Government of the District of Columbia
Department of Insurance, Securities and Banking

Karima Woods
Acting Commissioner

BEFORE THE
INSURANCE COMMISSIONER OF
THE DISTRICT OF COLUMBIA

Re: Report on Examination – **Group Hospitalization and Medical Services, Inc.** as of December 31, 2018

ORDER

An Examination of **Group Hospitalization and Medical Services, Inc.** (the "Company") as of December 31, 2018, has been conducted by the District of Columbia Department of Insurance, Securities and Banking ("the Department").

It is hereby ordered on this 8th day of May 2020, that the attached financial condition examination report be adopted and filed as an official record of this Department.

Pursuant to Section 31-1404(d)(1) of the D.C. Official Code, this Order is considered a final administrative decision and may be appealed pursuant to Section 31-4332 of the D.C. Official Code.

Pursuant to Section 31-1404(d)(1) of the D.C. Official Code, within 30 days of the issuance of the adopted report, the Company shall file affidavits executed by each of its directors stating under oath that they have received a copy of the adopted report and related order.

Pursuant to Section 31-1404(e)(1) of the D.C. Official Code, the Department will continue to hold the content of the report as private and confidential information for a period of 10 days from the date of this Order.

Dana Sheppard

Acting Deputy Commissioner

GOVERNMENT OF THE DISTRICT OF COLUMBIA

DEPARTMENT OF INSURANCE, SECURITIES AND BANKING

REPORT ON EXAMINATION

OF

GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC.

AS OF

DECEMBER 31, 2018

NAIC Company Code: 53007
NAIC Group Code: 0380

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Washington, D.C.
March 11, 2020

The Honorable Karima Woods
Acting Insurance Commissioner
Department of Insurance, Securities and Banking
Government of the District of Columbia
1050 First Street, NE, Suite 801
Washington, D.C. 20002

Dear Acting Commissioner Woods:

In accordance with Section 31-1402 of the District of Columbia Official Code, we have examined the financial condition and activities of

Group Hospitalization and Medical Services, Inc.

hereinafter referred to as "Company" or "GHMSI," a District of Columbia domiciled multi-state hospital and medical services corporation. The examination was conducted at the administrative office of the Company located at 10455 Mill Run Circle, Owings Mills, MD, 21117, and the following Report of Examination ("Report") is hereby respectfully submitted.

SCOPE OF EXAMINATION

The Company was last examined by representatives of the District of Columbia, Department of Insurance, Securities and Banking ("DISB" or the "Department") and covered the period from January 1, 2009 through December 31, 2013. The current full-scope risk-focused examination, covering the period from January 1, 2014 to December 31, 2018, and including any material transactions and/or events occurring after the examination date and noted during this examination was conducted by examiners representing the Department.

The examination was conducted in accordance with procedures and guidelines prescribed by the NAIC *Financial Condition Examiners Handbook* (Handbook). The Handbook requires that we plan and perform the examination to evaluate the financial condition, assess corporate governance, identify current and prospective risks of the Company, and evaluate system controls and procedures used to mitigate those risks. An examination also includes identifying and evaluating significant risks that could cause an insurer's surplus to be materially misstated, both currently and prospectively.

The examination of Washington, D.C. domestic companies of CareFirst, was called by the Department in accordance with the Handbook guidelines, through the NAIC's Financial Examination Electronic Tracking System. This examination was conducted as part of a multi-state risk-focused examination (the "Coordinated Examination") of the CareFirst, Inc. insurance entities, in which the Department served as the lead state on the examination. The Maryland Insurance Administration (the "MIA") accepted the invitation to participate in the Coordinated

Examination of the following insurance companies examined at the same time during the above examination:

Company and State of Domicile	NAIC#	Acronym [1]
CareFirst, Inc. (MD)	47201	CFI
CareFirst BlueChoice, Inc. (DC)	96202	CFBC
CareFirst of Maryland, Inc. (MD)	47058	CFMI
The Dental Network, Inc. (MD)	13130	TDN
First Care, Inc. (MD)	60113	FirstCare

Concurrent with this examination, we have also examined the Company's affiliate, CareFirst BlueChoice, Inc., a District domiciled Health Maintenance Organization ("HMO"). A report of examination of CFBC will be issued under a separate cover. In addition, reports of examination for each of the four (4) Maryland domiciled entities will be issued under separate covers by the MIA.

All accounts and activities of the Company were considered in accordance with the risk-focused examination process. This may include assessing significant estimates made by management and evaluating management's compliance with Statutory Accounting Principles. In planning and conducting our examination, we gave consideration to the concepts of materiality and risk, and our examination efforts were directed accordingly. The examination does not attest to the fair presentation of the financial statements included herein. If during the examination, an adjustment is identified, the impact of such adjustment will be documented separately following the Company's Financial Statements.

In addition to the above, the examiners have reviewed work papers prepared by Ernst & Young, LLP, the Company's independent auditors, in their audit of the Company's accounts and records for the year ended December 31, 2018. The firm expressed unqualified opinions on the Company's financial statements for calendar years 2014 through 2018. A portion of the auditor's workpapers have been incorporated in the workpapers of the examiners and have been utilized in certain phase of the examination.

The examination Report includes significant findings of facts, as mentioned in Section 31-1404 of the District of Columbia Code and general information about the Company and its financial condition. There may be other items identified during the examination that, due to their nature (e.g., subjective conclusions, proprietary information, etc.), are not including in the Report but may be separately communicated to the other regulators and/or the Company.

SUBSEQUENT EVENTS

[1] This Report uses the term "CareFirst" in a broad sense to refer to CFI, GHMSI, CFBC, CFMI, TDN, and FirstCare, collectively. When necessary, the report uses the term GHMSI, CFBC, CFI, CFMI, TDN and FirstCare to refer to the respective entities.

Maryland 1332 State Innovation Waiver

The state of Maryland established a state assessment under the Maryland Health Care Access Act of 2018 to provide funding for a reinsurance program of the state's individual health insurance market. Insurance entities subject to the 2019 assessment are assessed 2.75% of 2018 premiums. The Company paid its entire assessment of $9,331,000 in March 2019. At December 31, 2019, the Company recognized its total assessment, of which $2,412,000 was recorded as a reduction of premiums earned and $6,919,000 was recorded as general and administrative expense. Only insurers of the Affordable Care Act individual products are eligible for reinsurance recoveries from the risk pools. The coinsurance rate for 2019 is 80% of per member claims between $20,000 and $250,000. The Company included actual paid claims in calculating the receivable, which is included within amounts recoverable from reinsurers and recorded as a reduction of claims incurred. The Company recorded a receivable of $25,383,000 at December 31, 2019. The receivable is expected to be collected from the state in 2020.

Medicare Advantage

A Form D Prior Notice of Transaction and Statement of Proposed Action dated August 20, 2019, was filed with the Department on behalf of CFI, CFMI, GHMSI, and CFBC, (collectively "CareFirst") seeking approval to create and provide initial funding for a new corporation for the purpose of offering Medicare Advantage ("MA") coverage and to further the liquidity repositioning of CareFirst.

CareFirst intends for this new carrier, referred to here as "CareFirst Advantage," to enter the Maryland market with coverage beginning on January 1, 2021. CareFirst Advantage will offer health maintenance organization ("HMO") and point of service ("POS") plans. The initial service area is not yet defined, and CareFirst upon receipt of all necessary approvals expects ultimately to offer Medicare Advantage benefits and services throughout the entire Service Territory, including Maryland, the District of Columbia, and Northern Virginia. The Department approved the Form D filing on September 18, 2019.

Stop Loss Reinsurance Agreement with FirstCare

CareFirst submitted a Form D filing on September 9, 2019, with a request for FirstCare to reinsure all of CFMI's and GHMSI's stop-loss claims for eligible employer groups. In addition to traditional insurance, CFMI and GHMSI sell stop-loss insurance to protect employer groups against large or unpredictable losses that may be incurred by their self-insured health plans. The Company submitted an intercompany reinsurance agreement that will permit FirstCare to reinsure employer stop-loss plans sold by CFMI and GHMSI. The Department approved the Form D filing on October 2, 2019.

Investment in Zipari, Inc.

