT 1

Chet Burrell
President and Chief Executive Officer

CareFirst BlueCross BlueShield
1501 S. Clinton Street, Suite 700
Baltimore, MD 21224-5744
Tel. 410-605-2558
Fax 410-781-7606
E-mail: chet.burrell@carefirst.com

CareFirst BlueCross BlueShield

June 1, 2011

The Honorable William P. White
Commissioner
D.C. Department of Insurance, Securities and Banking
810 First Street, NE, Suite 701
Washington, DC 20002

Dear Commissioner White:

Pursuant to DCMR Sections 4601.1-4601.2, Group Hospitalization and Medical Services, Inc. (GHMSI), an affiliate of CareFirst, Inc. (CFI), submits this Report on GHMSI's surplus as of Year-End 2010. Also included is a brief summary of the history of GHMSI's surplus positions as well as related information and background material to provide context intended to aid your review. The major points discussed below are as follows:

- GHMSI's surplus at Year-End 2010 was 1098 percent Risk-Based Capital - Authorized Control Level (RBC-ACL), up from 902 percent at Year-End 2009, as a result of an unprecedented, industry-wide drop in medical care trend costs.

- When it became clear that medical care costs would be lower than anyone had anticipated, GHMSI began taking steps to limit surplus, including filing for premium rate reductions where appropriate.

- In light of the changes and uncertainty accompanying federal health care reform, GHMSI commissioned new actuarial evaluations of its appropriate surplus range from two separate independent experts. Those reports identified substantial new risks posed by federal health care reform and recommended surplus ranges of 1050-1300 percent RBC-ACL and 1000-1550 percent RBC-ACL.

- The Boards of CFI, GHMSI and CareFirst of Maryland, Inc. (CFMI) have reviewed these recommendations and chosen to adopt for GHMSI the lower recommended figure for both the bottom and top of the range, producing a target of 1000-1300 percent RBC-ACL for the period 2011-2013. GHMSI plans to re-evaluate surplus requirements by mid-2013 in light of what will undoubtedly be the availability of substantially more data on the impacts of federal reform.

- GHMSI continues to give generously to the community in order to serve the most vulnerable populations in our community, contributing nearly $55 million in community health reinvestment in 2008-2010.

Background and History

This report follows the issuance last year of two orders by the Commissioner of the Department of Insurance, Securities and Banking (DISB) regarding GHMSI's surplus level in 2008. On August 6, 2010, the Commissioner issued an initial Decision and Order which, among other things, addressed the two-part statutory test for surplus required under the Medical Insurance Empowerment Amendment Act (MIEAA), after extensive public hearings and examining five reports submitted by various actuarial experts in connection with the proceeding.

The Decision and Order noted that, despite using varying methodologies to calculate an appropriate RBC-ACL for GHMSI's surplus, the results of four of the five expert reports "overlap substantially." One of these reports was performed by the expert Invotex Group (Invotex) engaged by the Maryland Insurance Administration (MIA) to review both GHMSI's and CFMI's surplus positions. The DISB Commissioner accorded no weight to the fifth report by Actuarial Risk Management (ARM) retained by the DC Appleseed Center. The Decision and Order noted that "all four ranges determined by the experts include the RBC-ACL range of 750% to 850% as a subset."

However, the Commissioner declined at that time to reach a decision about a reasonable surplus level for GHMSI, noting that two events following the experts' reports – federal health care reform and certain statutory changes in the District of Columbia that limited GHMSI's ability to increase rates – could affect GHMSI's future risks and surplus needs. Accordingly, the Commissioner reopened the record, in particular seeking additional input on the impact on GHMSI's surplus needs resulting from federal health care reform.

Following receipt and evaluation of additional reports from the experts, the Commissioner on October 29, 2010, issued her Final Decision and Order in which she established 850 percent RBC-ACL as the approved surplus level and accordingly determined that GHMSI's Year-End 2008 surplus of 845 percent RBC-ACL was not unreasonably large. While noting that GHMSI's surplus had increased to 902 percent RBC in 2009, the Commissioner recognized that "the Federal Health Care Reform Act may have a financial impact on GHMSI in the short term that warrants a higher level of surplus." The Commissioner noted that "the underlying assumptions of this review [the 2008 review] are expected to change." Hence, her Final Decision and Order stated that the DISB would undertake a new review of GHMSI's surplus by July 2012, after federal rules and their likely impacts were more thoroughly understood.

This process followed by the Commissioner, as well as her decision, were entirely consistent with the MIEAA which requires the Commissioner to periodically review GHMSI's surplus (annually in the discretion of the Commissioner, but no less frequently than every three years). The Commissioner must "review the portion of the surplus of the corporation [GHMSI] that is attributable to the District and may issue a determination as to whether the surplus is excessive." D.C. Code §31-3506(e). GHMSI's surplus may be considered excessive only if:

(1) The surplus is greater than the appropriate risk-based capital requirements as determined by the Commissioner for the immediately preceding calendar year; and

(2) After a hearing, the Commissioner determines that the surplus is unreasonably large and inconsistent with the corporation's obligation under §31-3505(a).

