Plan of
Group Hospitalization and Medical Services, Inc.
Filed With the Department of Insurance, Securities and Banking
Pursuant to December 30, 2014 Order No. 14-MIE-012

March 16, 2015

Group Hospitalization and Medical Services, Inc. ("GHMSI" or "the Company") files this Plan with the Department of Insurance, Securities and Banking ("DISB") pursuant to the instruction in the DISB's December 30, 2014 Order ("the Order" or "the December 30 Order").

Background and Context

The subject of this Plan is the surplus of GHMSI that is held for the protection of its subscribers.

GHMSI is a not-for-profit plan – that together with its affiliate companies that constitute CareFirst – offers a single type of product (health care coverage) to 3.3 million members in Maryland, Northern Virginia and the District of Columbia ("the District"). The Company offers only health coverage products and no other forms of coverage. It operates only in the geographic region noted. GHMSI was created by Congressional Charter enacted in 1939.

Approximately 15% of GHMSI subscribers live in the District of Columbia – with almost all others living in Maryland or Virginia.

Like other health insurance carriers, the Company is required by the laws of the three jurisdictions in which it operates to hold a reserve above and beyond any funds it uses in ongoing operations to pay claims and other expenses. This reserve is called a "surplus" since it is intended to stand apart and ready for any number of large uncontrollable or unforeseeable events (such as a flu epidemic) or combination of smaller events or risks that could threaten the Company's ability to meet its obligation to its subscribers.

The surplus is the only source of capital the Company has. The Company cannot borrow to meet surplus needs except in extraordinary circumstances (with regulatory approval) and, therefore, does not hold debt and cannot raise funds through stock issuance or private equity investment. It cannot diversify its operations geographically or diversify its products into unrelated fields in order to mitigate its risks or supplement its revenue stream. As the Company's exclusive source of capital, the surplus is the only source for investment in the complex technology and other capabilities that support the Company's products.

The surplus the Company holds has been built up over a long period of time from small operating margins that represent the difference between premium revenue and all Company operating expenses (usually less than 1 percent margin per year). All earnings on surplus funds are invested in conservative investment vehicles according to requirements in law and are used to

offset costs that would otherwise have been borne by subscribers through their premium payments.

The central concern of regulators over many years has been that companies offering health care coverage hold enough in reserve (surplus) to protect their ability to meet their obligations to their subscribers. This is not unlike the stress tests done on the capital strength of banks for a similar purpose. Elaborate rules have evolved on surplus requirements that have been established by the National Association of Insurance Commissioners ("NAIC") with a particular focus on how surplus is to be measured and to make sure that adequate surplus exists within each carrier.

From this evolving regulatory framework, the concept of Risk Based Capital ("RBC") has emerged. RBC attempts to express in a single percentage, the amount of surplus (capital) a carrier has in relation to the risks to which it is exposed. The focus of the RBC methodology is to establish a minimum threshold of surplus needed by each carrier given its unique risk profile. The Blue Cross and Blue Shield Association has even more stringent standards to assure there is strength behind the Blue brand – one of the most respected brands in the world.

The surplus of the Company today is about average for Blue Cross and Blue Shield Plans across the country and represents less than four months of claims. The Company ranks in the middle among 37 Blues Plans across the country in RBC. However, approximately twenty years ago, the Company was virtually bankrupt and was rescued by new management and a capital infusion from fellow Blue Cross and Blue Shield Plans.

The surplus of the Company is a single fund and is intended to stand behind and support – be available for – the general obligations of the Company wherever and for whatever may arise. It is contributed to by all subscribers in all three jurisdictions and is available when needed by subscribers in all three jurisdictions. It is, therefore, a common pool of funds and is accounted for as such in the Company's financial statements. Surplus is built up principally from subscriber payments, and is dedicated to their benefit.

The Company's RBC is constantly fluctuating based on the ever-changing risk exposures of the Company. The Affordable Care Act has added greatly to the currently volatile risk environment due to the sweeping nature of its requirements such as the need to accept all applicants (guaranteed issue) and offer coverage plans that expand the scope of covered services (Essential Health Benefits). The Company has been a steadfast supporter of these requirements.

The determination of what RBC level constitutes enough surplus and what is too much is a complex actuarial task requiring great expertise. It is not unlike the engineering challenge of determining the strength of a bridge under different traffic loads and weather conditions. To this end, the Company has focused its efforts over the past decade on finding an optimum range of surplus within which to operate.

The District has placed great emphasis in its review of GHMSI's surplus on examining whether GHMSI may hold too much surplus – particularly on that portion of the surplus that might relate to the District itself – in the belief that this fund may be used as a source for "community health reinvestment", whereby subscriber funds would be given to the community

"to the maximum extent feasible" while still keeping the Company in a financially sound and efficient position for its subscribers. The only way for the regulator to command the disbursement of surplus for the purpose of "community health reinvestment" is to find excess applicable to the District.

And now, the Commissioner's December 30 Order expresses the finding that GHMSI held too much surplus – both overall as well as on the portion of its surplus related to the District in 2011 – despite uniformly contrary views by Maryland regulators and virtually every independent actuarial expert that has ever examined the Company's surplus, including the DISB's own consulting actuary brought in by the DISB to advise on the subject after careful study. This is a matter of public record.