CareFirst Holdings, LLC ("CFH") submitted a Form D request with the Department on September 20, 2019, to invest in Zipari, Inc., in exchange for convertible preferred stock and a seat on Zipari's board. Zapari is a software company that develops enterprise software and offers an online platform for the health insurance industry to help people understand and use insurance products. CareFirst intends to become strategic partners with Zipari in hopes to better engage with

its members, providers, and employers'/group policyholders. The Department approved this transaction on September 30, 2019.

Merger and Acquisitions:

On December 20, 2019, CareFirst Filed a Form A Statement regarding the Acquisition of Control of a Domestic Insurer with the Department requesting approval on behalf of CFBC to merge CapitalCare, Inc., an existing subsidiary of CFBC, with Trusted Health Plans, Inc., which is the holding company and Trusted Health Plan (District of Columbia), Inc.'s parent. Concurrent with the filings of Form A, CareFirst filed a Form D with the Department on behalf of CFI, CFMI, GHMSI, and CFBC, providing notice and seeking approval from the Department among a number of corporate actions to acquire Trusted Health Plan (District of Columbia), Inc., a licensed HMO domiciled in the District of Columbia that participates in the District's Medicaid program. The acquisition was approved by the Department on January 24, 2020.

Pursuant to a Form A filing with the MIA on December 20, 2019, CFBC intends to acquire 100% of the stock of University of Maryland Health Partners, Inc. ("UMHP"), a licensed Managed Care Organization ("MCO") that currently administers Medicaid managed care plans in 21 Maryland counties. According to the Company, upon closing, UMHP will be renamed CareFirst Community Partners, Inc. ("CareFirst Community Partners"). Concurrent with the filing of this Form A, CareFirst filed a Form D application with the MIA and DISB on behalf of CFI, CFMI, GHMSI, and CFBC, providing notice and/or seeking approval of a number of corporate actions required to effectuate the Acquisition. Forms A and D were approved by the MIA on January 24, 2020, and by DISB on January 28, 2020.

Administrative Services Agreement Amendments:

Effective September 29, 2019, the Company amended the Administrative Services Agreement, described below in the "Intercompany Agreements" section of this Report, to add CareFirst Advantage as a party to the agreement. Effective January 28, 2020, the agreement was again amended to add CareFirst Community Partners, Trusted Holdco, and Trusted DC as parties to the agreement.

CFI Fee Sharing Agreement Amendments:

Effective September 29, 2019, the Company amended the CFI Fee Sharing Agreement, described below in the "Intercompany Agreements" section of this Report, to add CareFirst Advantage as a party to the agreement. Effective January 24, 2020, the agreement was again amended to add CareFirst Community Partners and Trusted DC as parties to the agreement.

Amended and Restated Shared Services Agreement:

Pursuant to a letter dated November 1, 2019, the Company filed a Form D Notice to request approval from the Department pertain to an Amended and Restated Shared Services Agreement between GHMSI, CFMI and Service Benefit Plan Administrative Services Corporation ("SPB"), in connection with a new 10-year administrative services agreement between the BlueCross and BlueShield Association and SPB. The Department approved the Form D on January 22, 2020.

Amended GHMSI By-laws:

Pursuant to a letter dated February 28, 2020, the Company filed a Form D Notice to request approval to amend its By-laws. The intent of the amendment was to bring consistency to certain procedural requirements (such as when Board members must leave the Board upon attaining age 72) as well as correcting prior errors, incorporating certain legal requirements, best practices and addressing regulators' recommendations since the prior bylaw amendments for GHMSI in 2009. The amendment would also permit the reductions in the size to the GHMSI Board through attrition over the next several years. The Department approved the amendment effective January 1, 2020.

COVID-19 Pandemic:

The Company and the industry at large are impacted by economic conditions triggered by the global pandemic crisis of SARS-Cov-2 (COVID-19 or CoronaVirus Infectious Disease 2019). Although, as of the date of this report, it is early in the event, the Company continues to monitor and model the various associated financial impacts of COVID-19 on a group basis, including the potential cost of COVID-19 related care, the deferment of elective and non-emergent care, and the various short-term and long-term impacts of economic downturn. In response to the COVID-19 Pandemic, the organization has established a Coronavirus Task Force and implemented a framework to facilitate the day-to-day decision making and response coordination, including identifying and managing operational risks related to COVID-19. The Company has a diverse mix of business, as well as a surplus and a liquidity position that it anticipates will sustain the Company for an extended period of time. However, the Company is in the midst of evaluating the financial and operational impacts of the COVID-19 Pandemic, as well as continues to monitor and assess the impacts of decisions being made in response, including closely monitoring revenue streams, claims volumes and payment and investment activities. Furthermore, the organization maintains comprehensive business continuity plans and indicates that it is working to minimize disruption through this pandemic.

HISTORY

The Company provides a comprehensive array of health insurance and managed health care products and services primarily through indemnity health insurance and health benefits administration to individuals, businesses, and governmental agencies. The Company began its existence in 1934 as a hospital association under the name of Group Hospitalization, Inc. ("GHI"). GHI was reconstituted on August 11, 1939, as a non-stock, non-profit corporation through a Congressionally granted charter by act of the U.S. Congress. After the grant of its charter, and through a series of transactions, GHI merged with Medical Services, Inc. (MSDC), creating the entity known as GHMSI. MSDC was incorporated in the District of Columbia on April 1, 1948, to provide prepaid coverage for a limited number of physician services to all subscribers who had contracts with GHI.

The Company's charter has been amended by Congress several times since 1939, including in 1984 to reflect the merger with MSDC and expand its purpose to include arranging for the providing of medical services. Congress amended the charter again on October 5, 1992, and October 1, 1993, which established the legal domicile of GHMSI to be the District and that GHMSI shall be licensed

by and subject to the insurance laws and regulations of the District. In 1997, Congress again acted to amend the charter to allow GHMSI to have a non-profit corporate member – CareFirst, Inc., established on January 16, 1998, as a nonprofit health service plan and the holding company parent for both GHMSI and CFMI. CFMI is a not-for-profit Maryland corporation. This amendment cleared the way for GHMSI to pursue licensing by the BlueCross BlueShield Association ("BCBSA"). On December 18, 2015, GHMSI's charter was once more amended to reflect 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, and also require the corporation not to 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[2].

GHMSI and CFMI began doing business as "CareFirst BlueCross BlueShield" in 1998, as the BlueCross BlueShield affiliates for the District of Columbia, Montgomery County, and Prince George's County in Maryland, and the area of northern Virginia. On December 31, 2010, virtually all of the for-profit subsidiaries owned either individually or collectively by the Company and/or CFMI were transferred to a newly created intermediary holding company, CareFirst Holdings, LLC ("CFH"). The restructure was made to consolidate the ownership of the subsidiaries under a single intermediary holding company, and for the Company and CFMI to have essentially equal ownership interest in that intermediate holding company. CFH and its subsidiaries are owned 50.001% by CFMI and 49.999% by GHMSI. Since control over CFH is vested in CFI, the Company determined that neither CFMI nor GHMSI exercise control over CFH.

The Company's subsidiary, Services Benefit Plan Administration Services Corporation (SBP), was created to operate the Federal Employee Program Operations Center under a contract with BCBSA. SBP is 90% owned by GHMSI and 10% owned by BCBSA. SBP performs certain administrative functions as the national operations center for the Federal Employees Health Benefits Program ("FEHBP") under its five-year cost-reimbursement contract with BCBSA.

MANAGEMENT AND CONTROL

Trustees

The Company's By-Laws call for one class of members. CareFirst, Inc., a not-for-profit health service plan organized under Maryland Law, has been designated as the sole member of GHMSI. The By-Laws also state that the governing body of the Company shall be the Board of Trustees, which shall conduct the business and affairs of the Company. All trustees are nominated by the sole member and are elected by the Board of Trustees of GHMSI. The By-Laws state that the Board of Trustees consists of up to fourteen members. Of the fourteen members, at least seven of the trustees shall be individuals that serve as Class I Directors of the Sole Member.

[2] Section 747(b) of the Financial Services and General Government Appropriations Act, 2016, enacted as part of the Act of December 18, 2015, Pub. L. No. 114-113, 129 Stat. 2242, states "The 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 addition, DC Code § 31-706(c)(3) requires that not less than one-third of trustees and one-third of each committee shall be persons who are not officers or employees of the Company. DC Code § 31-706(c)(4) requires that any committee that has the responsibility for the following functions shall be composed entirely of non-employees of the Company or of any entity controlling, controlled by, or under common control with the insurer: 1) Nomination of candidates for director; 2) Evaluation of the performance of the officers, and 3) Recommending the selection and compensation of the Company's principal officers. The Company complied with all requirements of the Code.