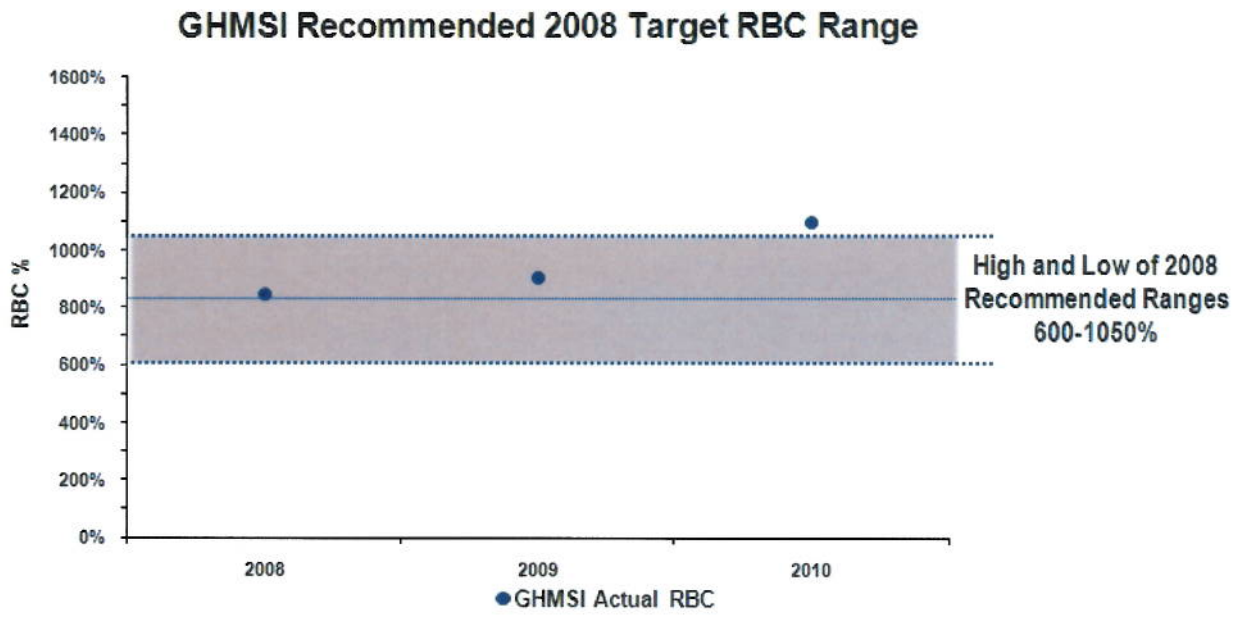
Id. This latter clause refers to a provision that requires "[a] corporation [to] engage in community health reinvestment to the maximum feasible extent consistent with financial soundness and efficiency." Id. § 31-3505.01. It is noteworthy that "community health reinvestment" is defined to mean "expenditures that promote and safeguard the public health or that benefit current or future subscribers, including premium rate reductions." Id. §31-3501(1A).

As a plain reading of the statute reveals, surplus must be both "unreasonably large" and "inconsistent" with the obligation to engage in community health reinvestment if it is to be considered "excessive" by the Commissioner. Based on the substantial record of largely overlapping expert analyses developed pre- and post-public hearing, the Commissioner determined that GHMSI's surplus level in 2008 was not unreasonably large.

Coordination with Maryland

MIEAA requires the Commissioner to coordinate with other jurisdictions in reaching any determination on GHMSI's surplus. For purposes of DISB's 2008 surplus review this was facilitated by the fact that the MIA performed its own extensive analysis of GHMSI's surplus at essentially the same time as the matter was under review at the DISB. As noted above, the MIA used its own outside expert – Invotex -- whose results were included in the DISB Commissioner's review and referenced in her Orders. The MIA came to the same conclusion on the same set of facts: that GHMSI's surplus was "neither unreasonably large nor excessive." The MIA issued its own order to this effect in January 2010. In so doing, it established a target surplus range for GHMSI of 700-950 percent RBC. **Chart 1** shows GHMSI's RBC in the context of the lowest and highest of the four recommended ranges to which the Commissioner gave weight.

Chart 1



Recently, at the MIA's request, GHMSI and CFMI negotiated and executed a Consent Order with the MIA that provides a framework in Maryland for establishing a balance in the setting and regulatory review of surplus. This Consent Order, along with an accompanying letter from the companies on the matter of establishing targeted surplus ranges, is provided for reference as **Attachment A** in light of the MIEAA's coordination requirement. Finally, we understand that MIA has taken steps to retain outside expertise in its review of GHMSI's new targeted surplus range under the Consent Order and expects to get underway with this review over the next several months. This will provide an important new reference point which we believe should be taken into account by the DISB as part of its coordination with Maryland regulators.

CareFirst Surplus Policy

In 2008, well before the Commissioner's 2010 orders, the Boards for GHMSI, CFMI and CFI collectively adopted a policy on the interaction between surplus, rate setting and community giving. This policy is titled *Summary of CareFirst BlueCross BlueShield's Approach to Community Giving in the Context of its Role as a Not-for-Profit Health Plan* and is attached to this letter as **Attachment B**. Simply put, this policy provides that the companies establish a surplus range for each affiliate no less frequently than every three years based on the best possible expert advice from highly qualified independent actuaries. The range for each affiliate is intended to be appropriate, reasonable and prudent, with a midpoint that serves as the target surplus level each affiliate strives to maintain.

