CAREFIRST BLUECROSS BLUESHIELD
OFFICE OF CORPORATE COUNSEL
1501 S. Clinton Street, CT10-06
Baltimore, Maryland 21224

Randolph Stuart Sergent
Vice President & Deputy General Counsel
Telephone: 410-528-7926
Fax: 410-720-5277
randolph.sergent@carefirst.com

December 3, 2013

VIA E-MAIL AND REGULAR DELIVERY

Philip Barlow
Associate Commissioner
Department of Insurance, Securities, and Banking
810 First Street, N.E., Suite 710
Washington, DC 20002

Sarah W. Schroeder
President
Rector & Associates, Inc.
172 East State Street, Suite 305
Columbus, OH 43215

Dear Phil and Sarah:

I write on behalf of Group Hospitalization and Medical Systems, Inc. (GHMSI) to provide comments on the November 20, 2013 draft report by Rector & Associates (the draft report). Thank you for the opportunity to comment. We have submitted comments in the chart below and in the attached commentary from Milliman (Attachment 1).

As we have stated throughout the course of these proceedings, GHMSI continues to have significant concerns with rate adequacy, increasing medical costs, and the expansion of enrollment in a guaranteed issue population, all of which have been diminishing GHMSI's surplus, and will further diminish GHMSI's surplus in the coming years. At the same time, we believe that surplus that is lost will be nearly impossible to recover, because the medical loss ratio (MLR) rules will limit the extent to which surplus can be built into rates, there are significant market pressures and turmoil in the individual and small group markets, and GHMSI's large group and self-insured market segments are highly competitive markets in which GHMSI has little pricing power. We set out these concerns at length in my letter to Sarah dated

July 19, 2013 (with attachments), in which we expressed why we believe that any surplus model should expressly account for these significant market pressures.

You have asked that we limit our comments on the draft report to factual matters that we have identified. We have attempted to follow this instruction, with the understanding that GHMSI does not waive its right to address the substance of the report in a subsequent hearing. We incorporate into this response, by reference, the substantive points in our July 19, 2013 submission and therefore do not repeat them below.

The specific comments are set out in the chart below. Two issues show up in several different comments within the chart and merit a separate explanation:

- ***Rate reduction as community reinvestment*** – As Rector notes on page 5 of the draft report, community reinvestment expenditures are defined in the statute to include premium rate reductions. It is therefore important to include premium rate reductions in any discussion of GHMSI's past or expected future community reinvestment. We have previously shown that GHMSI instituted $27 million in pricing reductions in the DC market in 2010 to 2012 (as discussed further in the chart below). However, it is also important to discuss rate reduction specifically in relation to Rector's suggested approach to managing surplus. Rector proposes that GHMSI should increase or decrease community reinvestment to manage surplus within a range and trending towards a point. Such management would be accomplished through the rate setting process, and therefore any 'increases' or 'decreases' in community reinvestment would in actuality be reflected in rates. The chart below identifies the specific passages in the draft Report to which this comment applies.

- ***The Court of Appeals decision*** – Rector in a few places refers to the decision of the District of Columbia Court of Appeals as requiring two separate standards of review of GHMSI's surplus. We do not think that this characterization is correct. The test for whether surplus is excessive is contained entirely within Section 31-3506(e) of the DC Code, and it has two parts that must be considered at the same time – whether the surplus is unreasonably large, and whether it is inconsistent with the community health reinvestment mandate. The key point is that only a single standard of review is applied, and there is not a separate or distinct "community reinvestment" analysis required under Section 31-3505.01. Rector accurately characterizes the statute on page 8, so we believe that this may be an issue of editing the language, rather than a disagreement on substance. We propose specific edits in the chart below.