The following individuals were serving on the Company's Board of Trustees as of December 31, 2018:

Name and Address	**Principal Occupation**
Shirley M. Allen Washington, D.C.	Managing Director The Kirkland Byrd Group, LLC
Jonca C. Bull Washington, D.C.	Consultant
Robert R. Hagans, Jr. Mitchellville, MD	Not employed
Robert C. Kovarik, Jr. McLean, VA	Retired
Elena V. Rios, M.D, M.S.P.H. Washington, D.C	President and CEO National Hispanic Medical Association
Clifford E. Barnes[3] Washington, D.C.	Partner Epstein Becker Green
Mark J. Chastang[4] Washington D.C.	Chief Executive Officer Saint Elizabeth's Hospital
Artis G. Hampshire-Cowan Mitchellville, MD	Principal Leveraged Leadership Group, LLC
Michael J. McShea[5] Ellicott City, MD	Johns Hopkins Applied Physics Laboratory (APL), Health Systems Innovation Lead
Patricia A. Rodriguez, M.D. Arlington, VA	U.S. Oncology
Sherri L. Bohinc Bethesda, MD	Not employed
Jeffrey P. DiLisi, M.D. Vienna, VA	Senior Vice President and Chief Medical Officer Virginia Hospital Center

[3] Subsequent to the examination date, Clifford E. Barnes resigned as a member of the Board of directors effective February 28, 2020 due to a conflict of interest that had arisen with the Company's entry into the Medicaid market.

[4] Mark Chastang, who was a member of the GHMSI Board, has been elected to serve on the CareFirst, Inc. Board and is no longer a member of the GHMSI Board. Effective December 3, 2019, Julissa Marenco was elected to serve on the GHMSI Board.

[5] Michael McShea, who was a member of the GHMSI Board, has been elected to serve on the CareFirst of Maryland, Inc. Board and is no longer a member of the GHMSI Board.

Name and Address	Principal Occupation
Wendell L. Johns Washington, D.C.	Retired
Shirley R. Patterson Accokeek, MD	Retired

Officers

The By-Laws require the following officers: Chairman of the Board of Trustees, a chief executive officer, president, a secretary, and a treasurer. The Board of Trustees elects these officers of the Company at its annual meeting and may from time to time approve other appointed officer positions appointed by the Chief Executive Officer. Each officer elected at the annual meeting serves until a successor is elected or until removed by the Board of Trustees and each appointed officer may be removed at any time by the Chief Executive Officer, or majority of the Board of Trustees at a meeting. The following persons were elected or appointed and serving as the Company's officers as of December 31, 2018:[6]

Name	Title
Brian D. Pieninck	President and Chief Executive Officer
Jeanne A. Kennedy[7]	Corporate Treasurer and Vice President
Meryl D. Burgin	Corporate Secretary, Executive Vice President and General Counsel
Gregory M. Chaney[8]	Executive Vice President and Chief Financial Officer
John D. Kaercher	Executive Vice President and Chief Information Officer
David J. Corkum	Executive Vice President, Large Group SBU
Rose V. Megian	Executive Vice President, Small and Medium Group SBU
Wanda K. Oneferu-Bey	Executive Vice President, Consumer Direct & Government Programs SBU
Stacia A. Cohen	Executive Vice President, Medical Affairs
Maria H. Tildon	Executive Vice President, Marketing Communication and External Affairs
Jennifer A. Baldwin	Senior Vice President, Patient-Centered Medical Home Program
Stacey R. Breidenstein	Senior Vice President, Networks Management
Michelle J. Wright	Senior Vice President, Human Resources
Peter A. Berry	Senior Vice President, Chief Actuary
Vickie S. Cosby	Senior Vice President, Consumer Direct SBU
Sandra A. Dilworth	Senior Vice President, IT Operations

[6] Effective December 3, 2019, Randolph S. Sergent was elected as Assistant Secretary

[7] On December 3, 2019, the Board of Directors elected Brian J. Keefe as Treasurer replacing Jeanne A. Kennedy, who retired on November 1, 2019.

[8] Effective December 27, 2019, Gregory Mark Chaney retired as Executive Vice President and Chief Financial Officer. He was replaced by Jenny L. Smith effective April 6, 2020.

Name	Title
Andrew J. Fitzsimmons	Senior Vice President, Chief Informatics Officer
Kenneth P. Sullivan	Senior Vice President, IT applications
Melvelyn M. Greene	Senior Vice President, FEP Local Operations
Jonathan N. Kromm	Senior Vice President, Marketing and Communication
Usha Nakhasi	Senior Vice President and General Manager, Service Benefit Plan Administrative Services Corporation and FEP Operations Center

Committees

As of December 31, 2018, the Company's Board of Trustees had established the following committees:

Audit and Compliance Committee
Robert R. Hagans, Jr., Chair
Jonca C. Bull, M.D.
Jeffrey P. DiLisi, M.D.
Artis G. Hampshire-Cowan
Wendell L. Johns
Robert C. Kovarik, Jr.
Michael J. McShea[12]

Finance and Investment Committee
Clifford E. Barnes, Chair[9]
Mark J. Chastang[10]
Jeffrey P. DiLisi, M.D.
Robert R. Hagans, Jr.
Artis G. Hampshire-Cowan
Michael J. McShea[11]

Governance and Nominating Committee
Artis G. Hampshire-Cowan, Chair
Clifford E. Barnes
Jonca C. Bull, M.D.
Jeffrey P. DiLisi, M.D.
Wendell L. Johns
Elena V. Rios, M.D.
Patricia A. Rodriguez, M.D.

Mission Oversight Committee
Shirley M. Allen, Chair
Sherri L. Bohinc
Jonca C. Bull, M.D.
Shirley R. Patterson
Elena V. Rios, M.D.

[9] Subsequent to the examination date, Clifford E. Barnes resigned as a member of the Board of directors effective February 28, 2020 due to a conflict of interest that had arisen with the Company's entry into the Medicaid market.

[10] Effective December 3, 2019, Patricia A. Rodriguez was elected by the Board and replaced Mark J. Chastang and Michael J. McShea

[11] *Ibid*

[12] Effective December 3, 2019, Julissa Marenco was elected by the Board and replaced Michael J. McShea

Service and Quality Committee
Elena V. Rios, M.D., Chair
Shirley M. Allen
Sherri L. Bohinc
Mark J. Chastang[13]
Shirley R. Patterson
Patricia A. Rodriguez, M.D.

Executive Committee
Wendell L. Johns, Chair
Robert C. Kovarik, Jr.
Patricia A. Rodriguez, M.D.

Conflict of Interest

The By-Laws state that the Board of Trustees shall adopt a code of business conduct and compliance that governs the conduct of the Company's trustees, officers, and associates. In accordance with the By-Law, the Company adopted a conflict-of-interest policy. This policy required all trustees, officers, and associates to annually complete a Conflict of Interest Disclosure Statement documenting any potential conflicts.

It was determined that all Trustees and Officer listed in the Management and Control section of this Report of Examination have reviewed and signed their statements as of December 31, 2018.

Corporate Records

The Company's Corporate Charter and By-Laws were reviewed. The minutes of the meetings of the Board of Trustees and its committees for the period under examination through the fieldwork date were also reviewed. The minutes documented the Company's significant transactions and events, which the trustees then approved, and complied with the Charter and By-Laws.