The policy provides that should one of the affiliates be low in its intended range (i.e., below midpoint, or below the bottom of the range as is currently the case for CFMI), the affiliate would include a margin in its rates to slowly build up its surplus position toward the midpoint of the range. Conversely, if an affiliate were high in its range or above its intended range, the affiliate would remove any margin in its rates or even reduce rates below cost to bring surplus back to the midpoint of the intended range.

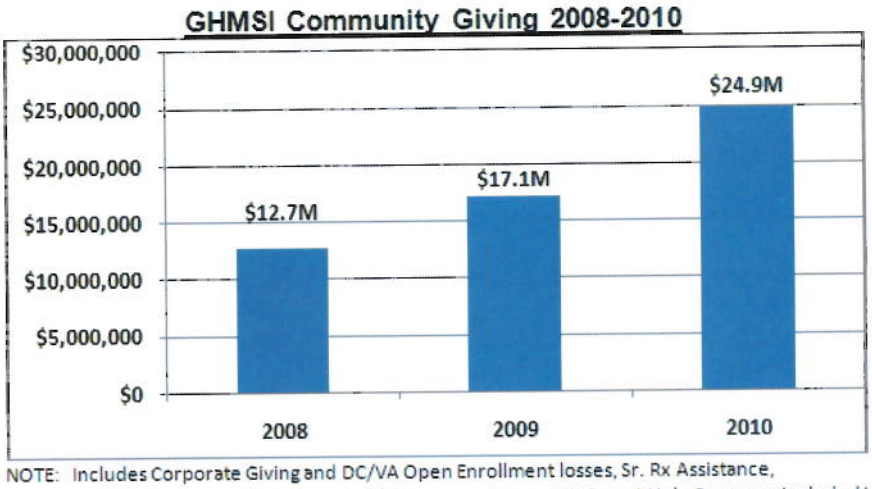
Thus, the companies seek to hold only the level of surplus necessary to preserve their financial solvency and meet their financial needs – and no more. The target level is the midpoint of a range for each affiliate that reflects each affiliate's particular risk profile and financial solvency needs. It is the responsibility of the Boards of CFI and its affiliates to establish the appropriate targeted surplus range in the first instance. To do otherwise would strip accountability from them – thereby seriously undermining their duty to protect subscribers and drive to remain viable and competitive in the market and press on with infrastructure and product enhancements.

CareFirst Community Giving Policy

GHMSI believes that the Congressional Charter under which it operates and the fulfillment of its mission require it to provide the lowest possible rates for its subscribers and that this represents the greatest good it can do for the larger community it serves. In other words, rate moderation constitutes the best and most effective way for GHMSI to make a "community health reinvestment." As shown above, MIEAA explicitly recognizes rate moderation and reduction as "community health reinvestment." Indeed, there is a long history of this view, going back to then-DISB Commissioner Lawrence Mirel's 2005 finding that GHMSI could fulfill its obligation to the community and carry out its mission solely by service to its subscribers.

Nevertheless, beyond keeping premium rates as low as possible, GHMSI takes its commitment to give to its community very seriously. To this end, GHMSI gives generously to a wide range of community organizations and causes. The level of this community giving has risen steadily to its highest levels in recent years, totaling nearly $55 million in the three years 2008-2010. This is shown in **Chart 2**.

Chart 2



NOTE: Includes Corporate Giving and DC/VA Open Enrollment losses, Sr. Rx Assistance, DHMH, MD Rx Discount, Md. Comm. Health Resource Comm. MD Donut Hole Coverage included in subsidies effective Jan. 2009, contribution to Healthy DC Fund effective Jan. 2010.

When the premium taxes GHMSI pays to the District of Columbia are added to its other community giving, GHMSI's "community health reinvestment" is among the most robust in the nation relative to other Blue Cross and Blue Shield plans. Indeed, GHMSI was recently recognized in the *Washington Business Journal* as the second most generous corporate contributor in the District, giving to various worthy causes that focus heavily on the most vulnerable populations in the community. These contributions to the community are important to GHMSI – but they also represent a substantial cost to subscribers, and as a result GHMSI's Board of Trustees must be careful to balance community giving against subscribers' need for the lowest possible rates.

The Nature of the Challenge in Surplus Setting

Setting a prudent surplus level for a company like GHMSI is a complex undertaking that requires special expertise and sophisticated computer-based modeling. The results of modeling must then be passed through the filter of experience and sound actuarial/business judgment. The task is somewhat similar in nature to determining the stress-bearing capabilities of a suspension bridge under varying loads of traffic, wind, currents and earthquake risks. What effect on the bridge's stability will all these forces have when taken individually or in various combinations? And, what degree of confidence does one want when crossing the bridge – 90 percent? 98 percent? 100 percent? To reach an answer requires special expertise and knowledge.

The stresses on GHMSI are considerable and constantly shifting. Risks range from capital market risks and customer payment risks to misjudging medical care cost trends for thousands of individuals and small groups with different demographics, products and health risks. GHMSI's risk exposure is accentuated by the fact that it is a one product line-one region company of modest size when compared to the multi-region, multi-product line profiles of its primary competitors. It is also seen as a preferred source of insurance services by those most in need of such services – a place of safety for adverse risks. Indeed, GHMSI's own policies induce this perception since they convey the intent of the company to reach and serve as many of these risks as possible consistent with the requirements of solvency and competitiveness.