Report Location (page)	**Comment**
5, block quote, bottom of page	The block quote should be revised as follows: "may ~~shall~~ issue a determination."
5, note 6	The citation should be D.C. Code § 35-3501(1A).
6	For the block quote from 26-A DCMR § 4601.4, we suggest reinserting the citation to D.C. Official Code §§ 31-3851.01 et seq. (2008 Supp.), because this is the source of the statutory requirement to remain above 200% RBC-ACL.
7, first paragraph	We suggest removing the bullets and introductory paragraph on this page. As discussed above, the Court did not identify two standards of review, but held that the two requirements of an excessiveness finding under Section 31-3506(e) must be considered in tandem. If Rector wishes to keep the bullets, we suggest revising the introductory paragraph to state: "In the Appeals Court Decision, the D.C. Court of Appeals first reviewed the relevant MIEAA provisions and identified two ~~standards for review of GHMSI's surplus, as set forth in~~ relevant provisions of the MIEAA."
8, beginning of Part II	The filing date is June 1, 2011, rather than July 1.
9, second paragraph	Please see the attached comments from Milliman.
11, first paragraph in Section B.	We suggest revising this paragraph to be consistent with our comment above regarding the Court of Appeals decision. The analysis of community reinvestment is not conducted under a separate statute, but is tied to whether the surplus is unreasonably large. Accordingly, we suggest revising the bullets following the first paragraph to state as follows: *In the Appeals Court Decision, the D.C. Court of Appeals made clear that in accordance with the MIEAA standards, the DISB is required to make two determinations regarding GHMSI's surplus:* • *Whether GHMSI's surplus is unreasonably large, and* • *Whether GHMSI's surplus is inconsistent with GHMSI's community health reinvestment mandate.*

Report Location (page)	**Comment**
12, second full paragraph Pages 14 and 31	For the same reasons discussed with respect to page 11, we suggest revising the second full paragraph as follows: *Stated another way, we conclude that ~~GHMSI has engaged in community health reinvestment to the maximum feasible extent consistent with financial soundness and efficiency (i.e., it meets the first determination) and does not possess surplus that is unreasonably large and inconsistent with GHMSI's community health reinvestment mandate (i.e., it meets the second determination)~~ GHMSI does not possess surplus that is unreasonably large (i.e., it meets the first determination) and that the surplus is not inconsistent with GHMSI's community health reinvestment mandate (i.e., it meets the second determination) if GHMSI's surplus does not exceed the benchmark. We therefore conclude that, if GHMSI's surplus is greater than the benchmark, ~~it is not engaging in community health reinvestment to the maximum feasible extent (i.e., it does not meet the first determination) and it has surplus that is unreasonably large and inconsistent with its community health reinvestment mandate (i.e., it does not meet the second determination)~~ it has surplus that is unreasonably large (i.e., it does not meet the first determination) and the surplus is inconsistent with the community health reinvestment mandate (i.e., it does not meet the second determination).* Similar statements are made in the draft report on pages 14 and 31 – we suggest that the same edits should be made on those pages that are suggested above.
13, first full paragraph	We suggest that a broader range be proposed, given the likelihood of changes in RBC level from year to year. Please see the attached comment from Milliman.
13, second full paragraph	This paragraph suggests that if surplus exceeds the Benchmark Range, GHMSI should increase community reinvestment expenditures. As discussed in our first general comment, we suggest adding the words "including rate moderation," to ensure that readers are aware that rate moderation is a community reinvestment expenditure (as defined in the statute). We believe that this is particularly necessary, given that the draft report proposes managing surplus within a range, which management will be performed through rate increases or reductions.

Report Location (page)	Comment
13, second bullet	Please see the attached comment from Milliman.
17, penultimate paragraph	The draft report states that GHMSI's status on the BCBSA watch list, if its surplus were to fall below 375%, would be confidential. We do not believe that this is correct as a practical matter. GHMSI's surplus itself would not be confidential and we expect that the market would become aware of GHMSI's status on a BCBSA watch list. We further believe that competitors would seek to capitalize on GHMSI's status to circulate fear, particularly in the group and self-insured markets.
19, first and third bullets	Please see the attached comments from Milliman.
20, first full paragraph and last full paragraph	Please see the attached comments from Milliman.
22, last bullet	Rector did not provide an explanation regarding the exclusion of MLR restrictions from the modeling. GHMSI has previously submitted materials to show that MLR restrictions will contribute to rate inadequacy over the long term, because of the fact that MLR rules fragment GHMSI's market into multiple segments to which MLR is separately applied, and that the MLR rules will limit GHMSI's ability to recover surplus after a downward trend begins. For the reasons stated in our prior submissions, we believe that this should be part of the model. In addition, Milliman has proposed additional revised language about its approach in its attached comments.
23, second full paragraph	We believe that the issue of whether GHMSI is able to obtain adequate rates through the rate approval process should be monitored in future years, and may need to be revisited as more experience is gained under the Affordable Care Act.
25, after Section 3 and note 30.	Milliman uses the term "provision for unidentified growth and development," rather than the term "unidentified growth and development charges." Please see the attached comments from Milliman.
24	Please see Milliman's proposed comments about FEP and non-FEP growth rates.
35, first full paragraph	"befit" should be changed to "benefit"
35, first full paragraph	The word "directors" should be changed to "trustees"