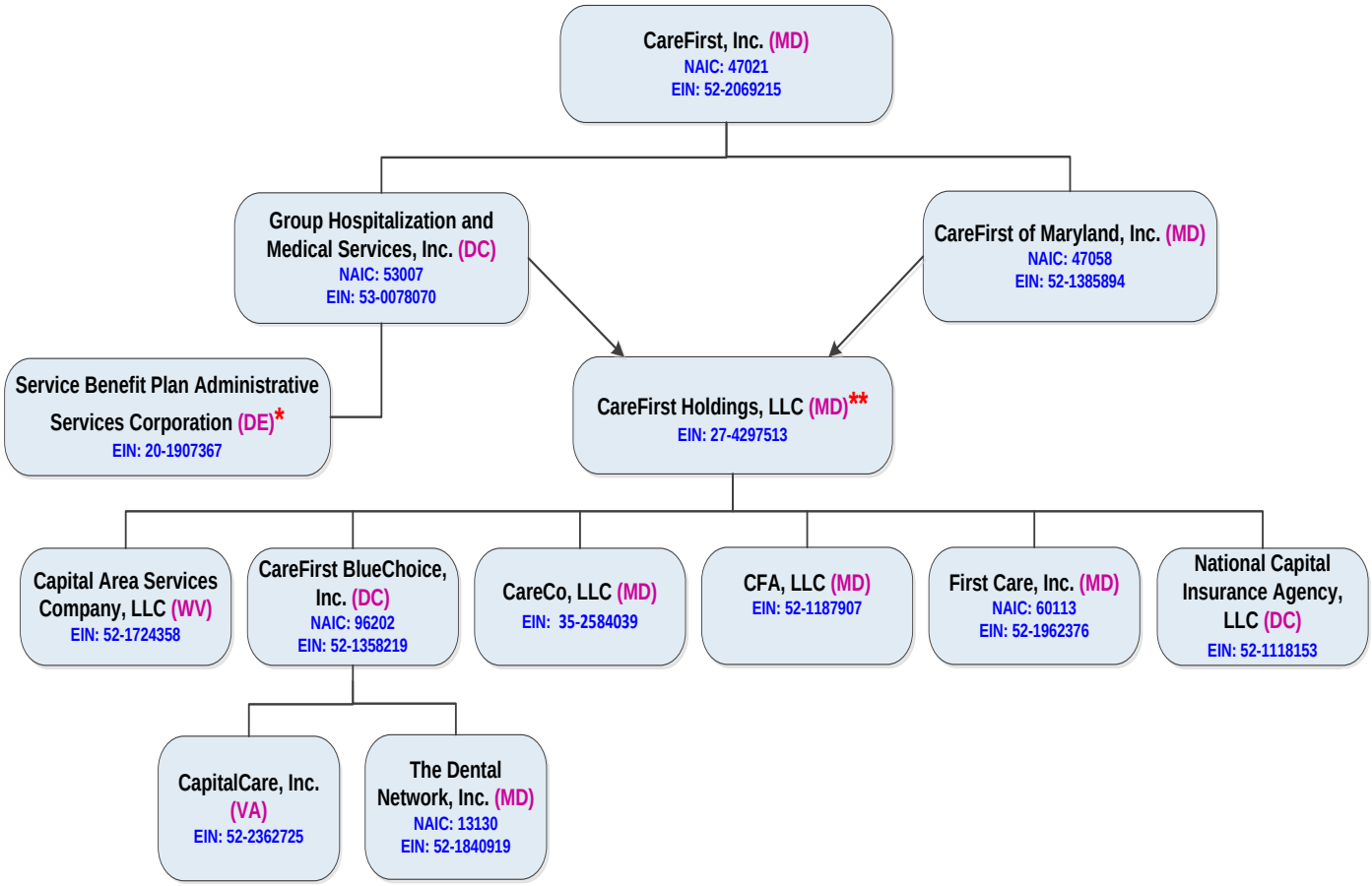
AFFILIATED COMPANIES

Organizational Structure

The Company is a member of an insurance holding company system pursuant to the provisions of the District of Columbia Code Section 31-701. The Company is controlled by CareFirst, Inc. (CFI), a non-profit health service plan incorporated on January 16, 1998, in the State of Maryland to become the non-for-profit parent of the Company and its affiliate CFMI.

The CareFirst, Inc. holding company structure as of December 31, 2018, is depicted in the following organizational chart:

[13] Effective December 3, 2019, Jonca C. Bull, M.D. and Julissa Marenco were elected by the Board and replaced Mark J. Chastang



***Service Benefit Plan Administrative Services Corporation** is owned 90% by Group Hospitalization and Medical Services, Inc. and 10% by the Blue Cross and Blue Shield Association.

****On December 31, 2010, **CareFirst Holdings, LLC (CFH)** was created as an intermediate holding company to streamline and restructure the ownership of all of the subsidiaries of CFMI and the Company (excluding SBP). **CFH** is owned 50.001% by CFMI and 49.999% by GHMIS.

Intercompany agreements

In addition to intercompany reinsurance agreements described below under the "Reinsurance" caption of this Report, the following agreements and transactions were disclosed as part of the Form B – Holding Company Registration Statement and were filed with the Department, as required, in accordance with DC Code § 31–706(a)(2):

Administrative Services Agreement

Effective January 1, 2009, the Company, CareFirst, Inc., CareFirst of Maryland, Inc. (CFMI) and all of their respective subsidiaries entered into an administrative services agreement. The agreement calls for the Company and CFMI to provide its parent and other related entities, including each other, with administrative and operational support services. In consideration of the services provided, the Company and CFMI are paid a fee based upon direct and indirect costs plus (for CFBC only) a mark-up based on market rates. Settlements of amounts due occur on a monthly basis. Net charges allocated by the Company to the subsidiary and CFH under these agreements were $131,288,000 for

the year ended December 31, 2018. These allocations are netted against general and administrative expenses.

Administrative Services Agreement with Capital Area Services Company, LLC

Effective January 1, 2010, the Company, CFMI, CFBC, FirstCare, and TDN entered into an administrative services agreement with Capital Area Services Company, LLC (CASCI). The agreement calls for CASCI to perform the following services: 1) Claims processing, adjudication, and customer services; 2) Document storage and retention; and 3) Miscellaneous administrative services. In consideration of the services provided, CASCI is paid a fee based upon direct and indirect costs plus a mark-up based on market rates. Settlements of amounts due occur on a monthly basis.

Shared Services Agreement

Effective January 1, 2005, the Company and CFMI entered into a Shared Services Agreement with SBP. SBP performs certain administrative functions as the national operations center for the Federal Employees Health and Benefits Program under its ten-year cost-reimbursement contract, which was effective January 1, 2005, with the BlueCross BlueShield Association (BCBSA). The agreement calls for the Company and CFMI and their subsidiaries to provide services to SBP, including management, human resources, legal, corporate services, finance, and accounting. Settlements of amounts due occur monthly.

Financial Support Agreement

Effective December 31, 2010, the Company, CFI, CFMI, and CFH entered into an intercompany agreement which requires that in the event that the capital reserves of the entities or their respective subsidiaries, who are required by law to maintain a statutory or regulatory requirement, fall below their respective statutory, regulatory or BCBSA requirements, the party with the shortfall shall notify all other parties of the shortfall. The other parties, subject to specific terms, conditions, and limitations, shall transfer to the requesting party such financial resources as needed to satisfy the shortfall. In addition to reserve shortfalls, the agreement provides for financial support for other situations, including the inability to pay claims and/or other legally enforceable obligations including, but not limited to, creditor demands, judgments, and surplus notes. The determination as to whether any of the aforementioned conditions exists shall be made by the Board of Directors of CFI.

Federal Income Tax Sharing Agreement

Effective December 31, 2010, the Company, CFI, CFMI, SBP, and all of their wholly-owned limited liability subsidiaries entered into a Tax Sharing Agreement. The agreement calls for the allocation of current federal income tax liability/recoverable attributable to the companies on the basis of the percentage of the consolidated federal income tax liability/recoverable due to the companies computed on a separate company basis (as if they were to file a separate corporate income tax return) to the total consolidated federal income tax liability/recoverable. The agreement also provides that to the extent the Company's tax attributes (e.g., NOLs) reduce the consolidated federal income tax liability, CFI Shall pay the Company for the use of such attributes in the year utilized.

CFI Fee Sharing Agreement

Effective January 29, 2014, the Company, CFMI, CFBC, First Care, and TDN (collectively, the "Subsidiaries") entered into a Fee Sharing Agreement with CFI pursuant to the Affordable Care Act, which required covered entities, including health insurance issuers, health maintenance organizations, and insurance companies, to pay the annual Health Insurer Fee (the "HIF"). Pursuant to the Fee Sharing Agreement, each entity shall pay CFI the entity's individual HIF liability based upon each entity's proportional share of net premiums as reported.