Further, GHMSI must serve as its own source of funding for investment in new health coverage plan products and their underlying technologies. This must occur in an increasingly demanding and rapidly changing environment where complexity is increasing nearly exponentially and where national competitors have deeper pockets. To meet these demands, GHMSI can take on debt only under extreme limitations and cannot issue

shares to raise capital and surplus. It must fund all initiatives out of its own cash flow and surplus. And, it knows from hard experience that were it to run into serious financial difficulty, there are no safety nets or bailouts from government at any level.

Now, the era of federal health care reform is dawning and adds tremendously to the complexity and uncertainty of the environment in which GHMSI must operate. The advent of minimum medical loss ratio requirements with their attendant rebate exposure, unreasonable rate limits, risk adjustments, stringent benefit/coverage requirements, guaranteed issue of policies to all comers and a host of other newly imposed obligations and standards create crosswinds and stresses on the GHMSI "bridge" to a degree never envisioned. New product standards, new methods of bringing products to market (Insurance Exchanges) and the unintended effects of all these things – when taken together – creates uncertainty in outcome at a level never known before. All of this occurs without removing or mitigating the considerable risks that have historically defined the nature of the business.

Indeed, there is an asymmetrical nature to the risks GHMSI now faces. The speed, agility and range of action the company may be able to take in reaction to a worsened risk profile are all constrained – and will continue to be increasingly constrained by federal health care reform – while the risks and unknowns are augmented. In short, the Commissioner was correct in saying that the assumptions and conclusions reached in the relatively placid "old" world of 2008 may no longer apply to the "new" more stormy and uncertain world of early reform (2010-2013) in which the company now operates. The later stages of reform (2014 onward) are likely to further exacerbate both the risks and the constraints on GHMSI in dealing with them.

The central point here is obvious: Setting surplus levels wisely and correctly is a complex undertaking. In this case, for GHMSI the correct surplus level must allow the company to reliably bear up under the heavy traffic loads it handles for its subscribers and the larger community with little or no margin for error and no government safety net.

Nevertheless, GHMSI recognizes the legitimate concern of government to see to it that the drive for solvency does not lead to excess in surplus any more than it should lead to insufficiency. The CFI and GHMSI Board of Trustees, as explained above, have put in place policies in an effort to assure that excess surplus is not maintained. And, these policies have been put into practice – principally through rate moderation and rate reductions as explained below.

Updated Actuarial Analyses Reveal Need for Higher Surplus Level

In recognition of the changing environment described above, the GHMSI, CFMI and CFI Boards decided to undertake an immediate, comprehensive review of the current surplus levels of the affiliates and of the companies as a whole. This new review was undertaken sooner than company policy calls for (i.e., less than three years after completion of the last reviews) in light of the already-emerging impacts of federal health care reform.

Milliman, Inc. (Milliman) and The Lewin Group (Lewin) were asked to conduct these *de novo* reviews because of their status as leading, nationally recognized experts in the field of actuarial science, their breadth of experience with other Blue Plans, and their familiarity with the circumstances, experience and history of the companies. Each was given full access to all underlying company experience and data and each was instructed to conduct its review completely independently. Each used its own different, proprietary methodological approach. Neither spoke to nor consulted with the other in any way.

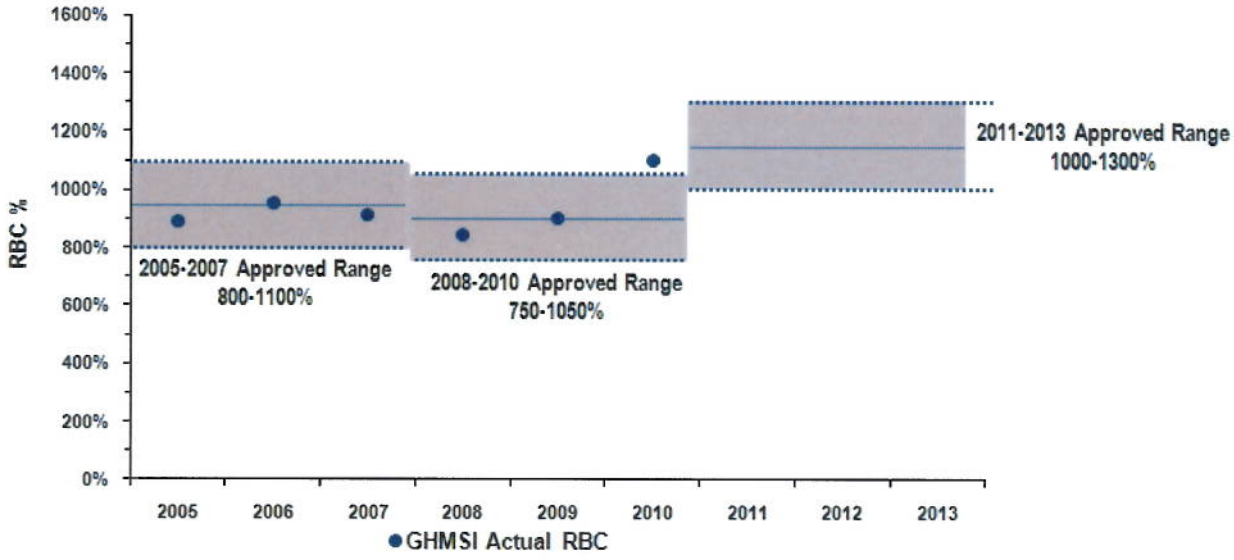
In essence, the Boards wanted to know whether their approved surplus range for GHMSI of 750 to 1050 percent RBC-ACL was still appropriate, reasonable and prudent given the changing landscape the company