Report Location (page)	Comment
35-36	In this section, Rector sets out the various elements of GHMSI's community reinvestment spending. As noted on page 5 of the report, community reinvestment expenditures are defined in the statute to include premium rate reductions. We have previously submitted a chart, another copy of which is attached (Attachment 2), showing $27 million in pricing reductions in the DC market in 2010 to 2012. We request that Rector include this as an element of discussion among other community reinvestment expenditures. We believe this is particularly necessary because future increases or decreases in surplus will most likely be managed through the rate setting process.
36, second full paragraph	This paragraph refers to the $5 million annual funding of the DC HealthCare Alliance Program, stating that "it appears that GHMSI's expenditures for 2014 and future years will not include" this funding. However, the partnership agreement on which the funding requirement is based extends *through* 2014 – GHMSI expects to include $5 million in funding for this purpose in 2014 expenditures. In addition, GHMSI expects to incur losses of approximately $6 million in 2014 attributable to the DC open enrollment program, as that program winds down.
37	We believe that the calculation of GHMSI's Community Reinvestment Expenditures should include expenses throughout GHMSI's service territory, and those attributable to GHMSI from BlueChoice, in addition to the analysis of DC expenditures. The reason for this is that most of the revenue, cost, and other figures used to analyze GHMSI's surplus have reflected its total operations, including the attributed portions of BlueChoice, and we believe that it would be consistent to include the broader Community Reinvestment Expenditures as well. For this reason, we recommend updating the exhibit to include both DC-attributed and total expenditures. Please also note that the draft report includes DC-only expenses for 2011 and 2012, but DC and Virginia expenses for the 2013 estimates. We have attached a chart with the recommended changes, as Attachment 3. We also believe that the DC premium taxes should be updated to included taxes paid on behalf of CareFirst BlueChoice, Inc., a wholly-owned subsidiary of GHMSI.

Thank you for the opportunity to submit these comments and the attached materials. We are available to answer any questions at your convenience.

Sincerely yours,

Randolph S. Sergent

Attachment(s)

Milliman

1550 Liberty Ridge Drive, Suite 200
Wayne, PA 19087-5572
Tel + 610 687.5644
Fax + 610 687.4236
www.milliman.com

December 3, 2013

Jeanne Kennedy
Vice President and Treasurer
CareFirst BlueCross BlueShield
10455 Mill Run Circle
Mail Stop 01-700
Owings Mills, MD 21117-5559

Re: Comments on Rector & Associates, Inc. Draft Report of November 20, 2013

Dear Jeanne:

Attached are a number of comments based on a review of the draft report produced by Rector & Associates, Inc. (Rector) dated November 20, 2013, titled "Report to the D.C. Department of Insurance, Securities and Banking; Group Hospitalization and Medical Services, Inc." The Rector report discusses, among other things, their review of Milliman's May 31, 2011 GHMSI report on the Development of an Optimal Surplus Target Range, as well as the Milliman model and assumptions underlying that report.

We have included comments on certain items in Rector's report that we believe to be inaccurate or inappropriate.

Limitations and Caveats

The comments in this letter refer to, and relate to, Milliman's 2011 GHMSI report on the Development of an Optimal Surplus Target Range. It should be considered only in connection with that report; applicable terms and concepts are not repeated here. The limitations and caveats presented in that report also apply to this letter.

The authors of this material are Consulting Actuaries for Milliman, are members of the American Academy of Actuaries, and meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinions contained herein.

ATTACHMENT 1

Please let us know if you have any questions regarding this information, or if you wish to discuss it.