Network Access Agreement

Effective April 1, 2008, the Company and CFBC entered into a Network Access Agreement with TDN. The agreement calls for TDN to provide the Company and CFBC access to its provider network in the state of Maryland and its benefits administration services. In exchange, the Company and CFBC will pay TDN a set amount per member per month to be paid monthly.

Quota-Share Reinsurance Agreement between the Company, CFMI, and CFBC

Effective April 1, 2014, the Company, CFMI, and CFBC entered into a Quota-Share Reinsurance Agreement. In certain instances, CFI offers large groups the option to purchase indemnity products from the Company or CFMI, and HMO products (dual option policies) from CFBC at a uniform rate increase (blended rate). The purpose of this agreement is to transfer premiums among entities to achieve an equivalent medical loss ratio for the dual option policies on the Company, CFMI, and CFBC. The companies do not apply reinsurance accounting for this agreement as there is no transfer of risk. The agreement is accounted for as an intercompany agreement.

Point-of-service Agreement between the Company, CFMI, and CFBC

The Company and CFMI bear all of the out-of-network (indemnity) underwriting risk, and CFBC bears the in-network (HMO) underwriting risk for certain fully insured point-of-service (POS) health care products. Effective January 1, 2018, the Company and CFMI entered into an agreement with CFBC in which CFBC pays a per member per month fee to the Company and CFMI for providing the out-of-network (indemnity) benefits for CFBC's POS products. The fee is based on actual membership and paid in exchange for CFBC's POS products gaining access to the Company's regional provider network and claims processing for the out-of-network services. All premiums, cost of care, and operating expenses of CFBC's POS products are recorded directly by CFBC.

Pharmacy Benefit Management Administrative Services Agreement:

Effective January 1, 2014, the Company and CFMI entered into a Pharmacy Benefits Management Administrative Services Agreement ("Pharmacy Agreement") with CFA, LLC ("CFA"). The purpose of this Pharmacy Agreement is to set forth the terms under which the participants may share in proceeds from pharmacy benefit services to self-insured employer groups who contract with CFA. These services include maintaining a network of "in-network" pharmacies,

processing and paying claims for pharmacy benefits, sending legally required notices to members related to pharmacy benefits, and similar tasks. Under the terms of this Pharmacy Agreement, services are provided by a Pharmacy Benefits Management ("PBM"), pursuant to contracts between CFMI, GHMSI, and the PBM, and charges are allocated to CFA based upon the amount actually spent by CFMI and GHMSI. The Pharmacy Agreement requires the Company to provide CFA with all of the Company's PBM-negotiated pharmacy drug discounts and rates. In addition, the Company funds payments for CFA pharmacy claims to the PBM weekly and then bills CFA monthly for this funding. The funding arrangement takes approximately 60 to 90 days to settle. For access to the pharmacy network, discounts, and pharmacy claims funding, CFA compensates the Company by sharing earned pharmacy rebates.

Surplus Notes:

Effective March 1, 1999, CareFirst, Inc., issued a subordinated surplus note to the Company for $167,000 and CFMI for $333,000. The notes are unsecured and bear interest at 6% per annum, payable in arrears commencing on the initiation date. No payment of principal or interest shall be made on the notes unless and until CFI has sufficient earned surplus to make such payment, after providing for its minimum required surplus, all required reserves and other liabilities. In October 2017, these notes were amended to extend the maturity date from January 16, 2018 to January 16, 2028. The principle on these notes, if not paid sooner, shall be due and payable on January 16, 2028.

Intercompany Loan Agreements between the Company, CFMI, and CFBC

On November 29, 2018, CFBC entered into five-year term loan agreements with CFMI and GHMSI to increase the liquidity of CFMI and GHMSI and to facilitate a transfer of additional funds from CFMI and GHMSI to CFH. Under the loan agreements, CFBC provided $150,000,000 each in securities and cash to CFMI and GHMSI on identical terms. The loan amount is subject to interest, which is accrued and paid quarterly at the mid-term applicable federal rate set by the Internal Revenue Service. The loan amount and any outstanding interest on such loan amounts shall be repaid in full to CFBC on or before the end of the term.

REINSURANCE

The Company was party to the following affiliated reinsurance agreements during the examination period:

Quota-Share Reinsurance Contract between the Company, CFMI, and FirstCare.

Effective January 1, 2009, the Company and CareFirst of Maryland, Inc. (CFMI), (collectively the Reinsurers) entered into a Reinsurance Contract with affiliate FirstCare to assume FirstCare's Medicare Part D coverage. Effective July 11, 2014, FirstCare is no longer a Medicare Part D plan sponsor.

Quota-Share Reinsurance Contract between the Company and CFMI

Effective January 1, 2008, the Company entered into a Cross-Jurisdictional Parity Agreement with CFMI. Historically, the two companies have sold products in each other's BCBSA market regions and thus incurred underwriting results for these cross-jurisdictional products. The purpose of this agreement is to properly redistribute those underwriting gains/losses in each other's jurisdiction from the entity who earned them to the entity whose service area the subscriber/group resided. Under the terms of the agreement, each company tracks the premium revenues, administrative expenses, and care costs related to the other company's geographic region. On a quarterly basis, the amounts from this cross-jurisdictional business are transferred via a quota share reinsurance contract. There is a typical indemnity and hold harmless clause between the parties for any actions alleging injuries out of or related to the acts or omissions with performance under this agreement.

Stop Loss Reinsurance Contract between the Company, CFMI, and CFBC

Effective January 1, 2009, the Company and CFMI (collectively the Reinsurers) entered into a Stop Loss Reinsurance Contract with CFBC. Under the terms of the agreement, the Reinsurers provide stop-loss coverage for all of CFBC claims that exceed 105% Medical Loss Ratio. The reinsurers share any liability based upon their respective ownership percentage in CFBC at the beginning of the calendar year.

FIDELITY BOND AND OTHER INSURANCE

The Company, along with other affiliates, was included as named insureds in a fidelity bond issued to the Company's parent, CFI. The Company was protected under a Fidelity Bond with a single loss limit and an aggregate loss limit of $25,000,000, and a deductible of $100,000. The coverage exceeded the minimum amount of fidelity bond coverage recommended by the NAIC for these companies on a consolidated basis.

Additionally, the Company's ultimate parent, CFI, had a cyber-liability policy that had an aggregate limit of liability of $10,000,000, with a single loss deductible of $2,500,000, covering the CareFirst entities. The Company was also a named insured in its ultimate parent's excess cyber liability policy covering the same companies. The CareFirst cyber liability tower has $125,000,000 in Cyber Liability Coverage. The tower is made up of multiple excess layers above the primary $10,000,000 policy. Each layer can have one insurer or multiple insurers that provide the coverage. All excess carriers in the tower follow the terms and conditions of the primary policy.

In addition, the Company had other insurable risks. In this regard, the Company had insurance policies that provided coverage for other operational risks incurred by the Company and its affiliates (e.g., general liability, workers' compensation, and business property).

PENSIONS AND INSURANCE PLANS

Pension Benefits

Prior to December 31, 2002, the Company maintained a qualified noncontributory defined benefit retirement plan covering substantially all full-time employees (the GHMSI Plan). Effective December 31, 2002, the GHMSI Plan merged with a qualified noncontributory defined benefit retirement plan maintained by CFMI (the CFMI Plan) to become the CareFirst, Inc. Retirement Plan (the CFI Plan). Although CFI merged the CFMI and GHMSI plans, it has committed to maintaining separate recordkeeping of plan assets and benefit obligations so that it will comply with certain regulatory restrictions that apply the Company and CFMI. Consistent with the standards for multiple-employer plan accounting, the Company and CFMI have accounted for their net pension obligations as if the plans remained separate. Employees hired on or after January 1, 2009, no longer participate in the CFI Plan. These employees participate in an enhanced 401(k) program.

The Company also has nonqualified supplemental retirement benefit plans covering certain officers, which provide for these individuals to receive additional benefits based principally on compensation and years of service. These plans provide for incremental benefit payments so that total benefit payments equal amounts that would have been payable from the Company's principal retirement plans if it were not for limitations imposed by the Internal Revenue Service. The Company contributes to the nonqualified pension plan s as benefits are paid.

Post-Retirement Benefits

The Company provides certain health care benefits for retired employees. The Company's postretirement benefit program provides for a specific credit amount, which may be used to purchase health insurance upon retirement. The credit amount is based upon the retiree's age and years of service with the Company. The Company also contributes to a non-qualified supplemental benefit plan for certain officers as those benefits are paid.