In disregard of all of this, the December 30 Order requires the Company to develop a plan to distribute the District's excess surplus in community health reinvestment in a "fair and equitable" manner.

It is the Company's view that it holds a sound and reasonable amount of surplus and that this surplus belongs – under the terms of the Company's Congressional Charter – to the subscribers, who paid the premiums that built the surplus. The Company asked the Commissioner for reconsideration of the Order. This request for reconsideration was denied. As a consequence, the Company filed an appeal in the Court of Appeals for the District of Columbia.

The December 30 Order

In the Order, the DISB concluded that:

1. GHMSI's total surplus, for all jurisdictions, as of December 31, 2011 was $964 million representing a 998% RBC.

2. The portion of the surplus attributable to the District as of December 31, 2011 was 21% of the total, or $202 million.

3. The appropriate level of the entire surplus for GHMSI was 721% RBC. The Commissioner did not assess the specific risks relating to business in the District nor determine a target RBC for the District alone. Nevertheless, in denying GHMSI's Motion for Reconsideration, the Commissioner appears to have determined that the target surplus for the portion attributable to the District is also 721% RBC.

4. GHMSI "must submit a plan to the Commissioner for dedication of its excess 2011 surplus attributable to the District of Columbia to community health reinvestment in a fair and equitable manner." In its December 30 Press Release, the DISB referred to a $56 million reduction in "excess" surplus attributable to the District at year-end 2011.

As noted above, GHMSI disagrees with all but the first of these conclusions (which is a fact) and has filed an appeal to dispute them.

The Medical Insurance Empowerment Amendments Act ("MIEAA") requires that any plan pursuant to the Commissioner's Order can only be applicable to the surplus that is attributed to the District by the Commissioner. See **Exhibit 2.** Therefore, the starting point for GHMSI's plan is the $202 million that the Commissioner determined to be the District's portion of GHMSI's total surplus at year-end 2011. The Order applies only to this specific year.

GHMSI's Plan

GHMSI has already reduced the surplus attributable to the District by more than is required under the December 30 Order. Between 2012 and 2014, GHMSI incurred $62 million in underwriting losses attributable to the District and provided more than $70 million in community health reinvestment. By the end of 2015, the surplus attributable to the District is expected to have fallen by $61 million since year-end 2011. Therefore, no further reduction in GHMSI surplus attributable to the District would be appropriate.

It is important to recognize that any surplus distribution by GHMSI pursuant to the Commissioner's Order must be made from the surplus that exists in the current year since this reflects the current resources of the Company.

This is significant because, as noted above, between 2012 and 2014, GHMSI experienced $62 million in underwriting losses attributable to the District. These losses were partially offset by investment income. Even when investment income is attributed to the District, the District attributable surplus was $37 million lower at year-end 2014 than it had been at year-end 2011.

Further, due to continuing losses in the District, GHMSI expects the surplus attributable to the District to fall to $141 million by the end of 2015. This is $61 million below its 2011 year-end level of $202 million. **Exhibit 1, Table 2** shows this.

It is critical to note that while the District-specific surplus of GHMSI has fallen sharply, GHMSI's overall surplus has fallen less during this period. This is because the losses incurred by GHMSI in the District have been offset by more favorable results in Maryland and Virginia. See **Exhibit 1, Table 1** for summary of GHMSI financial results.

Thus, the two other jurisdictions have enabled the Company to sustain a higher level of overall surplus than otherwise would have been the case if GHMSI's whole surplus had been based solely on results of its business operations in the District. This is a bit like two parties pouring water into a common tub while a third drains some off at the same time.

It should also be noted that the District benefits from being incorporated into the far larger business operations of GHMSI in Virginia and Maryland because their larger size contributes to a relatively more stable and predictable risk environment on which it is possible to hold a lower RBC level. If the District portion of GHMSI's surplus were truly on its own for the relatively small number of District subscribers covered, it would face a far higher RBC need due to the volatility inherent in small, insured populations. It is likely that an appropriate target for a District only RBC would exceed 1,400%. The District-only portion of GHMSI's business, therefore, derives great benefit from being contained within the larger GHMSI risk pool.

A calculation made by GHMSI in accordance with NAIC standard rules shows that the $202 million surplus the Commissioner attributed to the District in the Order as of year-end 2011 equates to a 780% RBC specific to the District. This calculation is set forth in **Exhibit 1, Table 3**. From this level, steady declines have followed:

By year-end 2012, the surplus attributable to the District had fallen to 669% RBC;

By year-end 2013, the surplus attributable to the District had fallen to 647% RBC;

By year-end 2014, the surplus attributable to the District had fallen to 569% RBC; and

By the end of 2015, the surplus attributable to the District is expected to be 472% RBC.

The Commissioner's December 30 press release stated that the DISB Order would cause $56 million in "excess surplus" to be disbursed. This number was apparently calculated by multiplying the difference between the 998% RBC the Company held at the end of 2011 and the 721% RBC the Commissioner says it should have held overall – and then allocating 21% of that number to the District.

If the cited number of $56 million were to be taken from the actual District-specific surplus that is expected to be available at the end of 2015, only $85 million in District-specific surplus would remain. This would equate to less than 300% RBC attributable to the District – which is just over one month of claims – a dangerously low and irresponsible level that is less than half of the level determined by the Commissioner for "financial soundness and efficiency".

