Chet Burrell
President and Chief Executive Officer

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

CareFirst BlueCross BlueShield

June 1, 2011

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

Dear Commissioner White:

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

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

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

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

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

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

Background and History

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

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

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

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

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

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

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

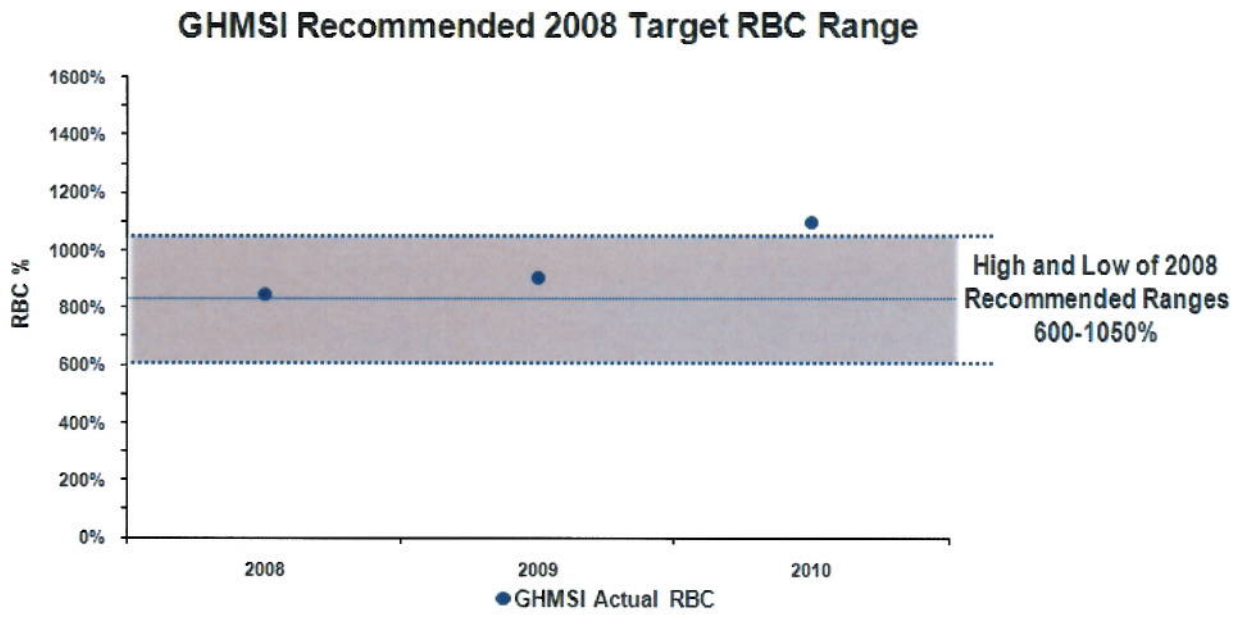
Id. This latter clause refers to a provision that requires "[a] corporation [to] engage in community health reinvestment to the maximum feasible extent consistent with financial soundness and efficiency." Id. § 31-3505.01. It is noteworthy that "community health reinvestment" is defined to mean "expenditures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

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

Coordination with Maryland

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

Chart 1



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

CareFirst Surplus Policy

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

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

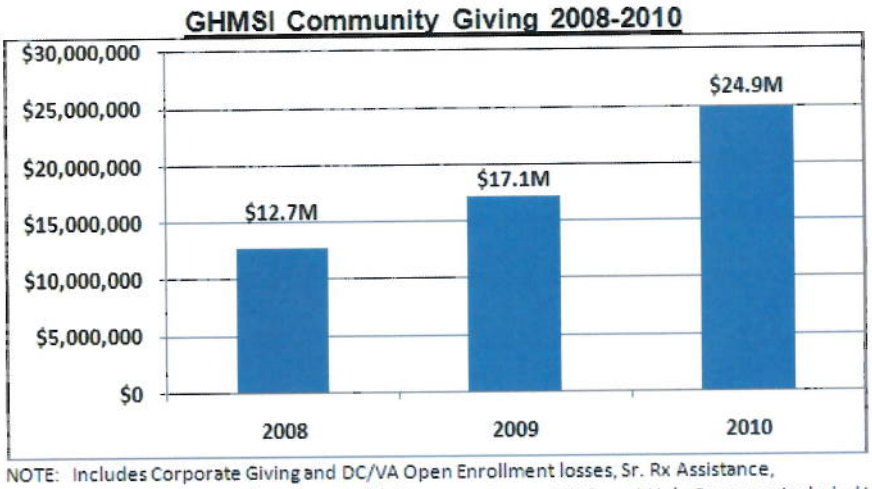
Thus, the companies seek to hold only the level of surplus necessary to preserve their financial solvency and meet their financial needs – and no more. The target level is the midpoint of a range for each affiliate that reflects each affiliate's particular risk profile and financial solvency needs. It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