Other Insurance and Benefits

The Company provides Medical and Dental Insurance (with the Company paying most of the cost), a Vision Plan, Short Term and Long Term Disability, Life Insurance, a Flexible Spending Account, Tuition Reimbursement, and Paid Time Off (in the form of "vacation time" and "sick leave").

STATUTORY DEPOSITS

As a not-for-profit health service plan licensed under the Medical Insurance Empowerment Amendment Act of 2008, codified pursuant to DC Code § 31-3501 *et seq*., the Company is not subject to the trust deposit requirements.

TERRITORY AND PLAN OF OPERATION

The Company conducts business in the District of Columbia as a hospital and medical services corporation licensed and regulated by the Department, pursuant to the Medical Insurance Empowerment Amendment Act of 2008 (DC Code § 31-3501 et seq.), which amended the Hospital

and Medical Services Corporation Regulatory Act of 1996, effective April 9, 1997. The Company writes comprehensive medical, vision, Medicare Supplement, Federal Employees Health Benefits Program ("FEHBP"), Stop Loss, and provides administrative services to certain customers under self-insured agreements. Other products and services include preferred provider and point of service networks, third-party administrator services, and other managed care services. These products and services are provided to individuals, businesses, and government agencies primarily in the Washington, DC Metropolitan area, Northern Virginia, and the state of Maryland. The Company is a licensee of the BlueCross BlueShield Association and markets its products under the BlueCross BlueShield trade name.

The Company contracts with various health care providers, including hospitals, nursing homes, home health care facilities, alcohol and drug treatment facilities, pharmacies, physicians, and dentists, as participating providers to render services to subscribers of health care plans administered by the Company. In most instances, those providers accept the usual and customary or reasonable allowance set by the Company for a particular service as payment in full. Provider contracts were filed with the DISB as required by DC Code, Section 31-3507.

26 U.S. Code Section 833 of the Internal Revenue Code (the 'Code") states explicitly that BlueCross and BlueShield organizations are subject to federal income taxes as if they were a stock insurance company. Accordingly, the Company is subject to federal income tax under Section 501(m) of the Code. The Company, however, is exempt from all state income taxes in the jurisdictions for which it is registered to do business.

The significant lines of business and premiums written by the Company are presented below based on the 2018 statutory financial data filed by the Company with the Department:

Lines of Business	Total Revenues	Percentage of Total
Comprehensive (hospital and medical)	$ 1,060,566,552	30.63%
Medicare Supplement	34,510,268	1.00%
Dental Only	70,430,569	2.03%
Vision Only	14,853,737	0.43%
FEHBP	2,258,418,983	65.21%
Other Health	12,952,229	0.37%
Health subtotal	3,451,732,338	99.67%
Other Non-Health[14]	11,346,046	0.33%
Totals	$ 3,463,078,384	100%

[14] FEP Bridge – The Company offers Federal Employees Health Benefits Program (FEHBP) claims processing services to other BlueCross and BlueShield plans that participate in the FEHBP.

ACCOUNTS AND RECORDS

The Company's accounting procedures, practices, account records, and supporting data were reviewed and tested to the extent deemed necessary. A review of the Company's Information Technology General Controls (ITGC) and General Application Controls (GAC) was also performed as required by the Handbook. Based on the scope of the Information Technology (IT) examination, certain items were noted and discussed with the Company. However, the review did not disclose any significant deficiencies in these records.

FINANCIAL STATEMENTS

The following financial statements are based on the statutory financial statements filed by the Company with the Department and present the financial condition of the Company for the period ended December 31, 2018. The accompanying comments on the financial statement reflect any examination adjustment to the amounts reported in the annual statement and should be considered an integral part of the financial statements.

Statement of Admitted Assets, Liabilities, Capital and Surplus

Assets		
Bonds	$	536,486,634
Common stocks		144,240,907
Cash, cash equivalents and short-term investments		144,167,498
Other invested assets (Schedule BA)		510,453,134
Subtotal, Cash and invested assets		1,335,348,173
Investment income due and accrued		3,722,794
Uncollected premiums and agents' balances		263,011,694
Accrued retrospective premiums and contracts subject to redetermination		116,420,067
Amounts recoverable from reinsurers		84,581
Other amounts receivable under reinsurance contracts		4,997,152
Amounts receivable relating to uninsured plans		56,684,712
Current federal and foreign income tax recoverable and interest thereon		58,889,922
Net deferred tax asset		56,200,562
Guaranty funds receivable or on deposit		9,365,219
Electronic data processing equipment and software		17,392,537
Receivables from parent, subsidiaries and affiliates		11,778,108
Health care ($121,961,434) and other amounts receivable (**Note 2**)		826,391,849
Aggregate write-ins for other than invested assets		1,319,570
Total admitted assets	$	2,761,606,940
Liabilities		
Claims unpaid (**Note 1**)	$	281,728,414
Unpaid claims adjustment expenses (**Note 1**)		9,480,375
Aggregate health policy reserves, including the liability of $3,680,000 for medical loss ratio rebate per the Public Health Service Act (**Note 2**)		740,009,246
Premiums received in advance		31,203,281
General expenses due or accrued		129,946,009
Amounts withheld or retained for the account of others		25,458,013
Remittances and items not allocated		616
Borrowed money and interest thereon		150,380,000
Amounts due to parent, subsidiaries and affiliates		120,653,840
Liability for amounts held under uninsured plans		31,405,978
Aggregate write-ins for other liabilities		41,238,513
Total liabilities	$	1,561,504,285
Capital and Surplus		
Unassigned funds (surplus)		1,200,102,655
Total capital and surplus		1,200,102,655
Total liabilities and surplus	$	2,761,606,940

Statement of Revenue and Expenses
For the Year Ended December 31, 2018

Member months		6,875,759
Net premium income	$	3,340,563,663
Change in unearned premium reserves and reserve for rate credits		87,857,171
Aggregate write-ins for other health care related revenues		23,311,504
Aggregate write-ins for other non-health revenues		11,346,046
Total revenues		3,463,078,384
Hospital and Medical:		
Hospital/medical benefits		1,893,095,089
Other professional services		247,590,644
Outside referrals		25,895,050
Emergency room and out-of-area		69,679,001
Prescription drugs		806,085,869
Subtotal		3,042,345,653
Less: Net reinsurance recoveries		30,668,943
Total hospital and medical		3,011,676,710
Claims adjustment expenses, including $50,347,404 cost containment expenses		124,482,773
General administrative expenses		306,636,901
Total underwriting deductions		3,442,796,384
Net underwriting gain (loss)		20,282,000
Net investment income earned		20,147,518
Net realized capital gains (losses) less capital gains tax of $1,121,831		4,220,220
Net investment gains (losses)		24,367,738
Aggregate write-ins for other income or expenses		21,579
Net income or (loss), after capital gains tax and before all other federal income taxes		44,671,317
Federal and foreign income taxes incurred		(55,576,402)
Net income (loss)	$	100,247,719

Statement of Changes in Capital and Surplus
From January 1, 2014 through December 31, 2018

Capital and surplus, December 31, 2013	$	934,751,475
Net income or (loss)		(15,666,451)
Change in net unrealized capital gains (losses) less capital gains tax		24,670,344
Change in net deferred income tax		30,484,797
Net change in capital and surplus		5,841,271
Aggregate write-ins for gains or (losses) in surplus		(45,672,802)
Capital and surplus, December 31, 2014		934,408,634
Net income or (loss)		34,975,085
Change in net unrealized capital gains (losses) less capital gains tax		(8,809,687)
Change in net deferred income tax		3,352,600
Change in nonadmitted assets		(1,965,033)
Aggregate write-ins for gains or (losses) in surplus		(1,747,076)
Capital and surplus, December 31, 2015		960,214,523
Net income or (loss)		(9,472,502)
Change in net unrealized capital gains (losses) less capital gains tax		(3,947,481)
Change in net deferred income taxes		7,791,307
Change in nonadmitted assets		(8,640,003)
Aggregate write-ins for gains or losses in surplus		17,292,205
Capital and surplus, December 31, 2016		963,238,049
Net income or (loss)		34,497,590
Change in net unrealized capital gains (losses) less capital gains tax		4,975,829
Change in net deferred income taxes		136,188,592
Change in nonadmitted assets		(1,260,034)
Aggregate write-ins for gains or losses in surplus		23,573,949
Capital and surplus, December 31, 2017		1,161,213,975
Net income or (loss)		100,247,719
Change in net unrealized capital gains (losses) less capital gains tax		11,242,816
Change in net deferred income taxes		(73,322,428)
Change in nonadmitted assets		13,053,664
Aggregate write-ins for gains or losses in surplus		(12,333,091)
Examination adjustments		-
Capital and surplus, December 31, 2018	$	1,200,102,655

Analysis of Examination Changes to Surplus

There were no changes to the Company's reported surplus as a result of the examination.