Sincerely,

Phyllis Doran

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

PAD/jpj

Milliman Comments on Rector Draft Report

(1) From page 9 of Rector report:

We propose eliminating the word "arbitrarily", as noted in the following paragraph, from Rector's draft report.

Rector: *More problematically, there is no universally accepted approach establishing an appropriate range. Milliman established its range by ~~arbitrarily~~ selecting two assumptions (trend miss and premium growth) and running the model with different values for those assumptions. However, other assumptions could just as easily have been chosen. We believe it is better to use a best estimate assumption and to calculate an optimal capital range relative to that best estimate. A point value will give the company a capital level to strive toward when balancing the needs for solvency protection with the requirement for community health investments.*

Milliman's decision to treat the trend miss and premium growth assumptions in the specific manner that they were treated was not in any way arbitrary. Rather, these were conscious choices made by Milliman, reflecting the structural characteristics of Milliman's model and a desire to define the surplus target range based on a range of assumptions with respect to these two variables (a common actuarial approach to establishing ranges of projected results).

In our model the assumption regarding the trend miss time period assumption is embedded in a portion of the model that carries out a series of complicated calculations, and operates in a different manner than the other assumptions that are expressed as probability distributions. The premium growth assumptions are handled in the pro forma projection segment of the model, and do not directly lend themselves to the probability distribution structure of the other assumptions.

While we believe that our treatment was reasonable, we agreed to handle these assumptions in the manner requested by Rector for purposes of their analysis. With respect to the premium growth assumptions, this required that we first test treat these assumptions in the manner used in our own modeling, and then transform the results by iteration into the form of the probability distributions requested by Rector. It is a far more cumbersome and time-consuming process, which is the reason we did not choose to use that approach in our modeling.

While we believe that both approaches have merit, the wording in Rector's report suggests that there is one "better" approach, and that Milliman's approach was "arbitrary". We disagree.

(2) From page 13 of Rector Report:

The paragraph which follows describes Rector's approach to development of a range for routine fluctuation in GHMSI's RBC ratio around the 958% target. It does not appear that Rector considered the correlation year to year that could be expected in such fluctuation. Further, it does not appear that Rector considered the fact that there is a not-insignificant probability that the change in surplus ratio year by year will be greater than the calculated 82.5 basis point average of such changes over the past few years For example, if surplus were at the target level in a given year, then there is a possibility that the change to the next year will be more than 82.5 basis points, plus the likelihood that the change for the subsequent year will be in the same direction, thereby creating a high likelihood of routinely falling outside of the range over a two-year period. (This can be illustrated by comparing the average two-year change in the RBC ratio to the 82.5 basis point average of one-year values; the two-year value is greater.) Such a high frequency of this occurrence would be needlessly disruptive. We would suggest a wider range, such as twice the calculated average of 82.5 basis points.

Rector page 13: *To arrive at an appropriate range, we reviewed changes in GHMSI's RBC historical levels over the period 1999-2012. Although GHMSI's RBC varied from year to year by 100 or more basis points during the early part of the period, most year to year changes since 2004 have been less than 100 basis points. The average year to year change during the 2004-2012 period was 82.5 basis points. For these reasons, we have selected a range consisting of the target level surplus (958% RBC) +/- approximately 82.5 basis points.*

(3) From page 13 of Rector report:

We propose certain rewording as noted in the following paragraph from Rector's draft report.

Rector: *Second, when the health RBC formula was devised (and in subsequent revisions to the formula), the individual risk factors that comprise the formula were developed with the intent ~~calibrated~~ to achieve a ~~very~~ high level of confidence ~~levels~~ that an insurer would not become insolvent. ~~In other words, the RBC formula was constructed with a high degree of conservatism embedded into the formula.~~*

Although certain modeling was conducted in the early stages of the development of the health RBC underwriting risk factors, ultimately the combination of factors in the RBC formula reflected a great deal of informed judgment. The application of factors and algorithms in the formula to create various RBC thresholds was determined by the NAIC, with consideration as to the impact on certain independent nonprofit non-Blue health plans which were not strongly capitalized at the time. Confidence levels in the form of statistical values were not developed for the RBC formula in the aggregate, and various risks have been subsequently identified as relevant to health insurers that are not recognized in the RBC formula. Further, the fact that the surplus

threshold values produced by the RBC formula were substantially lower than the values produced by the Blue Cross and Blue Shield Association's predecessor "Capital Benchmark" formula was a significant impetus for the Association to adopt an "early warning" monitoring threshold (now 375% of the ACL value from the RBC formula). For these reasons, we would propose that Rector make the wording changes shown above.

