

BEFORE THE
**INSURANCE COMMISSIONER OF
THE DISTRICT OF COLUMBIA**

Re: Report on Examination – **Group Hospitalization and Medical Services, Inc.** as of
December 31, 2023

ORDER

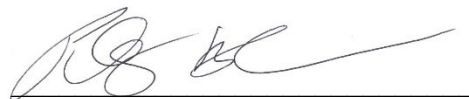
An Examination of **Group Hospitalization and Medical Services, Inc.** as of December 31, 2023 has been conducted by the District of Columbia Department of Insurance, Securities and Banking (“the Department”).

It is hereby ordered on this 28th day of May 2025, that the attached financial condition examination report be adopted and filed as an official record of this Department.

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

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

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



Philip Barlow
Associate Commissioner

REPORT ON EXAMINATION
Group Hospitalization and Medical
Services, Inc.
AS OF
DECEMBER 31, 2023

TABLE OF CONTENTS

| | |
|--|-----------|
| SCOPE OF EXAMINATION | 1 |
| SUMMARY OF SIGNIFICANT FINDINGS | 3 |
| COMPANY HISTORY | 3 |
| General | 3 |
| Dividends to Stockholder | 4 |
| MANAGEMENT AND CONTROL | 4 |
| Board of Directors | 5 |
| Officers | 5 |
| Committees | 6 |
| Conflict of Interest | 6 |
| Corporate Records | 7 |
| Pension and Stock Ownership Plans | 7 |
| HOLDING COMPANY SYSTEM | 8 |
| Organizational Chart | 9 |
| AGREEMENTS AND TRANSACTIONS WITH AFFILIATES | 9 |
| FIDELITY BOND AND OTHER INSURANCE | 12 |
| STATUTORY DEPOSIT | 13 |
| TERRITORY AND PLAN OF OPERATION | 13 |
| REINSURANCE | 14 |
| ACCOUNTS AND RECORDS | 14 |
| FINANCIAL STATEMENTS | 15 |
| Statement of Assets, Liabilities, Capital and Surplus | 16 |
| Statement of Revenue and Expenses | 18 |
| Statement of Changes in Capital and Surplus | 19 |
| Notes to the Financial Statements | 20 |
| Analysis of Changes in Surplus Resulting from the Examination | 22 |
| COMMENTS ON FINANCIAL STATEMENT ITEMS | 23 |
| SUBSEQUENT EVENTS | 23 |
| SUMMARY OF RECOMMENDATIONS | 24 |
| CONCLUSION | 24 |
| SIGNATURES | 25 |

Washington, D.C.
May 8, 2025

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

Dear Commissioner Woods,

In accordance with Section 31-1402 of the District of Columbia Official Code (“D.C. Code”), we have examined the financial condition and activities of

Group Hospitalization and Medical Services, Inc.

hereinafter referred to in this report as the “Company” or “GHMSI.” The examination was conducted remotely. The Company’s statutory home office is located at 840 First Street NE, Washington, D.C., 20065, and the following Report on Examination is submitted.

SCOPE OF EXAMINATION

The Company was last examined by representatives of the District of Columbia, Department of Insurance, Securities and Banking (“DISB” or the “Department”) and covered the period from January 1, 2014, to December 31, 2018. The current full-scope risk-focused examination was conducted by examiners representing the Department and covered the period from January 1, 2019, to December 31, 2023, including any material transactions and/or events occurring after the examination date and noted during this examination.

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

The examination of Washington, D.C. domestic companies of CareFirst was called by the Department in accordance with the Handbook guidelines, through the NAIC's Financial Examination Electronic Tracking System. This examination was conducted as part of a multi-state risk-focused examination (the “Coordinated Examination”) of the CareFirst, Inc. group of insurance entities in which the Department served as the lead state on the examination. The Maryland Insurance Administration (“MIA”) accepted the invitation to participate in this Coordinated Examination for the following Maryland-domiciled insurance companies examined at the same time during the above examination:

| Company Name | NAIC | Acronym |
|---|-------------|----------------|
| CareFirst, Inc. (MD) | 47021 | CFI |
| CareFirst of Maryland, Inc. (MD) | 47058 | CFMI |
| First Care, Inc. (MD) | 60113 | FirstCare |
| The Dental Network, Inc. (MD) | 13130 | TDN |
| CareFirst Advantage, Inc. (MD) | 16724 | CFAI |
| CareFirst Advantage DSNP, Inc. (MD) | 15528 | CFDSNP |
| CareFirst Advantage PPO, Inc. (MD) | 16971 | CFAI PPO |
| CareFirst Community Partners, Inc. (MD) | 15015 | CFCP |