NOTES TO FINANCIAL STATEMENTS

1. Claims unpaid & Unpaid Claims Adjustment Expenses: As of December 31, 2018, the Company reported: "Claims Unpaid" and "unpaid Claims Adjustment Expenses" (collectively "Claims Reserves") totaling 281,728,414 and $9,480,375, respectively. These amounts represent management's best estimate of the cost settling all known and unknown claims that had been incurred as of December 31, 2018. The Company's Board of Trustees appointed David Markowitz, FSA, MAAA, Actuary, to render the Company's Statement of Actuary Opinion ("Opinion") in connection with the preparation of the Company's December 31, 2018, Annual Statement.

   In connection with this examination, the Department retained an independent actuary Margaret Hermann, FSA, MAAA, of INS Consultants, Inc., to conduct a review and analysis of the Company's actuarially determined accounts as of December 31, 2018. No significant adverse issues were noted as a result of that review.

2. Federal Employees Health Benefits Program (FEHBP): The Company participates in the FEHBP with other BlueCross BlueShield plans. This program includes an experience-rated contract between the U.S. Office of Personnel Management (OPM) and BCBSA, which acts as an agent for the participating BlueCross BlueShield plans. The excess of gross premiums for the life of the program over the charges for the life of the program is considered the special reserve under the contract between OPM and BCBSA. Each year, OPM also allocates additional funds to a contingency reserve, which may be utilized by the participating plans if funds set aside from annual premiums are insufficient or fall below certain prescribed levels by OPM. Funds available to each participating BlueCross BlueShield plan, including the special reserve and the contingency reserve, are held at the U.S. Treasury, including amounts unused from prior periods. Any funds which remain unused upon termination of the BCBSA contract, after the claims run-out and reimbursement of allowable administration expenses, would be returned to OPM for the benefit of the FEHBP. BCBSA has reported the amount being held in the special reserve as $6,977,528,000 as of September 30, 2019, and $6,460,146,000 as of December 31, 2018. BCBSA has also reported the amounts being held in the contingency reserve as $10,947,330,000 as of September 30, 2019, and $11,317,381,000 as of December 31, 2018. Amounts incurred in excess of the total reserves held at the U.S. Treasury for the FEHBP would not be reimbursed to the Company.

   Based upon a formula developed by BCBSA, the Company has recorded its allocated share of the special reserve being held by OPM as an asset, with an equivalent amount recorded as a rate stabilization reserve. The amount is included in health care and other receivable and aggregate health policy reserves, respectively. This amount is $653,863,000 and $685,004,000 as of December 31, 2019 and December 31, 2018 respectively.

   Premium Stabilization Programs: Health Reform Legislation includes three programs designed to stabilize health insurance markets (Premium Stabilization Programs): a permanent risk adjustment program, a transitional reinsurance program, and a temporary risk corridor program. The risk adjustment program is a permanent program that transfers funds from insurers who enroll individuals with lower relative health risks to insurers who enroll individuals with higher relative health risks. Risk adjustment payments/receipts are determined separately for each state and individual and small-group products. The risk adjustment receivable or payable, if any, would be

included within accounts receivable or accounts payable and accrued expenses and recorded as an adjustment to premiums earned. The Company developed an estimate of amounts to be recorded under the risk adjustment program considering data that is currently available. This data included a calculation of member risk scores for the Company, third party analysis of state average risk scores, and other data relevant to the Company's markets. Beginning with the 2018 benefit year, the risk adjustment methodology incorporates a high-cost risk pool calculation. The U.S. Department of Health and Human Services establishes two new high-cost risk pool parameters: a threshold and a coinsurance rate. The high-cost risk pools for high-cost enrollees would fund 60% of the insurer's costs for individual enrollees with claims above $1,000,000. Insurer will be reimbursed for a portion of actual enrollee-level claims above the threshold. To maintain the zero-sum nature of risk adjustment across each market, the insurer will be assessed for an amount, which is calculated as a percentage of the insurer's total premiums in the applicable market. The sum of the assessments across all insurers equals the sum of the high-cost risk pool claims reimbursements across all insurers. The risk adjustment payments/receipts are reported net of the high-cost risk pool amounts. As of December 31, 2019, and 2018, the Company has a net receivable of $94,010,000 and $108,038,000 respectively.

Medical Loss Ratio Rebates: The Patient Protection and Affordable Care Act and a reconciliation measure, the Health Care and Education Reconciliation Act of 2010, which the Company refers to together as the Health Reform Legislation, established minimum medical loss ratio (MLR) regulations that require payment of premium rebates (MLR rebates) to employers and individuals covered under the Company's comprehensive medical insurance if certain minimum MLRs (85% for a large group, 80% for small group and 80% for individual under 65) are not met. The MLR rebates are measured by a legal entity (CFMI, GHMSI, and CFBC) and by jurisdiction at the market segment level (large group, small group, and individual under 65). As of December 31, 2019 and 2018, the Company recorded an estimated MLR rebate accrual of $0 and $3,680,000, respectively, within the aggregate health policy reserves..

3. Liabilities, Contingencies, and Assessments:

The Company, along with the BCBSA, and all of the other BCBSA licensees, has been named as a defendant in multiple suits that make up the Blue Cross Blue Shield Antitrust Litigation. This matter is part of multi-district litigation combining several anti-trust cases, brought by two putative nationwide classes of plaintiffs, health plan subscribers, and providers, that challenge the exclusive service areas outlined in the BCBSA license agreements. The Company has been cooperating in the joint defense with the BCBSA. In April 2018, the U.S. District Court issued an order clarifying how specific legal standards will be applied to the case. The U.S. Circuit Court of Appeal for the Eleventh Circuit denied the Blues Plans' request for an interlocutory appeal of the order. The matter is proceeding in the trial court. In 2019, the BCBSA and the BCBSA licensees were in discussions regarding a potential settlement for the subscribers' litigation. Based on the Company's analysis of the draft terms of the settlement for the subscriber cases, the Company concluded that it is probable that a loss has been incurred and the amount of loss is reasonably estimable. Although settlement terms have been discussed, the Company is unable to predict the timing of this settlement or whether all parties will accept the draft terms. However, the Company has recorded a liability, which represents its best estimate of the loss that will be incurred. If the settlement process progresses, the Company will reconsider whether the accrual recorded is appropriate and record any necessary adjustments once that information becomes available. The Company has retained its independent counsel to continue to defend the providers

cases; however, it is unable to predict the outcome of the matter or to reasonably estimate a range of possible loss.