(4) From page 19 of Rector report:

The following description of the time period associated with the Milliman "trend miss assumption" is not correct. We propose the indicated revision:

Rector: *the projected period of time that GHMSI's actual trend differs from its anticipated trend ~~before GHMSI makes adjustments to its trend assumption (also known as the "trend miss assumption")~~*

Note that Milliman has assumed GHMSI makes changes prior to the end of this period, but due to rating cycle delays and imperfect information the changes do not fully compensate for the differences between actual and anticipated trends.

(5) From page 19 of Rector report:

We propose the following change to this paragraph which appears later on page 19:

Rector: *With respect to trend miss, the Milliman model applies two different trend miss periods through the stochastic modeling process to develop two alternative loss scenarios ~~calculate two different claim payment amounts~~ that then are incorporated into GHMSI's pro forma financial statements (the financial projection stage of the model).*

We believe that this wording change more accurately describes the process followed by Milliman in its modelling.

(6) From page 20 of Rector report:

We propose that the indicated phrase be deleted in Rector's comments, for the reasons outlined below:

Rector: *We had extensive discussions with GHMSI and Milliman staff regarding the manner in which trend miss and premium growth levels were used in the model. ~~GHMSI and Milliman staff did not provide justification as to why~~ these two components are not built into the stochastic*

testing methodology in the same manner as the other assumptions that are used to construct the loss cycle. Accordingly, we asked Milliman to incorporate the trend miss and premium level components into its model in the following manner:

- *With respect to trend miss, we asked Milliman to include the effect of trend miss and related probabilities into the stochastic model's rating adequacy and fluctuation factor.*

- *With respect to premium growth levels, we asked Milliman to include the probabilities of specific premium growth levels in the modeling process.*

The manner in which we asked Milliman to incorporate the trend miss and premium growth level components into its model are further described in Section IV.B.1. and Section IV.B.4.,respectively, of this Report.

We do not recall being asked to "justify" our approach to the treatment of the trend miss time period and premium growth assumptions, but as noted in Item (1) above, we had specific reasons for doing so. As we stated previously, we believe that both the Milliman and the Rector approaches have merit.

(7) From page 20 of Rector report:

We suggest the following revisions. They reflect the fact that Milliman's approach was to treat the impact of the noted health care reforms explicitly through appropriate assumptions in the model. The impact of such assumptions was measured by comparing the results with modeling results that excluded these assumptions.

Rector: *Based on our analysis of the Milliman model and our extensive discussions with GHMSI, Milliman, Appleseed, and ARM staff, we believe that the impact of health care reforms that were not in effect at the time of Milliman's analysis should ~~instead~~ be incorporated directly into appropriate assumptions used in the model~~, rather than estimating the potential increase in GHMSI's surplus target range due to these health care reforms outside of the modeling process.~~ The manner in which we asked Milliman to incorporate the potential impact of health care reform provisions that were not yet in effect at the time of Milliman's analysis is further described in Section IV.B. of this Report.*

(8) From page 22 of Rector report:

We recommend that the following paragraph on page 22 be revised to reflect an accurate description of Milliman's approach, as outlined below:

Rector: *In its model, we found that the method by which Milliman determined trend assumed that each loss cycle's ~~year's~~ trend is independent of prior periods and that each year's trend within a loss cycle is the same (i.e., it is treated as being fully dependent). Based on our analysis, we believe that trends occurring between time intervals are neither ~~not~~ independent nor dependent, but rather are correlated to trends from prior periods. Accordingly, we made changes to the manner in which trend is incorporated into the rating adequacy and fluctuation factor.*

The description of Milliman's approach in the draft Rector report is incorrect. The overall multi-year trend deviation is treated as independent. Trends within a given 2 or 3 year trend miss period are the same for each year and thus dependent on the prior year value. This approach was incorporated as a simplification of the more complicated calculation that Rector suggested, reflecting year to year correlation. Our analysis, which we shared with Rector, demonstrated that Milliman's simplified approach produced results very similar to those produced by the correlation approach suggested by Rector.