Concurrent with this examination, we have examined the Company's affiliates, CareFirst BlueChoice, Inc. (CFBC), a District domiciled Health Maintenance Organization ("HMO"), and Trusted Health Plans (District of Columbia), Inc., a District domiciled company which offers managed healthcare services for Medicaid and alliance members in Washington, DC. Reports for CFBC and THPDC will be issued under a separate cover. In addition, reports of examination for each of the eight (8) Maryland domiciled entities will be issued under separate covers by MIA.

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

In addition to the above, the examiners have reviewed workpapers prepared by Ernst & Young, LLP. (EY), the Company's independent auditors, in their audit of the Company's accounts and records for the year ending December 31, 2023. The firm expressed unmodified opinions on the Company's financial statements for the years 2022 and 2023. A portion of the auditor's workpapers has been incorporated in the workpapers of the examiners and has been utilized in certain phases of the examination.

The examination team also relied on the work of the internal auditors, including Model Audit Rule ("MAR") work, for the year ending December 31, 2023. A portion of the internal audit work was incorporated in the workpapers of the examiners and has been utilized in certain phases of the examination.

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

Report findings and comments from the prior examination were reviewed, and their status was followed-up on during the current examination.

SUMMARY OF SIGNIFICANT FINDINGS

The Examination did not result in any material adverse findings or adjustments that impact the Company's reported capital and surplus.

COMPANY HISTORY

General

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

The Company's charter has been amended by Congress several times since 1939, including in 1984 to reflect the merger with MSDC and expand its purpose to include arranging for the providing of medical services. Congress amended the charter again on October 5, 1992, and October 1, 1993, which established the legal domicile of GHMSI to be the District and that GHMSI shall be licensed by and subject to the insurance laws and regulations of the District. In 1997, Congress again acted to amend the charter to allow GHMSI to have a non-profit corporate member, CareFirst, Inc., established on January 16, 1998, as a nonprofit health service plan and holding company parent for both GHMSI and CFMI. CFMI is a not-for-profit Maryland corporation. This amendment cleared the way for GHMSI to pursue licensing by the BlueCross BlueShield Association ("BCBSA"). On December 18, 2015, GHMSI's charter was amended to reflect the surplus of the corporation is for the benefit and protection of all of its certificate holders and shall be available for the satisfaction of all obligations of the corporation regardless of the jurisdiction in which such surplus originated or such obligations arise, and also require the corporation not to divide, attribute, distribute, or reduce its surplus pursuant to any statute, regulation, or order of any jurisdiction without the express agreement of the District of Columbia, Maryland, and Virginia.

The Company's bylaws were updated January 20, 2023, to change the composition requirements of the Board of Trustees from no less than nine (9) and up to 14 persons, to no less than five (5) and up to nine (9) persons. The purpose of the amendment was to align procedural governance requirements, better articulate compliance with certain regulatory requirements, and permit the reduction of the size of the Board while continuing to maintain compliance with the applicable provisions of the law in the District.

In 1998, GHMSI and CFMI began doing business as “CareFirst BlueCross BlueShield”, as the BlueCross BlueShield affiliates for the District of Columbia, Maryland, and the area of northern Virginia. On December 31, 2010, virtually all of the for-profit subsidiaries owned either individually or collectively by the Company and/or CFMI were transferred to a newly created intermediary holding company, CareFirst Holdings, LLC (“CFH”). The restructuring was made to consolidate the ownership of the subsidiaries under a single intermediary holding company, and for the Company and CFMI to have essentially equal ownership interest in that intermediate holding company. CFH and its subsidiaries are owned 50.001% by CFMI and 49.999% by GHMSI.