The key point is this: GHMSI's total surplus is above the 721% RBC target in large part because of positive contributions made by Maryland and Virginia. Taking 21% from any alleged "excess" generated by these other jurisdictions would not be an appropriate, legal or justifiable result. Applying such an approach in future surplus reviews will result in perpetual depletion of surplus built up by other jurisdictions. This causes great concern to the Company and the other jurisdictions.

With this said, it is critical to recognize the key reasons that caused the surplus attributable to the District to decline since the end of 2011. The answer is that the decline occurred due to actions GHMSI, itself, took to make community reinvestments. These actions included:

1. Nearly $30 million in premium rate reductions and moderation in the District (over $20 million in 2012 and 2013) resulting from a deliberate decision by the Company to reduce its 2010 year-end RBC of 1,098% that became unusually high due to unanticipated favorable claims experience in that year. The actions taken have produced the decline intended in full conformity to the Company's own policy. This intent and result is documented in the minutes of the GHMSI and CareFirst Boards and Finance Committees (which are available to the DISB for review); and

2. $11 million in direct community giving to nearly 150 not-for-profit organizations to help address the unmet health care needs of vulnerable populations who reside in the

District. This giving supported those in the community who otherwise would not receive the services of these community-based organizations; and

3. $24 million in losses for an open enrollment program in the District that served District residents who had been turned down as adverse risks by other carriers and who were otherwise unable to obtain coverage except through GHMSI and its affiliate, BlueChoice; and

4. $15 million in program funding for the D.C. HealthCare Alliance Program used by the District government to improve the healthcare of District residents in any way the District saw fit.

Taken together, these community reinvestments by GHMSI in the 2012 to 2014 period greatly exceed the $56 million referenced in the DISB December 30 press release. Given their consequential impact on GHMSI's lower RBC level attributable to the District, no further reduction in District-attributable surplus is warranted. In effect, the Company has already implemented actions subsequent to 2011 to reduce its District-attributable surplus to levels well below that ordered by the Commissioner.

The Company is also extremely sensitive to the fact that all of the monies paid as "community health reinvestment" in the last three categories above were derived from subscribers. Subscribers quite rightly expect their premium payments to be applied to the costs of their care – not given away. They rightly believe that the cost of their coverage is high and do not want to see their burdens made heavier by giving their payments to others. The Company strives to strike the right balance in its community giving after duly weighing this justifiable concern.

Additional Context

It should be noted that MIEAA requires the District to coordinate with the two other jurisdictions in which GHMSI operates on any actions related to GHMSI's surplus. This recognizes the fact that approximately 85 percent of GHMSI subscribers live outside the District.

The Commissioner received pointed admonitions and concerns from the then Maryland Insurance Commissioner regarding the DISB approach during the lengthy review process that led up to the December 30 Order. The Maryland Commissioner offered assistance and sought consultation and coordination. None occurred. The current Maryland Commissioner has also reached out and sought to be consulted in the process. The Company is not aware of any consultation or coordination either before or after the December 30 Order was issued, other than the solicitation of written comments. To the Company's knowledge, there was no follow-up on the comments from other jurisdictions.

As a consequence, the concerns of Virginia and Maryland regarding this matter have reached such a heightened level that each state has undertaken legislation to strengthen the ability of its insurance regulator to assess and protect the interests of its respective subscribers resulting from District orders of the kind issued on December 30. The legislation has already passed in Virginia and its counterpart is expected to pass in the Maryland Legislature shortly.

The Company remains under directly conflicting orders from Maryland and the District. Under a standing order dated September 14, 2012, the Company is directed by the Maryland Insurance Administration to "strive" to increase its surplus in order to attain a surplus level in excess of the 998% RBC it held at year end 2011. The December 30 Order commands a substantial reduction for the same period in order to do more "community health reinvestment". The Company cannot comply with these contradictory Maryland and District orders at the same time.

In the end, the Company's Congressional Charter makes it very clear that the Company exists to serve its subscribers. Any surplus is for their benefit and is meant to protect them against the uncertainties of a volatile health care environment that has only become more uncertain in recent years.

Further, as already noted, the Company's surplus belongs to all of its subscribers regardless of jurisdiction and cannot and should not be divided. Attempts at division or allocation occur nowhere else in the country and are unprecedented. Each jurisdiction in which the Company operates has a material interest in the Company's overall surplus as a critically important stabilizing and protective resource for the Company's subscribers. Each contributes to it and draws from it as ever-changing circumstances dictate.

Regional View Needed

As is the case in many other areas of economic and public regional interest, it would be highly desirable for the three jurisdictions to consult, cooperate and coordinate on the matter of the Company's surplus in a consistent way. If there ever was a shared belief among the jurisdictions that the Company holds too much surplus for the protection of its subscribers, the three jurisdictions should reach this conclusion jointly based on the best possible independent, expert advice – given the complexity of the matter. If such a conclusion were ever reached, the jurisdictions should jointly agree on a plan for the resolution of the excess that benefits its subscribers. As matters stand now, none of this has occurred.

The Company has undergone 13 different studies of its surplus in the last decade – some as part of its own ordinary business operations and some undertaken by its regulators. The timing and results of these studies are shown in **Exhibit 4**. All have come to the same conclusion: the Company has no excess surplus.