was entering. Hence, the review was forward-looking and is meant to apply to the period 2011-13. Based on its extensive work, Milliman has made a recommendation that GHMSI's target surplus range be raised to a range of 1050 to 1300 percent of RBC-ACL. It notes in its report that when the full impacts and details of federal health care reform are known, an additional 100-150 percentage point increase in this new range may be called for. For its part, Lewin recommends a new, broader range of between 1000 to1550 percent of RBC-ACL. These ranges overlap substantially even though they were arrived at through different methodologies. The firms' full reports are attached as **Attachments C and D.**

Both firms based their ranges on confidence levels ranging from 90-95 percent certainty that GHMSI's surplus would not fall below the 375 percent BCBSA early warning monitoring threshold (requiring special reporting and aggressive financial management) and a 95-98 percent confidence level that GHMSI would not fall below the regulatory and loss of trademark threshold of 200 percent RBC-ACL. The reports explain why these confidence levels are appropriate, and why each range suffices to give GHMSI reasonable assurance against dropping below these thresholds. But, even these degrees of confidence still leave some risk that the lower threshold will be pierced, to the detriment of GHMSI and its subscribers.

The CFI, CFMI and GHMSI Boards extensively reviewed and discussed these recommendations during their regular committee and full Board meetings in May. They decided to adopt the lower recommended figure for both the top and bottom of the range, thus producing a target range of 1000 percent of RBC-ACL (Lewin's low end) to 1300 RBC-ACL (Milliman's high end) on a going-forward basis for the next 24 months. The Boards called for a full new review by mid-2013, at which point the Boards should have a far more complete understanding of the impacts of federal health care reform. The newly adopted range is shown in **Chart 3** below. The new ranges are in effect immediately.

Chart 3
GHMSI Approved Target RBC Ranges

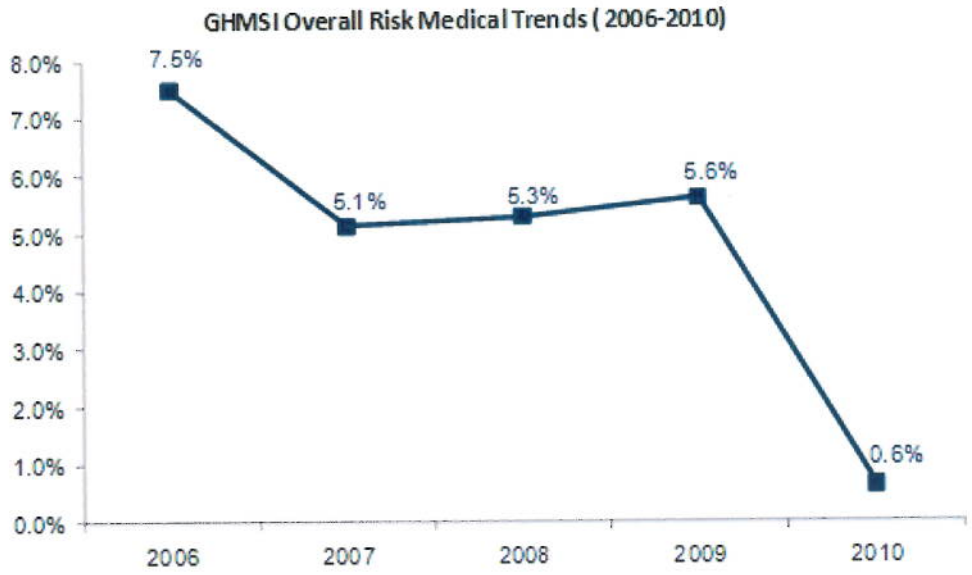


GHMSI's Current Surplus Level

GHMSI's surplus stood at 1098 percent RBC-ACL at Year-End 2010, a rise of 196 points from Year-End 2009. That increase was the result of an unforeseen, and precipitous, drop in what had been an upward trend for medical care costs. As was the case with most health insurance carriers in the U.S. last year, GHMSI saw