CareFirst Community Giving Policy

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

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

Chart 2



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

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

The Nature of the Challenge in Surplus Setting

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

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

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

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

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

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

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

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

Updated Actuarial Analyses Reveal Need for Higher Surplus Level

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

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

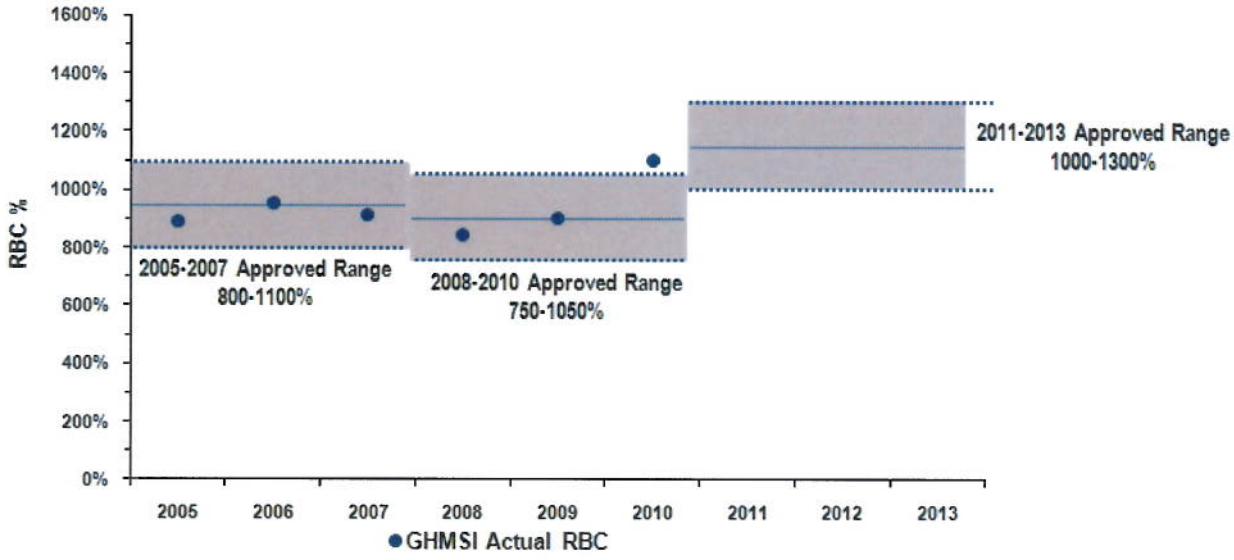
In essence, the Boards wanted to know whether their approved surplus range for GHMSI of 750 to 1050 percent RBC-ACL was still appropriate, reasonable and prudent given the changing landscape the company