The current and historical surplus positions and Board-approved ranges of the Company are shown in **Exhibit 5.**

Indeed, it is striking that the December 30 Order occurs at a time when the uncertainties, risks and costs in the health care field are at their most extreme and during a time when the Company's surplus is declining. This is all the more concerning because any surplus lost will be extremely difficult to restore due to new rules imposed by the Affordable Care Act.

The Company's surplus is not a pot to be dipped into for purposes other than for the benefit of its subscribers. Nor is it a pot that belongs to any one jurisdiction nor is it one that should be directed – implicitly or explicitly – by any one jurisdiction. Even MIEAA recognized

this in its command to the District Insurance Commissioner to coordinate with the other two jurisdictions.

The Company has long sought to benefit its subscribers in all of its jurisdictions by its many direct services that are dedicated to them as well as through a balanced and fair use of its resources in benefiting the broader community in which it operates. It has consistently been one of the top corporate givers in its region and is widely recognized for this. The Company has done this through thick and thin – during times when it has lost money on the many risks it takes and when it has made money when rare favorable health care cost trends permit.

The Company operates on razor thin margins because it seeks to return the highest possible portion of its premium collections in the form of claims payments (benefits) to its subscribers. It operates at very near actual cost. Because of this, the financial soundness of the Company – through the existence of a hard won and appropriate level of surplus – is a matter of considerable shared concern among the subscribers and regulators in the three jurisdictions in which the Company operates. The government that seeks to deplete the surplus is in no position to rescue the Company if it should fail as a consequence of such depletion. And, the Company has been in such a position before, as already noted.

Hence, the Company believes it has fully met its obligations under its Charter and MIEAA and asks those who regulate it to jointly discuss, consult and coordinate their thoughts and actions for the benefit of all subscribers in all three jurisdictions.

From Here

For all the reasons delineated above, GHMSI has already complied with the December 30 Order to reduce surplus.

However, the extent of concern within the other jurisdictions – as evidenced by legislation in both Maryland and Virginia – regarding the level and use of GHMSI's surplus has led to considerable discussion of the best path forward. Without question, the best path forward is inter-jurisdictional cooperation. Given the long, difficult and contentious road that has been traveled to date, a targeted, specific amendment to the GHMSI Congressional Charter is needed to provide for two common sense things:

- First, that any finding of excess regarding GHMSI's surplus should occur only through a joint, coordinated process among the three jurisdictions that results in a joint decision among the three that excess indeed exists; and

- Second, if an excess were ever determined by the three jurisdictions acting jointly, then development of a joint plan for resolution that returns any excess to its subscribers, from whom it was derived.

The Company strongly believes this to be in the best interests of the region as well as all of its subscribers.

The Company is confident of the support of the other two jurisdictions in which it operates for this approach and respectfully seeks the support of the District as well. The Company is convinced that together, this issue can be fully resolved to the satisfaction and benefit of all of our subscribers.

Exhibit 1 Narrative
Group Hospitalization and Medical Services, Inc.
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Pursuant to December 30, 2014 Order No. 14-MIE-012

The following tables support the amounts cited in the Plan as follows:

Table 1 – GHMSI Statement of Revenue and Expenses
Table 2 – D.C. Attributed GHMSI Statement of Revenue and Expenses
Table 3 – GHMSI and D.C. Attributed Risk Based Capital Calculation

Tables contain the following, and were developed using the sources noted below:

Table 1
Table 1 summarizes key financial amounts which are reported directly on the GHMSI Annual Statements filed for 2012 through 2014. Income statement line items are directly from the first page of the Statement of Revenue and Expenses and result in a net income (loss) annually. The capital and surplus amounts are directly from the second page of the Statement of Revenue and Expenses in the Annual Statement. For comparison purposes, a cumulative change in capital and surplus was added which compares each year's capital and surplus at the end of the reporting period to the year-end 2011 capital and surplus.

The "authorized control level risk-based capital" is directly from the Five Year Historical Data exhibit in the Annual Statement. The risk-based capital is the quotient of capital and surplus at the end of the reporting period divided by the authorized control level risk-based capital.

Table 2
Table 2 summarizes GHMSI's calculation of D.C.-attributed income statement and capital and surplus amounts directly from the GHMSI Annual Statements filed for 2012 through 2014, GHMSI's audited and regulator-approved cost accounting system, and, in certain instances, CareFirst's general ledger system which captures jurisdictional specific items.

Line	Title	Explanation
1	Total revenue	Revenues are from the D.C. Exhibit of Premiums, Enrollment and Utilization in the Annual Statement, adjusted for D.C.-specific regulator approved reinsurance amounts for cross-jurisdictional sales, the Affordable Care Act (ACA) reinsurance program and other minor reinsurance agreements as documented in CareFirst's general ledger.
2	Total hospital and medical expenses	Hospital and medical expenses are from the D.C. Exhibit of Premiums, Enrollment and Utilization in the Annual Statement, adjusted for D.C.-specific regulator approved reinsurance amounts for cross-jurisdictional sales, the ACA reinsurance program and other minor reinsurance agreements as documented in CareFirst's general ledger.
3	Claims adjustment and General administrative expenses	Claims adjustment and General administrative expenses are directly from the company's regulator-approved cost allocation system as well as from the company's general ledger system which tracks specific expenses by entity and jurisdiction.
4	Net underwriting gain or (loss)	Sum of lines 1 through 3.
5	Net investment gains (losses) and other income	Net investment gains (losses) and other income are allocated to the jurisdiction using the prior year-end D.C. surplus as a percentage of the total GHMSI capital and surplus times total investment gains (losses), net of capital gain tax.
6	Net income or (loss) before income tax	Sum of lines 4 and 5.
7	Federal income taxes incurred	Federal income taxes incurred are calculated for each jurisdiction based upon its net income (loss) before tax and its specific net investment gains (loss) and other income using the effective Federal income tax rates.
8	Net income (loss)	Sum of lines 6 and 7.