On December 30, 2014, the DISB issued an Order in which it concluded that GHMSI's RBC of 998% at December 31, 2011, was excessive, and that the appropriate RBC was 721%. The Order stated that 21% of GHMSI's 2011 surplus was attributable to the District, and instructed GHMSI to submit a plan for the dedication of the excess 2011 surplus attributable to the District's community reinvestment fairly and equitably. GHMSI contends that this Order is "erroneous in many respects," as set out in a Motion to Reconsider filed on January 22, 2015, which was denied. On February 10, 2015, the Maryland Insurance Commissioner issued an Order instructing GHMSI that it may not distribute or reduce its surplus in response to an order of the District without his express permission, which had not been granted. On June 10, 2015, the Virginia State Corporation Commission issued an order instructing GHMSI that it may not distribute or reduce its surplus in response to an Order of the District without its express permission, which had not been granted. The Virginia State Corporation Commission reiterated this position in a second order issued on October 10, 2016. On August 30, 2016, the DISB issued a final order, in which GHMSI was ordered to distribute $51,325,000 in rebates to subscribers within 120 days. GHMSI and DC Appleseed filed appeals with the District of Columbia Court of Appeals (DC Court of Appeals). In August 2019, the DC Court of Appeals affirmed in part and vacated in part the DISB's 2016 final order, and remanded for further proceedings. The DC Court of Appeals concluded that the DISB needed to elaborate further its reasoning on a number of points, including coordination with Maryland and Virginia, and apportionment of surplus between jurisdictions. The DISB has not yet issued a ruling on the further proceedings that it deems appropriate. According to statutory accounting guidance, the DISB order issued on August 30, 2016 is considered a judgment rendered by a court. Under statutory accounting guidance, when a judgment is rendered by a court, liability is required to be accrued. Therefore, as of December 31, 2016, GHMSI recorded a liability of $51,325,000, which is the amount stated in the DISB order issued on August 30, 2016. The amount was recorded as a reduction to earned premiums. As a result of the issuance of the August 2019 judgment from the DC Court of Appeals, the order issued on August 30, 2016, is vacated, and GHMSI is required to reassess the accrual based on the new judgment. Since the August 2019 judgment from the DC Court of Appeals affirmed key positions the DISB used to determine that GHMSI's surplus was excessive as of December 31, 2011, GHMSI has concluded that it is probable that a loss has been incurred. Therefore, the accrual recorded in 2016 will remain without adjustment as of December 31, 2019. GHMSI will continue to monitor the developments in this matter, which may require a reconsideration of this loss contingency.

The Company insures individuals and provides administrative services to non-risk groups with members who are qualified Medicare beneficiaries. During 2012, the Company and CFMI discovered a processing error related to the handling of claims for Medicare members of certain non-risk groups between the year from 2009 to 2012, of which the Company recorded $1,143,000. The liability was subsequently adjusted in 2013 and 2014 after the Company completed its review of the claims data related to this liability. As of December 31, 2014, the balance of the liability is $1,261,000 and is included in other liabilities. The Company asserted that there had been no adjustments to this liability since December 31, 2014, and the Company's management believes that the final resolution of this matter will not result in additional material liabilities to the Company.

Various lawsuits, including class action lawsuits and other claims, occur in the ordinary course of business and are pending against the Company. The Company records reserves for such matters when a loss is deemed to be probable and estimable. Management, after consultation with legal counsel, is of the opinion that the lawsuits and other claims, when resolved, will not have a material adverse effect on the accompanying consolidated financial statements; however, there can be no assurance in this regard.

The Company is subject to the Health Insurer Fee ("HIF") imposed under Section 9010 of the Patient Protection and Affordable Act. In accordance with SSAP No. 106 Affordable Care Act Section 9010 Assessment (SSAP 106) the company's estimated HIF payable in the followed year is required to be reclassified from unassigned surplus to special surplus. The HIF is not deductible for income tax purposes. The Company estimated its liability for the HIF based on a ratio of the Company's applicable written premiums compared to the U.S. health insurance industry total applicable written premiums, both for the preceding calendar year. In accordance with SSAP 106, the entire HIF is recognized as general administrative expense on January 1. The Company recorded in full its estimated liability in accounts payable at the beginning of the year with a corresponding deferred asset that was amortized to the general and administrative expense on a straight-line basis over the calendar year. The Company's 2018 HIF of $68,639,000 was paid in September 2018. The allocable portion of the HIF liability that was related to the premiums for insurance provided through the FEHBP is chargeable to the Federal Employees Program (FEP) contracts.

From 2014 to 2016, the Company was reimbursed for the allocable portion of the HIF liability chargeable to FEP. In addition, the Company was reimbursed for the tax gross-up amount related to the HIF that is nondeductible for income tax purposes. Under an arrangement approved by the BCBSA and OPM, the reimbursement was calculated at an effective tax rate of 20% for the period when the fee was incurred. The Tax Act was enacted on December 22, 2017, and among the other major changes in the tax laws, it eliminated the AMT and provided for the refund of AMT credits in excess of future tax liability over the next several years. As a result, the Company will receive a refund of the AMT credits accumulated from prior years. The refund amount will be credited to FEP as a cost reduction under the FEP contract provision and the federal acquisition regulations. Accordingly, the Company recorded a liability of $16,049,000 at December 31, 2017, representing the tax gross-up amount that the Company is obligated to return to the OPM. In 2018, as part of the 2017 federal income tax return filing, GHMSI updated the calculation for its 2016 effective tax rate. As a result of the updated 2016 effective tax rate, the Company recorded an additional liability of $7,210,000 at December 31, 2018. The balance of the liability is $23,259,000 as of December 31, 2018, and included in accounts payable and accrued expenses. During 2019, the Company refunded $11,615,000 to the OPM as AMT refunds were received. As of December 31, 2019, the Company has a remaining liability of $11,644,000. As the remaining AMT refunds are received in 2020 through 2022, the Company will refund the OPM its share of these refunds.

On March 1, 2017, the Commonwealth Court of Pennsylvania ordered long-term care insurer Penn Treaty Network America Insurance Company and one of its subsidiaries to be liquidated. The insolvency resulted in a retrospective premium-based guaranty fund assessment against the Company. As of December 31, 2018, the Company paid a total assessment of $16,246,000. In 2019, the Company paid additional assessment of $955,000. The assessment is expected to be updated in future periods for changes in the estimate of the insolvency. In addition, a portion of

this assessment was recognized as premium tax credits and applied to reduce the 2018 and 2019 premium tax liability. As of December 31, 2019 and 2018, the balance of the discounted premium tax credit receivable is $8,996,000 and $9,365,000, respectively, and is expected to be realized incrementally through 2029.

COMMENTS AND RECOMMENDATIONS

There were no recommended adjustments to the financial statements as of December 31, 2018, or significant adverse findings as a result of the examination.

CONCLUSION

The insurance examination practices and procedures as promulgated by the NAIC have been followed in ascertaining the financial condition of **Group Hospitalization and Medical Services, Inc**. as of December 31, 2018, consistent with the insurance laws of the District of Columbia. Such procedures performed on this examination do not constitute an audit made following generally accepted auditing standards, and no audit opinion is expressed on the financial statements contained in this Report. No material adjustments were identified during the examination; the balance sheet in this Report of Examination reflects the financial condition of the Company as of December 31, 2018, and is summarized as follows:

Total Admitted assets	$2,761,606,940
Liabilities	1,561,504,285
Unassigned funds (surplus)	1,200,102,655
Total surplus	1,200,102,655
Total liabilities and surplus	$2,761,606,940

Chapters 20 (“Risk-Based Capital”) and 31 (“Hospital and Medical Services Corporations Regulation”) of Title 31 (“Insurance and Securities”) of the District of Columbia Official Code specify the level of capital and surplus required for the Company. We concluded that the Company’s capital and surplus funds exceeded the minimum requirements during the period under examination.

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SIGNATURES

In addition to the undersigned, the following examiners representing the Department participated in certain phases of this examination:

Mark Jaster, The INS Companies, Examiner in Charge, Maryland
Neeraj Gupta, The INS Companies, Examiner in Charge, DC (6/3/19 – 8/15/19)
Don Catmull, The INS Companies, Financial Examiner
Richard Kramer, The INS Companies, Financial Examiner
Pat Neesham, The INS Companies, Financial Examiner
Carolyn Maynard, The INS Companies, Financial Examiner
April Spevak, The INS Companies, Financial Examiner
Dave Gordon, INS Services, Inc., IT Manager
John Albertini, INS Services, Inc., IT Supervisor
Terry Ryals, INS Services, Inc., IT Specialist
AJ Avezzano, INS Services, Inc., IT Specialist
Frank Edwards, INS Consultants, Inc., Reviewing Actuary
Peggy Hermann, INS Consultants, Inc., Lead Actuary
Ankush Verma, INS Consultants, Inc., Actuarial Analyst

The exam team also utilized the services of Professor Michael A. Angelina, ACAS, MAAA, CERA, Executive Director of the Maguire Academy of Insurance and Risk Management at Saint Joseph's University to review CareFirst's Own Risk and Solvency Assessment (ORSA).

Respectfully submitted,

Barry W. Lupus

Barry Lupus, CFE
Examiner-in-Charge
The INS Companies
Representing the District of Columbia
Department of Insurance, Securities and Banking

Under the Supervision of

Yohaness Negash, CFE
District of Columbia Department of Insurance, Securities and Banking