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

Effective January 1, 2023, CareFirst Management Company, LLC (CMC), a subsidiary of CFH, began operations, resulting in the consolidation of the employment of all CFI personnel, the ownership of all CFI equipment, and the contracting for all CFI real estate, leases, and services into CMC. In 2023, GHMSI and CFMI together contributed \$147,300,000 of cash and \$123,400,000 of fixed assets to CFH to capitalize CMC.

During the period under examination, several new entities were formed, and restructurings impacted the company’s holding company system. For additional information, refer to the ‘Holding Company System’ and ‘Subsequent Events’ sections.

Dividends to Stockholder

The Company has no common stock or preferred stock authorized, issued or outstanding. The gross paid in and contributed surplus was \$0 in both 2023 and 2022. GHMSI had no dividends paid or accrued during the period of examination.

MANAGEMENT AND CONTROL

The Certificate of Charter and Bylaws vests the management and control of the Company’s business affairs with the Board of Trustees. The By-Laws call for one class of members. CareFirst, Inc., a not-for-profit health service plan organized under Maryland Law, has been designated as the sole member of GHMSI. The By-Laws also state that the governing body of the Company shall be the Board of Trustees, which shall conduct the business and affairs of the Company. All trustees are nominated by the sole member and are elected by the Board of Trustees of GHMSI. The By-Laws state that the board of trustees shall consist of no less than five (5) and up to nine (9) persons. At least three (3) of the trustees shall be individuals that serve as Class I Directors of the Sole Member.

The following individuals were serving on the Company’s Board of Trustees as of December 31, 2023:

Board of Directors

| <u>Name and Residence</u> | <u>Principal Business Affiliation</u> |
|--|--|
| Jonca C. Bull, Chair District of Columbia | Consultant – Self Employed |
| Sherri L. Bohinc Maryland | Retired |
| Philip Fasano Virginia | Chief Executive Officer, Recuro Health |
| Tracy Harris District of Columbia | Chief Financial Officer Arabella Advisors |
| Jason D León District of Columbia | Managing Director, Diversified Search |
| Julissa Marengo Virginia | Assistant Secretary, Communications and External Affairs, Smithsonian Institution |

DC Code § 31-3518 requires that the board of trustees shall consist of not less than 5 or more than 21 members, who shall be elected by a majority of the members of the board. Furthermore, DC Code § 31- 3518(3) requires that majority of the board of trustees shall at all times consist of members other than employees and officers of the corporation, or of any affiliate or subsidiary of the corporation.

Officers

The By-Laws require the following officers: Chairman of the Board of Trustees, a chief executive officer, president, a secretary, and a treasurer. The Board of Trustees elects these officers of the Company at its annual meeting and may from time to time approve other appointed officer positions appointed by the Chief Executive Officer. Each officer elected at the annual meeting serves until a successor is elected or until removed by the Board of Trustees and each appointed officer may be removed at any time by the Chief Executive Officer, or majority of the Board of Trustees at a meeting. The principal officers elected or appointed and holding office at the Company as of December 31, 2023, were as follows:

| <u>Name</u> | <u>Title</u> |
|---------------------|---|
| Brian D. Pieninck | President & CEO |
| Meryl D. Burgin | EVP, General Counsel and Corporate Secretary |
| Randolph S. Sergent | Assistant Secretary |
| Xuejun J. Smith | EVP, CFO, Corporate Treasurer |
| Kwadwo O. Dodi | VP, Treasury & Investment Management, Assistant Treasurer |
| Angela L. Celestin | EVP, Chief Human Resources Officer |
| Susan G. Idzi | SVP, Commercial Operations |
| Ricardo R. Johnson | EVP, Enterprise Strategy & Healthworx |

| | |
|-----------------------|--|
| Rose V. Megian | EVP, Chief Admin Officer |
| Peter A. Berry | SVP, Chief Actuary |
| Dorothea H. Henderson | SVP, Chief Digital Information Officer |
| Brian R. Wheeler | SVP, Health Services |
| Matthew H. Snyder | SVP, Chief Risk Officer |

Committees

As of December 31, 2023, the Company’s Board of Trustees had established the following committees.

Audit and Compliance

Jason D. León, CPA - Chair
Jonca C. Bull, M.D.
Tracy S. Harris

Finance and Investment

Tracy S. Harris – Chair
Jason D. Leon, CPA
Jonca C. Bull, M.D.