Line	Title	Explanation
9	Capital and surplus prior reporting year	2012 beginning capital and surplus from the December 30, 2014 Order No. 14-MIE-012 (GHMSI 2011 surplus (line 20) multiplied by the DISB ordered D.C. attribution of 21%). Subsequent years equal Line 13 from the prior reporting year-end.
10	Net income or (loss)	Line 8 above.
11	Other surplus adjustments	Other surplus adjustments from the Statement of Revenue and Expenses include changes in unrealized gain (loss) on affiliated and unaffiliated investments, deferred taxes, non-admitted assets, pension and the cumulative effect of changes in accounting practices. Prior year-end D.C. surplus as a percent of GHMSI total surplus (line 15) is applied to total GHMSI other surplus adjustments.
12	Net change in capital and surplus	Sum of lines 10 and 11.
13	Capital and surplus end of reporting period	Sum of lines 9 and 12.
14	Change in surplus from 2011	Total of line 13 from the current year less line 9 from 2012 (2011 year-end D.C. attributed capital and surplus).
15	D.C. attributed surplus as a percent of GHMSI total surplus	Quotient of line 13 divided by GHMSI total capital and surplus from the Statement of Revenue and Expenses in the Annual Statement for the same calendar year.
16	D.C. Authorized Control Level	Calculated total of the D.C. attributed National Association of Insurance Commissioners (NAIC) specified measures of the underlying risk of the company's income statement and balance sheet including affiliate, asset, underwriting, credit and business risks (See Table 3 explanation).
17	D.C. RBC	Line 13 divided by line 16 applied annually.
18	GHMSI Target RBC	721% RBC as specified in the DISB December 30, 2014 Order No. 14-MIE-012.
19	Surplus "Excess" / (Deficit)	Capital and surplus end of reporting period (line 13) less the product of D.C. capital and surplus RBC (line 13) divided by D.C. RBC (line 17) multiplied by GHMSI Target RBC (line 18).
20	GHMSI Ending capital and surplus	Capital and Surplus from Line 49 of the GHMSI Statement of Revenue and Expenses.

Table 3

Table 3 summarizes the 2011 GHMSI and D.C.-attributed risk-based capital calculation. GHMSI data supporting the risk-based capital calculation is directly from the GHMSI Health Risk-Based Capital (RBC) filing for the year ending December 31, 2011.

Included in a risk-based capital calculation are National Association of Insurance Commissioners (NAIC) specified measures of the underlying risk of the company's income statement and balance sheet. The categories of "Risk" measured include the risk of affiliate operations, assets, underwriting, credit and general business risk. The specific data from the GHMSI risk-based capital calculation is directly from the filed RBC report calculated as prescribed by the NAIC. The GHMSI 2011 capital and surplus and RBC-ACL are directly from the Annual Statement, while the risk-based capital is capital and surplus divided by the RBC-ACL. The GHMSI "Target" surplus, per the December 30, 2014 Order No. 14-MIE-012, enables the calculation of the DISB deemed excess surplus.

The D.C. RBC calculation is prepared consistent with the NAIC methodology. However, it relies on the data in Table 2 in which attributed income statement and capital and surplus amounts are derived directly from the GHMSI Annual Statements filed for 2012 through 2014, GHMSI's audited and regulator-approved cost accounting system, and, in certain instances, CareFirst's general ledger system which captures jurisdictional specific items.

Table 1
Group Hospitalization and Medical Services, Inc. (GHMSI) – All Jurisdictions (MD, DC, VA)
Statement of Revenue and Expenses
($ in millions)

	Actual					Forecast	
	2011	2012	2013	2014	2012-2014	2015	
Net Income **[From Page 4 - Statement of Revenue and Expenses -** **of the 2012-2014 GHMSI Annual Statements Filed with Regulators]**							**Page 4** **Line Number(s)**
Total revenues		$ 3,166	$ 3,162	$ 3,347	$ 9,675	$ 3,484	Line 8
Total hospital and medical expenses		(2,844)	(2,800)	(2,883)	(8,527)	(3,032)	Line 18
Claims adjustment expenses & General administrative expenses		(370)	(398)	(507)	(1,275)	(477)	Lines 20 + 21
Net underwriting gain or (loss)		**(48)**	**(36)**	**(43)**	**(127)**	**(25)**	Line 24
Net investment gains (losses) and Other income		37	34	26	97	22	Lines 27 + 29
Net income or (loss) before income tax		**(11)**	**(2)**	**(17)**	**(30)**	**(3)**	Line 30
Federal income taxes incurred		3	11	1	15	(12)	Line 31
Net income (loss)		**$ (8)**	**$ 9**	**$ (16)**	**$ (15)**	**$ (15)**	Line 32
Capital and Surplus **[From Page 5 - Statement of Revenue and Expenses -** **of the 2012-2014 GHMSI Annual Statements Filed with Regulators]**							**Page 5** **Line Number(s)**
Capital and surplus prior reporting year		**$ 964**	**$ 941**	**$ 935**	**$ 964**	**$ 934**	Line 33
Net income or (loss)		(8)	9	(16)	(15)	(15)	Line 34
Other surplus adjustments		(15)	(15)	15	(15)	(30)	Lines 35 to 47
Net change in capital and surplus		$ (23)	$ (6)	$ (1)	$ (30)	$ (45)	Line 48
Capital and surplus end of reporting period	**$ 964**	**$ 941**	**$ 935**	**$ 934**	**$ 934**	**$ 889**	Line 49
Change in surplus from 2011		**$ (23)**	**$ (29)**	**$ (30)**	**$ (30)**	**$ (75)**	
Risk-Based Capital - End of Reporting Period **[From Page 29 - Five Year Historical Data -** **of the 2014 GHMSI Annual Statement Filed with Regulators]**							**Page 29** **Line Number(s)**
Authorized control level risk-based capital	$ 97	$ 102	$ 100	$ 106	$ 106	$ 111	Line 15
Risk-based capital percentage	998%	921%	932%	878%	878%	800%	Line 14 ÷ Line 15