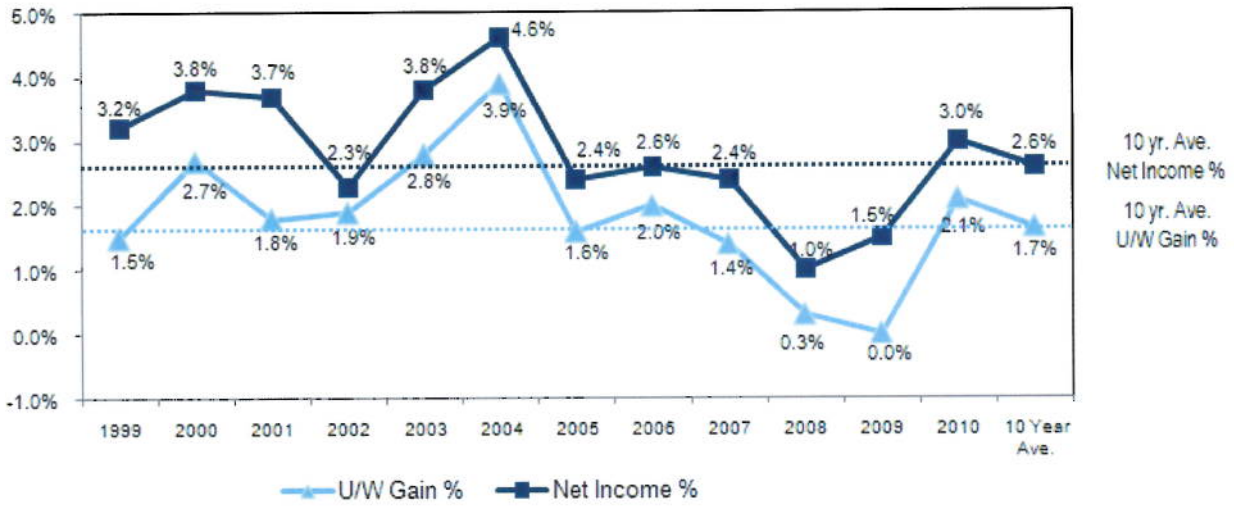
overall medical care cost trends plummet in 2010 to a level last seen in the early 1990's. No one, including the company itself, predicted this. Nor is anyone, including the company, sure of how long and to what degree it will last. **Chart 4** shows this abrupt downward trend taking hold in 2010.

Chart 4



This drop in trend had several effects on GHMSI's financial results. First, GHMSI saw an increase in its underwriting margin, which rebounded from a slight loss in 2009 to a gain of approximately 2 percent. 2009 was the low point in underwriting performance for the company in the last decade – a ten year period that saw average gains of 1.7 percent and a high of 3.9 percent in 2004. On the strength of this improvement in underwriting gain as well as strong returns in the financial markets in 2010, GHMSI's overall net income rose to 3.0 percent – a better than average year when looking back over the past decade, as reflected in **Chart 5**. The combination of the decline in medical care cost trends and the strong returns in capital markets translated into the increase in GHMSI's surplus, which resulted in a higher RBC-ACL for GHMSI.

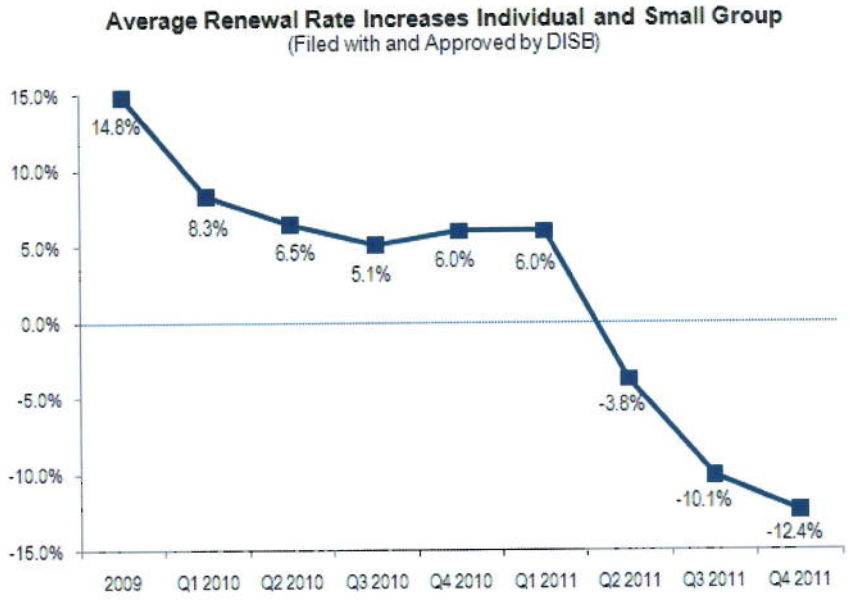
Chart 5



CareFirst/GHMSI Actions to Date in Accordance with its Policy

As the positive trends began to emerge in 2010, GHMSI began to act. It did so principally by filing ever-more moderate premium rate increases. This began in late 2010 and has continued into 2011 with each passing quarter as greater credibility was assigned to the emerging slowdown in the rise of medical costs. **Chart 6** shows this data.

Chart 6



In 2011, GHMSI took the initiative to file for premium rate reductions with the DISB, as did BlueChoice where operating results were unusually strong. GHMSI is closely monitoring emerging trends to assess any changes in direction, particularly a reversion to the former, higher mean. This reduction/moderation in premium rates is a self-initiated set of coordinated actions that are designed to prevent any further accumulation of surplus, return surplus levels to the middle of the target range and return value directly to subscribers through lower rates. Indeed, we believe such actions are the very essence of "community health reinvestment."