(9) From pages 22 - 26 of Rector report:

Rector makes multiple references to "charges" with respect to Milliman's provisions for catastrophic events and unidentified growth and development. For example: *". . . Milliman and GHMSI define unidentified growth and development charges . . ."* (page 25). We do not define or refer to any such "charges". Rather, we refer to a "provision for unidentified growth and development". Milliman's model does not reflect any charges for unidentified growth and development.

Similarly, the footnote on page 25 misquotes Milliman: *"We consider Milliman's use of the term "unidentified growth and development charges" to be a misnomer . . . ".* We do not use that phrase in our report.

(10) From page 29 of Rector report:

We suggest the following revision:

Rector: ***Distinction Between FEP and Non-FEP Premium.*** *As previously indicated, the Milliman model applied two different premium growth levels: a 7% premium growth level and an 11% premium growth level. In addition to applying these premium growth levels without probability distributions, the Milliman model also did not differentiate growth rates between FEP and non-FEP business written by GHMSI.*

Financial Impact of DC Individual and Small Group Pricing Decisions

	(A)		(B)	(C)		(D)			(E)				(F)			
	Premium		% of Contracts	Target	Filed	Implied	Needed	Approved	Financial Impact vs. Filed CtR ($'s in 1,000's)				Financial Impact vs. 0% CtR ($'s in 1,000's)			
4Q2010	(in 1,000's)	Contracts	Renewing	CtR	CtR	CtR	Renewal	Renewal	2011	2012	2013	Total	2011	2012	2013	Total
Individual	$27,748	7,934	24%	2%	1.8%	-0.6%	14.2%	11.8%	($134)			($134)	($34)			($34)
Small Group	$339,693	42,817	26%	3%	2.5%	2.4%	5.2%	5.1%	($46)			($46)	$1,773			$1,773
Combined	$367,440	50,751	26%				7%	6%	($180)			($180)	$1,739			$1,739
1Q2011																
Individual	$30,364	8,106	27%	2%	1.3%	-0.9%	11.7%	9.4%	($169)	($15)		($184)	($70)	($6)		($76)
Small Group	$381,748	41,719	31%	3%	0.7%	-2.3%	8.6%	5.6%	($3,269)	($297)		($3,566)	($2,538)	($231)		($2,769)
Combined	$412,112	49,825	30%				9%	6%	($3,438)	($313)		($3,751)	($2,608)	($237)		($2,845)
2Q2011																
Individual	$31,124	8,156	37%	2%	1.3%	-9.4%	8.2%	-2.5%	($772)	($463)		($1,235)	($676)	($406)		($1,082)
Small Group	$378,919	41,719	28%	3%	0.7%	-3.6%	-0.1%	-4.4%	($2,783)	($1,670)		($4,453)	($2,340)	($1,404)		($3,743)
Combined	$410,043	49,875	29%				1%	-4%	($3,555)	($2,133)		($5,688)	($3,016)	($1,809)		($4,825)
3Q2011																
Individual	$31,124	8,156	18%	2%	1.3%	-12.3%	3.0%	-10.6%	($284)	($474)		($759)	($257)	($428)		($685)
Small Group	$342,317	42,461	17%	3%	-4.0%	-3.9%	-12.7%	-12.6%	($836)	($1,394)		($2,230)	($836)	($1,394)		($2,230)
Combined	$373,440	50,617	17%				-10%	-12%	($1,121)	($1,868)		($2,989)	($1,093)	($1,822)		($2,915)
4Q2011																
Individual	$31,374	8,020	25%	2%	-10.0%	-9.7%	-13.3%	-13.0%	($128)	($639)		($767)	($128)	($639)		($767)
Small Group	$325,456	40,764	26%	3%	-2.0%	-2.0%	-12.6%	-12.5%	($275)	($1,375)		($1,650)	($275)	($1,375)		($1,650)
Combined	$356,830	48,784	26%				-13%	-13%	($403)	($2,014)		($2,417)	($403)	($2,014)		($2,417)
1Q2012																
Individual	$27,996	8,292	26%	2%	-5.0%	-5.4%	-8.8%	-9.2%		($368)	($33)	($402)		($368)	($33)	($402)
Small Group	$328,816	40,604	29%	3%	5.0%	-2.2%	-2.7%	-9.8%		($6,267)	($570)	($6,837)		($1,888)	($172)	($2,060)
Combined	$356,812	48,896	29%				-4%	-10%		($6,635)	($603)	($7,238)		($2,256)	($205)	($2,461)
2Q2012																
Individual	$27,761	7,890	28%	2%	0.0%	-5.8%	-6.7%	-12.5%		($301)	($151)	($452)		($301)	($151)	($452)
Small Group	$325,767	42,270	20%	3%	0.0%	1.1%	2.5%	3.7%		$486	$243	$729		$486	$243	$729
Combined	$353,527	50,160	21%				1%	1%		$185	$92	$277		$185	$92	$277
3Q2012																
Individual	$28,059	7,764	27%	2%	2.0%	-15.7%	20.1%	2.4%		($554)	($776)	($1,330)		($491)	($688)	($1,179)
Small Group	$348,826	42,290	25%	3%	0.7%	-1.6%	10.3%	8.0%		($831)	($1,163)	($1,994)		($587)	($821)	($1,408)
Combined	$376,885	50,054	25%				12%	7%		($1,385)	($1,939)	($3,324)		($1,078)	($1,509)	($2,587)
4Q2012																
Individual	$29,743	7,821	25%	2%	3.2%	-19.4%	31.0%	8.4%		($280)	($1,401)	($1,681)		($241)	($1,205)	($1,446)
Small Group	$342,260	42,616	26%	3%	2.0%	-10.5%	22.4%	9.9%		($1,866)	($9,331)	($11,197)		($1,567)	($7,834)	($9,401)
Combined	$372,003	50,437	26%				24%	10%		($2,146)	($10,732)	($12,878)		($1,808)	($9,039)	($10,847)
Total Financial Impact																
Individual									($1,487)	($3,096)	($2,361)	($6,944)	($1,164)	($2,881)	($2,077)	($6,122)
Small Group									($7,210)	($13,214)	($10,821)	($31,245)	($4,216)	($7,959)	($8,584)	($20,759)
Subtotal									($8,697)	($16,310)	($13,182)	($38,188)	($5,380)	($10,840)	($10,661)	($26,881)
Large Group									($1,600)	($5,400)		($7,000)				
Grand Total									**($10,297)**	**($21,710)**	**($13,182)**	**($45,188)**				