Governance and Nominating

Jonca C. Bull – Chair
Julissa Marengo
Jason D. León, CPA

Executive Committee

Jonca C. Bull, M.D. – Chair
Julissa Marengo

Service and Quality Oversight

Sherri L. Bohinc – Chair
Philip Fasano
Julissa Marengo

Mission Oversight

Sherri L. Bohinc – Chair
Jonca C. Bull, M.D.
Philip Fasano

DC Code § 31-706(c)(3) requires that not less than one-third of the trustees and one-third of each committee shall be persons who are not officers or employees of the Company. DC Code § 31- 706(c)(4) requires that any committee that has the responsibility for the following functions shall be composed entirely of non-employees of the Company or of any entity controlling, controlled by, or under common control with the insurer: 1) Nomination of candidates for director; 2) Evaluation of the performance of the officers, and 3) Recommending the selection and compensation of the Company’s principal officers. The Company complied with all requirements of the Code.

Conflict of Interest

The By-Laws state that the Board of Trustees shall adopt a code of business conduct and compliance that governs the conduct of the Company’s trustees, officers, and associates. In accordance with the By-Laws, the Company has adopted a conflict-of-interest policy. This policy required all trustees, officers, and associates to annually complete a Conflict-of-Interest Disclosure Statement documenting any potential conflicts. It was determined that all Trustees and Officers listed in the Management and Control section of the Report have reviewed and signed their statements as of December 31, 2023.

Corporate Records

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

Pension and Stock Ownership Plans

Prior to December 31, 2002, the Company maintained a qualified noncontributory defined benefit retirement plan covering substantially all full-time employees (the GHMSI Plan). Effective December 31, 2002, the GHMSI Plan merged with a qualified noncontributory defined benefit retirement plan maintained by CFMI (the CFMI Plan) to become the CareFirst, Inc. Retirement Plan (the CFI Plan). Although CFI merged the CFMI and GHMSI plans, it has committed to maintain separate recordkeeping of plan assets and benefit obligations so that it will comply with certain regulatory restrictions that apply to GHMSI and CFMI. Consistent with the standards for multiple-employer plan accounting, the Company and CFMI have accounted for their net pension obligations as if the plans remained separate. Employees hired on or after January 1, 2009, no longer participate in the CFI Plan. These employees participate in an enhanced 401(k) program. Effective January 1, 2023, the CFI Plan is considered frozen, and no additional benefits related to service or compensation will be accrued.

Based on the accumulated benefit obligation, this qualified noncontributory defined benefit retirement plan was 104.4% and 102.9% funded as of December 31, 2023, and 2022, respectively.

The annual contributions exceeded the minimum funding standards set forth in the Employee Retirement Income Security Act of 1974, as amended. The CFI Plan provides for eligible employees to receive benefits based principally on years of service with the Company and a percentage of compensation prior to normal retirement.

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

The Company provides health care benefits for retired employees. The Company's postretirement benefit program provides for a specific credit amount, which may be used to purchase health insurance upon retirement. The credit amount is based upon the retiree's age and years of service with the Company. The Company contributes to the postretirement plan as benefits are paid. Effective January 1, 2023, CMC, a subsidiary of CFH, began operations, resulting in the consolidation of the employment of all Company personnel into CMC. As a result, the Company's other postretirement benefit obligation was transferred to CMC.

As of December 31, 2023, and 2022, the unfunded nonqualified pension plans had accumulated benefit obligations and projected benefit obligations in excess of plan assets. These plans had a combined accumulated benefit obligation of \$1,862,000 and \$1,804,000 and a combined projected benefit obligation of \$1,862,000 and \$1,804,000.

As of December 31, 2023 and 2022, the expected return on plan assets is 6% and 5%, respectively for qualified pension benefits, and is not applicable for nonqualified pension benefits.

As of December 31, 2023, the rate of compensation increase is not applicable. Effective January 1, 2023, the plan was amended to cease all future benefit accruals related to service or compensation earned on or after January 1, 2023, completely freezing the plan as of such date. As of December 31, 2022, the rate of compensation was graded depending on the age of eligible employees.

The accumulated benefit obligation for the defined benefit pension plan was \$296,990,000 and \$297,501,000 as of December 31, 2023, and 2022, respectively.