Now, there is a new surplus range that must be addressed. The company expects to continue to moderate or reduce premium rates for as long as trends indicate this is the correct course. The 2010 ending level of 1098 percent of RCB-ACL is not quite at the middle of this new range. The company's objective remains the same: Keep the actual surplus at the middle of the new range through rate filings that prevent any further strengthening in surplus over the next two years until a new assessment can be made regarding the appropriateness of GHMSI's surplus level.

Conclusion

GHMSI is striving by its policies and its actions to carry out the mandates of its Congressional Charter and to operate within both the spirit and letter of the law in the District of Columbia. In furtherance of this, the Boards of GHMSI, CFMI and CFI have sought expert advice – on a timely basis – to assure that the companies operate with financial soundness within the ever changing environments in which they find themselves. The judgment the Boards bring to the issue of how much surplus GHMSI must carry is undertaken only after obtaining the best possible advice from leading experts.

The Boards have reviewed and adjusted surplus ranges as necessary. They have overseen the filing of self-initiated premium rate reductions that carry out a policy of community health reinvestment. They have seen to it that company resources are invested wisely and conservatively so that investment returns can contribute to increasing the affordability of health care coverage and lessen the financial burdens borne by subscribers who carry CareFirst coverage. They have seen to it that substantial community giving is carried out – indeed the most of any carrier in the region and the nation – with a particular focus on the most vulnerable and disadvantaged among us. And, they have used community giving to spur catalytic changes in the health care system that hold promise for more effective cost control in the future while stimulating improvements in quality as well.

It is GHMSI's view that a sound process for properly establishing and monitoring surplus level – and its close interconnection to community giving and premium rates – has been followed with great attentiveness, thoughtfulness and seriousness. Neither our Boards nor anyone else predicted the Great Recession, or the meltdown in the financial markets in 2008, or the positive impacts of the dramatic drop in medical care cost trends, or even that federal health care reform would become law. This all occurred in just the last three years. What other unknowns lie ahead? GHMSI operates in an ever-changing and uncertain environment – and, even in a good year, produces only slim margins in exchange for the substantial risks it bears.

A surplus level at the mid-point of a range established by the Boards on the coinciding and overlapping advice of two independent experts, we believe, cannot be unreasonably large or excessive. And, premium rate actions designed to keep it there in a changing, even stormy environment, are the very fulfillment of the community health reinvestment objective of MIEAA.

We look forward to discussing the material enclosed and to aiding your review of GHMSI's surplus in any way we can.

Sincerely,

Chet Burrell
President and Chief Executive Officer
CareFirst BlueCross BlueShield

Cc: Therese Goldsmith, Commissioner (appointed), Maryland Insurance Administration
Beth Sammis, Interim Commissioner, Maryland Insurance Administration
Jacqueline K. Cunningham, Commissioner Virginia Bureau of Insurance

Attachments:

A – Consent Decree – Maryland Insurance Administration 05-24-1

B – CareFirst's Policy: Summary of CareFirst BlueCross BlueShield's Approach to Community Giving

C – Milliman, Inc. Recommendations on GHMSI Reserves

D – The Lewin Group Recommendations on GHMSI Reserves

EXHIBIT 2

Estimated Negative Contribution to Surplus
GHMSI Small Group Rate Filings in the District of Columbia

Filing Effective Date	SERFF Numbers	Required Rate Change *	CtR in Required	Proposed Rate Change **	CtR in Proposed	Approved Rate Change ***	CtR in Approved	Dollars (Millions)
May-11	CFAP-127044248	2.90%	1.0%	-6.3%	-8.2%	-6.3%	-8.2%	($4.32)
August-11	CFAP-127118704	-11.2%	-7.1%	-11.2%	-7.1%	-11.2%	-7.1%	($3.29)
November-11	CFAP-127350283	-10.0%	-7.6%	-11.1%	-8.7%	-11.1%	-8.7%	($3.93)
January-12	CFAP-127388738	-1.6%	5.0%	-10.5%	-3.9%	-10.5%	-3.9%	($2.46)
April-12	CFAP-127779155	4.7%	0.0%	-4.5%	-9.2%	-4.5%	-9.2%	($4.07)
July-12	CFAP-128093858	13.6%	0.0%	4.4%	-9.2%	4.4%	-9.2%	($4.51)
October-12	CFAP-128355618	25.9%	2.0%	10.0%	-14.0%	10.0%	-14.0%	($9.15)
January-13	CFAP-128650978	22.5%	2.0%	13.8%	-6.7%	13.8%	-6.7%	($3.40)
Total								**($35.13)**

* This is the rate GHMSI calculated that is necessary to achieve the required contribution to reserve (CtR).

** This is the rate GHMSI filed for approval, and when lower than the Required Rate Change, results in a lower CtR than included in the Required Rate Change.