Comments

Calculation for Columns (E) and (F):

(E) = (A) * (B) * (D-C) if Filed CtR > 0

(E) = (A) * (B) * (D) if Filed CtR < 0

(F) = (A) * (B) * (D)

This number is then divided between calendar years based on the portion of that year impacted by the renewal increase. For example, for a 1Q2011 renewal we assumed the average group renews in February and therefore 11/12 of the rate action will impact 2011 while 1/12 will impact 2012.

PDR

For DC, we booked a PDR of $7.2m in 2011 and $13.1m in 2012.

ATTACHMENT 2

2011 GHMSI COMMUNITY REINVESTMENT EXPENDITURES

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

2012 GHMSI COMMUNITY REINVESTMENT EXPENDITURES

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

2013 ESTIMATED GHMSI COMMUNITY REINVESTMENT EXPENDITURES

	DC only	Total
Corporate Giving	$3.4 million	$6.4 million
Open Enrollment Subsidies	$9.6 million	$10.7 million
DC HealthCare Alliance Program Funding	$5.0 million	$5.0 million
TOTAL 2013 ESTIMATED EXPENDITURES	**$18 MILLION**	**$22.1 MILLION**

GHMSI PREMIUM TAX PAYMENTS – DC ONLY

2011 Premium Taxes $14.1 million
2012 Premium Taxes $14.2 million
2013 Estimated Premium Taxes $15.2 million

In addition to the Community Reinvestment Expenditures set out above, GHMSI and CareFirst BlueChoice, Inc. moderated rates in the District of Columbia individual and small group markets in the amount of approximately $27 million between 2010 and 2012, as shown in detail on Attachment 2.

ATTACHMENT 3