The Company sponsors a 401(k) plan for the benefit of all eligible employees. For the years ended December 31, 2023, and 2022, on behalf of the Company, CMC contributed \$9,902,000 and \$2,948,000, respectively, to this plan based on a percentage of employee contributions. This amount is included in the total charges for services provided by CMC.

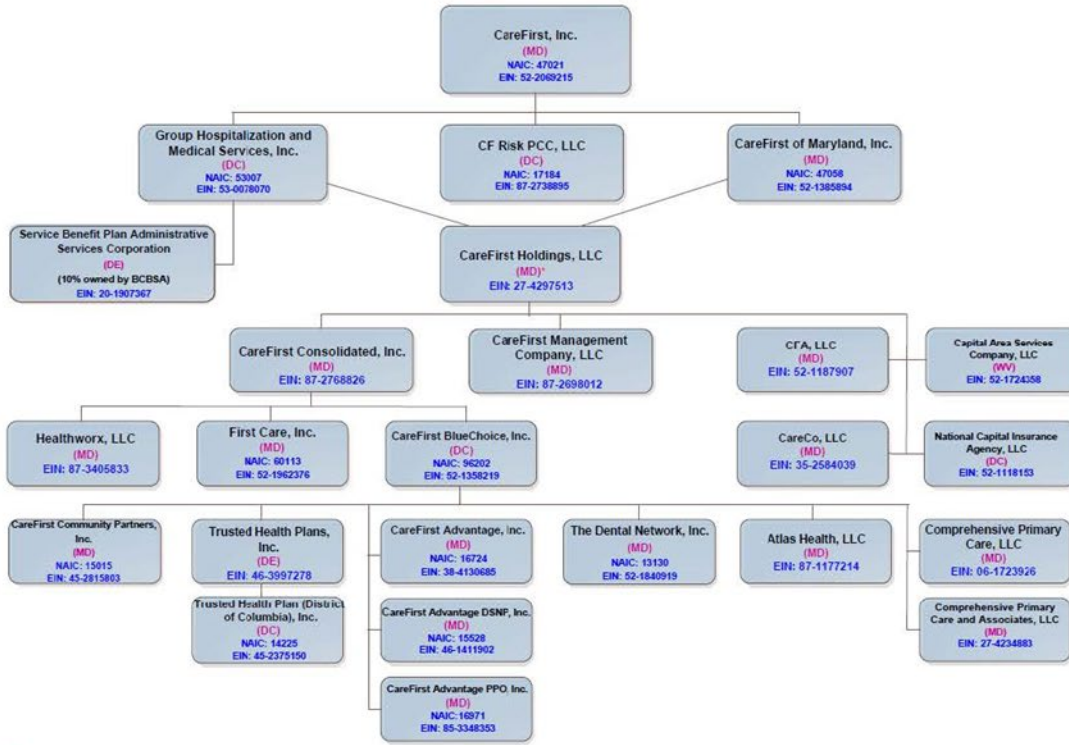
HOLDING COMPANY SYSTEM

The Company is a member of an insurance holding company system pursuant to the provisions of the District of Columbia Code Section 31-701. GHMSI, CFMI, and CF Risk PCC, LLC are affiliates of a not-for-profit parent company, CareFirst, Inc. GHMSI and CFMI hold joint interests in a holding company, CareFirst Holdings (CFH). CFH and its subsidiaries are owned 50.001% by CFMI and 49.999% by GHMSI. CFMI and GHMSI do business as CareFirst BlueCross BlueShield.

The organizational chart below depicts the direct and indirect ownership of companies within the CareFirst holding company system as of December 31, 2023.

Organizational Chart

**SCHEDULE Y – INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP
 PART 1 – ORGANIZATIONAL CHART**



* CareFirst Holdings, LLC is owned 50.001% by CareFirst of Maryland, Inc. and 49.999% by Group Hospitalization and Medical Services, Inc.