*** This is the rate and resulting CtR as approved by the DISB.

EXHIBIT 2

Estimated Negative Contribution to Surplus
GHMSI Individual Rate Filings in the District of Columbia

Filing Effective Date	SERFF Numbers	Required Rate Change *	CtR in Required	Proposed Rate Change **	CtR in Proposed	Approved Rate Change ***	CtR in Approved	Dollars (Millions)
June-11	CFAP-127049232, CFAP-127048531, CFAP-127049176	6.0%	1.0%	-4.8%	-9.8%	-4.8%	-9.8%	($1.33)
July-11	CFAP-127074098, CFAP-127074181	3.9%	1.4%	-5.0%	-7.5%	-4.4%	-6.9%	($0.38)
October-11	CFAP-127159629, CFAP-127159563	-12.3%	-10.0%	-12.2%	-9.9%	-12.2%	-9.9%	($0.58)
January-12	CFAP-127360767, CFAP-127360790	-9.6%	-5.0%	-8.2%	-3.6%	-8.2%	-3.6%	($0.23)
April-12	CFAP-127812299, CFAP-127812318	-10.8%	0.0%	-12.2%	-1.4%	-12.2%	-1.4%	($0.06)
July-12	CFAP-128088866	19.6%	2.0%	3.1%	-14.5%	3.1%	-14.4%	($0.24)
October-12	CFAP-128343804, CFAP-128343860	19.5%	3.0%	7.9%	-8.6%	7.8%	-8.7%	($0.50)
January-13	CFAP-128659634, CFAP-128659635	20.1%	0.0%	10.1%	-10.0%	10.1%	-10.0%	($0.53)
April-13	CFAP-128718553	22.0%	0.0%	14.6%	-7.4%	11.9%	-10.0%	($0.19)
July-13	CFAP-128902801, CFAP-128905891	17.4%	0.0%	13.6%	-3.8%	11.7%	-5.7%	($0.17)
October-13	CFAP-128905891	15.6%	0.0%	8.8%	-6.8%	6.3%	-9.3%	($0.13)
January-14	CFAP-129197731	31.2%	0.0%	14.9%	-16.3%	14.9%	-16.3%	($2.97)
Total								**($7.31)**

* This is the rate GHMSI calculated that is necessary to achieve the required contribution to reserve (CtR).

** This is the rate GHMSI filed for approval, and when lower than the Required Rate Change, results in a lower CtR than included in the Required Rate Change.

*** This is the rate and resulting CtR as approved by the DISB.

EXHIBIT 3

CareFirst Sales Flash

For Distribution to Brokers/General Producers/Full-Service Producers Only
(Not Intended for Distribution to Groups and Members)

March 8, 2011

Rate Reductions - Pricing Updates Effective 5/1/2011

MARKET: MSGR, VA 1-50, DC 1-50, NON-MSGR/MD PARITY

CareFirst BlueCross BlueShield (CareFirst) and CareFirst BlueChoice, Inc. (collectively CareFirst) are extremely pleased to announce the following rate reductions that have been filed and approved for May 1, 2011. Rates will be updated shortly in the CareFirst rating systems and in the General and Full-Service Producer proposal systems. Please note that the percentages indicated are changes over the 4/1/2011 rate actions. You will notice larger rate reductions in the DC and Virginia markets. CareFirst will revisit the next rate adjustments for DC and VA 1-50 groups sometime in August/September for an October effective date.

Reason for the Rate Reductions
Consistent with its mission, CareFirst strives to set rates that make health coverage affordable for the maximum number of residents in the communities that we serve, while maintaining prudent financial stability. Health insurers nationally have seen health care spending decrease from levels projected in late 2009 and early 2010. As a result, CareFirst is moderating rates even in the face of the uncertainties posed by federal health care reform.

MSGR (Medical and Rx):
- HealthyBlue: 5.0% **decrease** for non-CDH; 5.0% **decrease** for CDH

MD Non-MSGR/MD Parity (Medical and Rx):
- No Changes
- Renewal cap remains at 24%; floor is still at 0%

VA 1-50 (Medical and Rx):
- HealthyBlue: 11.0% **decrease** for non-CDH; 10.7% **decrease** for HSA; 10.3% **decrease** for HRA
- GHMSI: 8.2% **decrease** for non-CDH; 8.3% **decrease** for CDH
- BlueChoice: 10.9% **decrease** for non-CDH; 11.8% **decrease** for CDH
- Renewal cap remains at 34.5%; floor is still at 0%
- New Business discount remains at 12.5%

DC 1-50 (Medical and Rx):
- HealthyBlue: 8.4% **decrease** for non-CDH; 8.4% **decrease** for CDH
- GHMSI: 11.3% **decrease** for non-CDH; 11.1% **decrease** for CDH
- BlueChoice: 8.2% **decrease** for non-CDH; 9.2% **decrease** for CDH
- Renewal cap remains at 34.5%; floor is still at -25.7%
- New Business discount remains at 12.5%

Recent DC Legislation Results in Age Band Adjustments
Earlier this year, the District of Columbia passed Bill 792 the “Reasonable Health Insurance Ratemaking and Health Care Reform Act of 2010” part of which affects rating in the DC small group market. The law

states that “the standard rate for any age shall not be more than 104% of the standard rate for the previous age.” In order to comply, CareFirst will change from the 3-year age band currently used to a single year age band effective 5/1/2011. We will continue to use an average age methodology.

Moving forward, when CareFirst releases rate charts to our General and Full-Service Producers, there will be a total of 41 rows for the DC rates, where there used to be 12. There are no plans to make changes to the MD or VA rate charts, as those age bands will remain the same.

Should you have any questions, please contact your Broker Sales Representative.

C Shekar Subramaniam

Shekar Subramaniam
Associate Vice President, Broker Sales