Table 2
Group Hospitalization and Medical Services, Inc. (GHMSI) – Attributed to D.C.
Statement of Revenue and Expenses
($ in millions)

This table summarizes GHMSI's calculation of D.C. attributed income statement and capital and surplus amounts. These come directly from the GHMSI Annual Statements filed for 2012-2014, GHMSI's audited and regulator-approved cost accounting system, and, in certain instances, the CareFirst's general ledger system which captures jurisdictional specific items.

		Actual					Forecast
		2011	2012	2013	2014	2012-2014	2015
	Net Income						
1	Total revenues		$ 796	$ 859	$ 941	$ 2,596	$ 947
2	Total hospital and medical expenses		(716)	(747)	(811)	(2,274)	(829)
3	Claims adjustment expenses & General administrative expenses		(112)	(122)	(150)	(384)	(141)
4	**Net underwriting gain or (loss)**		**(32)**	**(10)**	**(20)**	**(62)**	**(23)**
5	Net investment gains (losses) and other income		8	7	5	20	4
6	Net income or (loss) before income tax		(24)	(3)	(15)	(42)	(19)
7	Federal income taxes incurred		4	3	1	8	0
8	**Net Income (Loss)**		**$ (20)**	**$ 0**	**$ (14)**	**$ (34)**	**$ (19)**
	Capital and Surplus						
9	Capital and surplus prior reporting year		$ 202	$ 179	$ 176	$ 202	$ 165
10	Net income or (loss)		(20)	0	(14)	(34)	(19)
11	Other surplus adjustments		(3)	(3)	3	(3)	(5)
12	Net change in capital and surplus		$ (23)	$ (3)	$ (11)	$ (37)	$ (24)
13	Capital and surplus end of reporting period	$ 202	$ 179	$ 176	$ 165	$ 165	$ 141
14	Change in surplus from 2011		$ (23)	$ (26)	$ (37)	$ (37)	$ (61)
15	**D.C. attributed surplus as a percent of GHMSI total surplus**		**19.0%**	**18.8%**	**17.7%**	**n/a**	**15.8%**
	Risk-Based Capital - End of Reporting Period						
16	GHMSI D.C. Authorized Control Level	$ 26	$ 26	$ 27	$ 29	$ 29	$ 30
17	GHMSI D.C. RBC	780%	669%	647%	569%	569%	472%
18	GHMSI Target RBC	721%	721%	721%	721%	721%	721%
19	Surplus "Excess" / (Deficit)	$ 15	$ (14)	$ (20)	$ (44)	$ (44)	$ (74)
20	**GHMSI Ending Capital and Surplus**	**$ 964**	**$ 941**	**$ 935**	**$ 934**	**$ 934**	**$ 889**

Table 3
Group Hospitalization and Medical Services, Inc. – Attributed to D.C.
Risk-Based Capital Calculation
($ in millions)

The Risk-Based Capital calculation is prescribed by the National Association of Insurance Commissioners (NAIC) and used by all licensed health insurance companies nationally.
Data supporting the GHMSI (all jurisdictions) Risk-Based Capital calculation is directly from the GHMSI Health Risk-Based Capital (RBC) filing for the year ending December 31, 2011.

RBC % = Capital and Surplus / Authorized Control Level (ACL)

$$RBC\ after\ Covariance = H0 + \sqrt{H1^2 + H2^2 + H3^2 + H4^2} \qquad ACL = \frac{RBC\ after\ Covariance}{2}$$

RBC Factor	Key Drivers
H0 - Affiliate Risk: Total asset, underwriting, credit and business risks of affiliates (not the primary legal entity).	Affiliate RBC ACL driven by Affiliate Risk Factors
H1 - Asset Risk: Risk that an entity's assets will default, based upon type of investment and NAIC rating.	Fixed Income and Equity investments; non insurance affiliates
H2 - Underwriting Risk: Risk associated with the unexpected fluctuation of incurred claims.	Risk contribution margin results and FEP incurred claims
H3 - Credit Risk: Risk of collection problems with respect to account receivables from customers, reinsurers, healthcare providers, etc.	Health Care Related, Reinsurance Receivables, and other receivables
H4 - Business Risk: Risk of losses in the entity's non-risk business, risk for excessive growth, and a charge for risk administrative expenses and premiums subject to guaranty funds assessment	General and Administrative Expenses, non-risk claims, and risk premiums