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

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

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

Chart 3
GHMSI Approved Target RBC Ranges

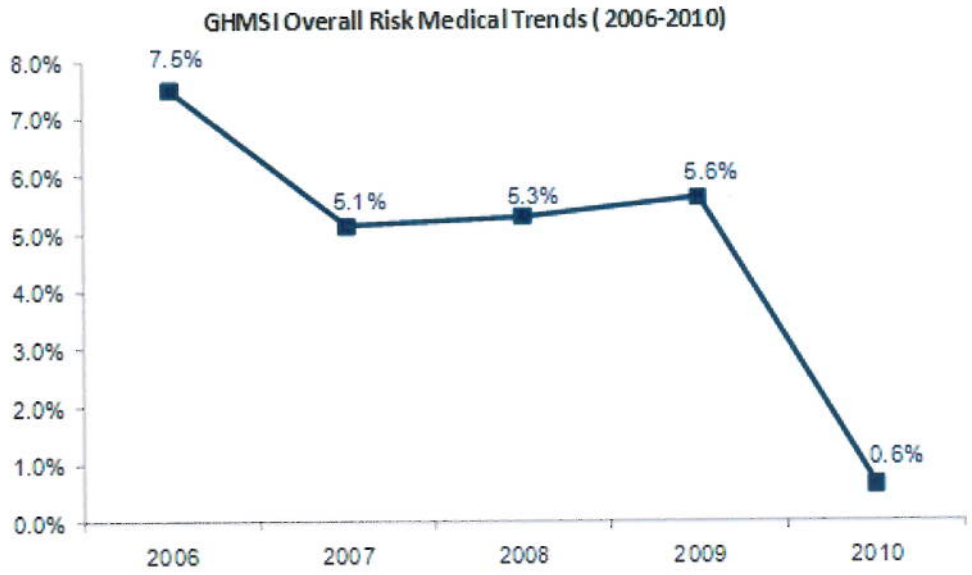


GHMSI's Current Surplus Level

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

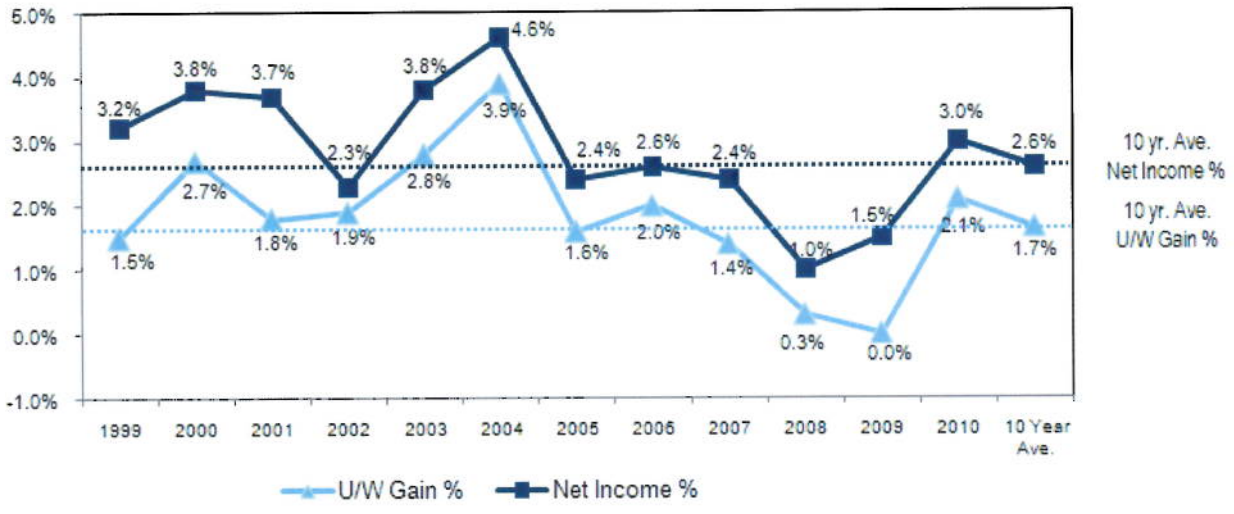
overall medical care cost trends plummet in 2010 to a level last seen in the early 1990's. No one, including the company itself, predicted this. Nor is anyone, including the company, sure of how long and to what degree it will last. **Chart 4** shows this abrupt downward trend taking hold in 2010.

Chart 4



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

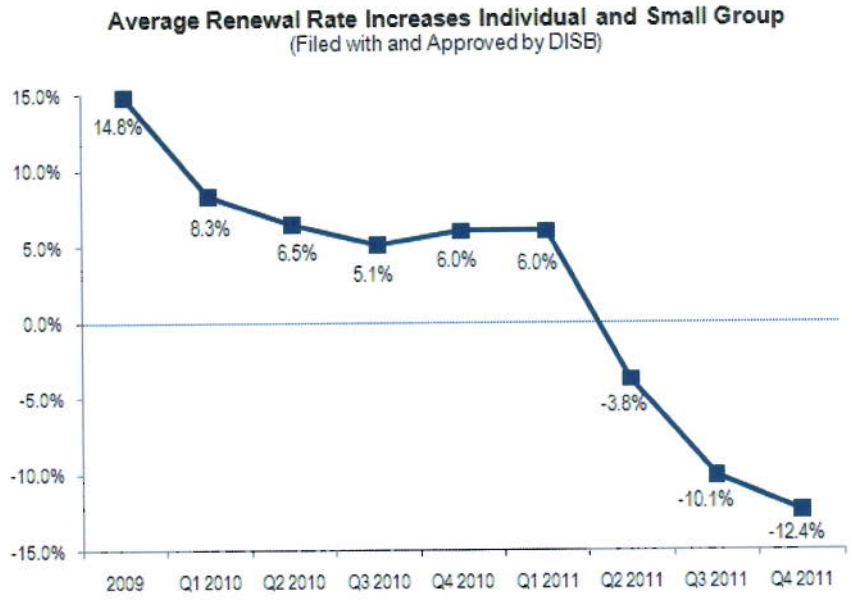
Chart 5



CareFirst/GHMSI Actions to Date in Accordance with its Policy

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

Chart 6



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

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

Conclusion

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

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

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

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

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

Sincerely,

Chet Burrell
President and Chief Executive Officer
CareFirst BlueCross BlueShield

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

Attachments:

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

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

C – Milliman, Inc. Recommendations on GHMSI Reserves

D – The Lewin Group Recommendations on GHMSI Reserves