AGREEMENTS AND TRANSACTIONS WITH AFFILIATES

The Company has entered into numerous agreements and cost-sharing arrangements with affiliated companies. We performed a review, and the significant agreements are described below:

Cross-Jurisdictional Parity Agreement

Effective January 1, 2008, a cross-jurisdictional parity agreement between CareFirst of Maryland, Inc., and Group Hospitalization & Medical Services, Inc. was executed. Historically, the two companies have sold products in each other’s BCBSA market regions and thus incurred underwriting results for these cross-jurisdictional products. The purpose of this agreement is to properly redistribute those underwriting gains/losses in each other’s jurisdiction from the entity that earned them to the entity whose service area the subscriber/group resided. Under the terms of the agreement, each company tracks the premium revenues, administrative expenses, and care costs related to the other company’s geographic region. On a quarterly basis, the amounts from this cross-jurisdictional business are transferred via a quota share reinsurance contract. There is a typical indemnity and hold harmless clause between the parties for any actions alleging injuries out of or related to the acts or omissions with

performance under this agreement.

Fourth Amended and Restated Intercompany Agreement

On January 1, 2011, CFI, CFMI, GHMSI and CFH (“Parties”) entered into a fourth amended and restated intercompany agreement to amend, restate and supersede the Third Restated Intercompany Agreement, dated January 1, 2009. Under the terms of the agreement, the Parties determined to carry on their respective business operations through an affiliation as contemplated in the Business Combination Agreement dated March 27, 1997, between CFMI and GHMSI, where combined business operations, directly or through Subsidiaries of the Parties, will offer insurance products, managed health care products and services and administrative health plan management services. The Parties desire to centralize certain functions, increase operational flexibility, provide employment opportunities to the employees of each of the Parties and facilitate intercompany transfers of assets and services with maximum administrative ease while maintaining adequate controls over the nature and size of such transfers. As a result of restructuring initiatives, the Parties entered into the amended Agreement to continue to fulfill purposes as implemented in previous intercompany agreements, including the Third Intercompany Agreement.

Amended and Restated Shared Services Agreement

Effective January 1, 2020, GHMSI and CFMI (collectively referred to as “SBP Shared Services Vendor”) entered into an amended and restated shared services agreement for services to be provide to Service Benefit Plan Administrative Services Corporation (“SBP”). Blue Cross and Blue Shield Association (“BCBSA”) and SBP entered into a Service Benefit Plan Administrative Services Contract (“Contract”) effective January 1, 2020, under which SBP will provide for the BCBSA certain administrative services including a Service Benefit Plan Operations Center and a Service Benefit Plan Data Center as well as such functions and services necessary to support and maintain the Operations Center and Data Center. SBP determined that to fulfill its obligations under the Contract it will enter an agreement with the SBP Shared Services Vendor to provide SBP, directly (or indirectly through Affiliates or agents of SBP Shared Services Vendor), those functions and services listed and described in Exhibit A and B, in accordance with terms of the agreement. SBP Shared Services Vendor desires to provide to SBP, directly (or indirectly through approved Affiliates or agents of Shared Services Vendor), those functions and services listed and described in Exhibit A and Exhibit B as attached in the agreement. SBP will reimburse SBP Shared Services Vendor for its reasonable, allowable, and allocable costs in accordance with the actual corporate cost allocation in effect at the time Services are rendered.

Administrative Services Agreement

Effective January 1, 2013, CFI, CFMI, GHMSI, and all of their respective subsidiaries entered into an administrative services agreement. The agreement calls for CFMI, GHMSI, and CareFirst Management Company, LLC (CMC) to provide administrative and operational support services to CareFirst Companies. In consideration of the services provided, CFMI, GHMSI, and CMC are paid a fee based upon direct and indirect costs plus a mark-up based on market rates. Settlement amounts are due on a monthly basis. The total charges to GHMSI for services provided by CMC were \$408,835,000 for the

year ended December 31, 2023. These allocations are included in general and administrative expenses. For additional information, refer to the “Subsequent Events” section of this Report.

Network Access Agreements

Effective April 1, 2008, GHMSI, CFBC, and TDN entered into a network access agreement. Under the terms of the agreement, TDN provides GHMSI and CFBC access to its network of Dentists and Dental Care Providers in Maryland and its benefits administration services. In exchange, GHMSI and CFBC pays TDN a set amount per member per month to be paid monthly.

CFI Fee Sharing Agreement

Effective January 29, 2014, all entities in the CareFirst group entered into a Fee Sharing Agreement with CFI pursuant to the Affordable Care Act, which required covered entities to pay the annual Health Insurer Fee (“HIF”). According to the Fee Sharing Agreement, each entity shall pay CFI the entity’s individual HIF liability based upon each entity’s proportional share of net premiums as reported.