2011 GHMSI and DC Risk-Based Capital Calculation

RBC Risk Factor	GHMSI ($M)	GHMSI - DC ($M)	D.C. Attribution Methodology
H0 - Affiliate Risk	$ 59.6	$ 12.5	Allocated the insurance affiliates' ACL using the year-end % of surplus. 21% Per DISB December 30, 2014 Order NO. 14-MIE-012.
H1 - Asset Risk	$ 47.5	$ 10.0	Allocated the non-insurance entities book value and all invested assets and EDP equipment using the year-end % of surplus. 21% Per DISB December 30, 2014 Order NO. 14-MIE-012.
H2 - Underwriting Risk	$ 121.8	$ 37.2	H2 is calculated using actual DC risk premiums and claims, FEP claims and stop loss premiums as reported in the Annual Statement.
H3 - Credit Risk	$ 5.8	$ 0.2	DC allocation excludes reinsurance balances related to cross jurisdictional sales and hospital advances (these amounts relate to Maryland business only). Receivables allocated using year-end % of surplus. 21% Per DISB December 30, 2014 Order NO. 14-MIE-012.
H4 - Business Risk	$ 26.1	$ 8.2	Reflects actual DC non-FEP premiums for guaranty funds assessment charge, administrative expenses and non-risk results.
RBC-ACL	$ 97	$ 26	[H0 + Square Root of ($H1^2$+$H2^2$+$H3^2$+$H4^2$)] ÷ 2
2011 Capital and Surplus	$ 964	$ 202	GHMSI from line 49 of page 5 of filed 2011 Annual Statement; GHMSI-DC is 21% of GHMSI per DISB December 30, 2014 Order NO. 14-MIE-012.
Risk-Based Capital	998%	780%	2011 Capital and Surplus divided by RBC-ACL
GHMSI Target RBC	721%	721%	Per DISB December 30, 2014 Order NO. 14-MIE-012.
2011 "Excess" Capital & Surplus	$ 268	$ 15	Amount that 2011 actual surplus exceeds surplus specified in DISB December 30, 2014 Order NO. 14-MIE-012.

Exhibit 2
Applicable District Law

Any plan for reduction or distribution of surplus under the Medical Insurance Empowerment Amendments Act ("MIEAA") must comply with two fundamental requirements:

First, the plan must focus on the surplus generated by business in the District of Columbia, and may not require distribution of surplus generated by business in Maryland and Virginia. As the December 30, 2014 Order states, "[t]he Act requires the Commissioner to determine whether '*the portion* of the surplus of the corporation *that is attributable to the District*' is excessive." Order at 51 (quoting D.C. Code § 31-3506, emphasis added by DISB). The DISB's regulations make it clear that such surplus must be "derived from the Company's operations in the District of Columbia." 26A DCMR 4699.2; Order at 50-51.

Both the text of the MIEAA and the DISB's own regulations require that any determination of excess and any reduction or distribution of surplus only be to the portion of surplus attributable to the District of Columbia. *See* D.C. Code § 31-3506(e), (f) & (h) (repeatedly referring only to the portion of GHMSI's surplus that is "attributable to the District"). Indeed, significant inter-jurisdictional conflict would result if the Commissioner were to order the distribution of surplus generated by business operations in Maryland or Virginia for the benefit of District residents. *See* Va. Code § 38.2-4229.2; Md. Code Ann., Ins. Art. § 14-124(a)(3).

To meet the requirement that only surplus attributable to the District be affected by the MIEAA, GHMSI has tracked the surplus attributable to the District in each year after 2011, incorporating both the gains and losses that are "derived from the Company's operations in the District of Columbia." 26A DCMR 4699.2.

Second, the plan must not require GHMSI's surplus attributable to the District of Columbia to fall below (or further below) the level required for "financial soundness and efficiency." D.C. Code § 31-3505.01. As the Order states,

> [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.

Order at 5. By definition, a surplus *below* the level set by the Commissioner is inconsistent with financial soundness and efficiency, and no remedial plan should force GHMSI's surplus below that level. Since the Commissioner has determined that the correct level for surplus attributable to the District is 721% RBC, any plan that forced surplus attributable to the District below that level (or further below it) would violate the MIEAA.

Exhibit 3
GHMSI Community Reinvestment Expenditures – 2012 to 2014

2012 GHMSI COMMUNITY REINVESTMENT EXPENDITURES

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

2013 GHMSI COMMUNITY REINVESTMENT EXPENDITURES

	DC only	Total GHMSI
Community Giving	$3.4 million	$7.6 million
Open Enrollment Subsidies	$10.3 million	$10.9 million
DC HealthCare Alliance Program Funding	$5.0 million	$5.0 million
TOTAL 2013 EXPENDITURES	**$18.7 MILLION**	**$23.5 MILLION**

2014 ESTIMATED GHMSI COMMUNITY REINVESTMENT EXPENDITURES (Updated 3.10.15)

	DC only	Total GHMSI
Community Giving	$3.7 million	$8.9 million
Open Enrollment Subsidies*	$6.2 million	$6.5 million
DC HealthCare Alliance Program Funding	$5.0 million	$5.0 million
TOTAL 2014 ESTIMATED*EXPENDITURES	**$14.9 MILLION**	**$20.4 MILLION**

The above tables update the figures previously filed with GHMSI's June 2014 prehearing brief. The open enrollment subsidies include the PPO open enrollment product offered by GHMSI and the HMO open enrollment product offered by CareFirst BlueChoice.

In addition to the Community Reinvestment Expenditures set out above, GHMSI and CareFirst BlueChoice, Inc. moderated rates in the District of Columbia individual and small group markets in 2011 and 2012.

*2014 open enrollment subsidies are estimated as of March 10, 2015. Some claims attributable to 2014 coverage may still be filed.

Exhibit 4: 13 RBC Studies in 10 Years – The Most Studied Surplus in the US

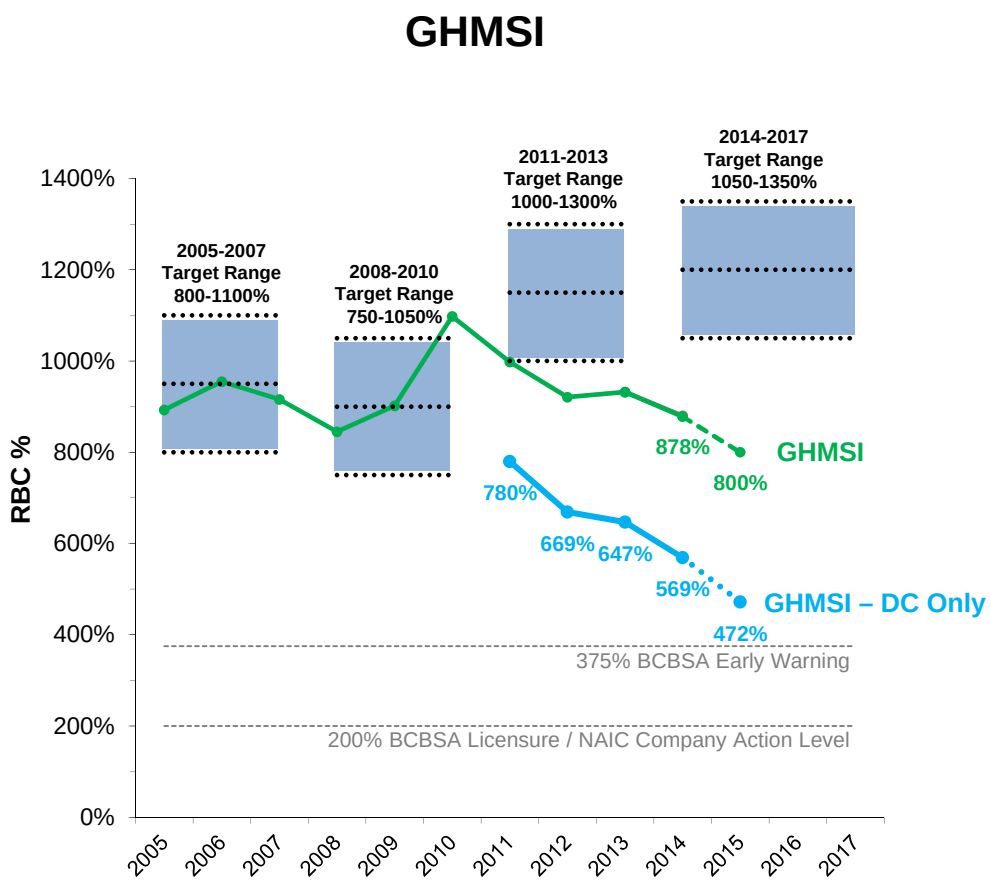
Study Year	Consultant	Engaged by	RBC Range GHMSI
2005	Milliman	CareFirst	800% - 1,100%
	Board Adopted for 2005 - 2007		***800% - 1,100%***
2008	Milliman	CareFirst	750% - 1,050%
	Lewin	CareFirst	750% - 1,000%
	Board Adopted for 2008 - 2010		***750% - 1,050%***
2009	Invotex	MIA	700% - 950%
	Rector	DISB	600% - 850%
2011	Milliman*	CareFirst	1,050% - 1,300%
	Lewin	CareFirst	1,000% - 1,550%
	Board Adopted for 2011 - 2013		***1,000% - 1,300%***
	RSM McGladrey	MIA	1,000% - 1,300%
2012	Milliman	CareFirst	1,000% - 1,300%
	Lewin	CareFirst	1,000% - 1,300%
	MIA 9/14/2012 Order		1,000% - 1,300%
2013	Milliman	CareFirst	1,000% - 1,300%
2014	Rector**	DISB	875% - 1,040%
	Milliman***	CareFirst	1,050% - 1,350%
	Board Adopted for 2014 - 2017		***1,050% - 1,350%***
	DISB 12/30/2014 Order	DISB	721%
2015	Lewis & Ellis	MIA	

* Upward adjustments recommended by Milliman for ACA impacts:
+ 100 - 150 points for GHMSI after exchanges
+ 50 - 100 points for CFMI after exchanges

** Specific target and benchmark range defined

*** Target defined - built range from standard deviations from target

Exhibit 5:
GHMSI Risk Based Capital: 2005-2014 Actual; 2015 Estimate



Note: In 2014, 40% of GHMSI's surplus represents the value of BlueChoice.