Tax Sharing Agreement

The Company is a party to a federal tax sharing agreement that exists among CFI and its affiliates. The tax sharing agreement calls for the allocation of the current income federal income tax liability to the Company on the basis of the percentage of the consolidated federal income tax liability attributable to the Company, computed on a separate company basis, of the total consolidated federal income tax liability. The agreement also provides that to the extent the Company’s subsidiaries’ tax attributes (e.g., net operating losses) reduce the consolidated federal income tax liability, CFI shall pay the Company for use of such attributes in the year utilized.

Pursuant to this agreement, the Company has the enforceable right to recoup federal taxes paid in prior years in the event of future net losses, which it may incur, or to recoup its net losses carried forward as an offset to future net income, subject to federal income taxes.

Quota Share Reinsurance Agreement Among CFBC, CFMI, and GHMSI

Effective April 1, 2014, CFMI, GHMSI, and CFBC, collectively referred to as the Party, entered into a quota share reinsurance agreement. Under the terms of the agreement, for any Dual Option Products in which CFMI and CFBC or GHMSI and CFBC provide adjusted or blended rates, each Party agrees to transfer premiums among entities to achieve an equivalent medical loss ratio for the dual option policies on CFBC, CFMI, and GHMSI. The companies do not apply reinsurance accounting for this agreement as there is no transfer of risk. The agreement is accounted for as an intercompany agreement. Intercompany cash settlements between CFMI/GHMSI and CFBC, based upon the distribution of the underwriting gains or losses shall occur no less frequently than each quarter. Total premiums allocated from CFBC to GHMSI for these products were \$64,196,000 for the year ended December 31, 2023.

Point-of-service Agreement between GHMSI, CFMI, and CFBC

Effective January 1, 2018, GHMSI and CFMI entered into an agreement with CFBC. GHMSI and CFMI bear all of the out-of-network (indemnity) underwriting risk, and CFBC bears the in-network (HMO) underwriting risk for certain fully insured point-of-service (POS) health care products. CFBC pays a per-member-per-month fee to GHMSI and CFMI for providing the out-of-network (indemnity) benefits for CFBC's POS products. The fee is based on actual membership and paid in exchange for CFBC's POS products, gaining access to GHMSI's regional provider network, and claims processing for the out-of-network services. All premiums, cost of care, and operating expenses of CFBC's POS products are recorded directly by CFBC. The total fee paid from CFBC to GHMSI was \$2,885,000 for the year ended December 31, 2023.

Broker arrangements

The Company maintains a relationship with brokers for CFBC and its subsidiaries. Under these arrangements, GHMSI pays broker commissions and incentives and allocates a portion of these amounts to CFBC and its subsidiaries based upon relevant statistics. Total broker fees allocated to CFBC and its subsidiaries as of December 31, 2023, were \$103,246,000.

Surplus Note

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

Loan Agreement

On October 1, 2023, CFMI and GHMSI entered into five-year term loan agreements with CFBC to increase the liquidity of CFBC and to facilitate a transfer of additional funds from CFBC to its subsidiaries. In accordance with the loan agreements, CFMI and GHMSI can provide up to \$300,000,000 loan to CFBC in proportion to their respective ownership interest in CFH. The loan amount is subject to interest, which accrues quarterly and is paid semi-annually at the mid-term applicable federal rate set by the Internal Revenue Service. As of December 31, 2023, CFMI and GHMSI each provided loans of \$2,500,000 to CFBC. For additional information, refer to the "Subsequent Events" section of this Report.

FIDELITY BOND AND OTHER INSURANCE

As of December 31, 2023, the Company & direct and indirect wholly owned subsidiaries and affiliates were included and named insureds in a fidelity bond issued to the parent, CareFirst Inc. The Company is protected under a Fidelity Bond with a single loss limit and an aggregate loss limit of \$25,000,000 and a deductible of \$250,000. The coverage exceeded the minimum amount of fidelity bond coverage

recommended by the NAIC for these companies on a consolidated basis.

In addition, the Company had other insurable risks. In this regard, the Company had insurance policies which provided coverage for other operational risks incurred by the Company and its affiliates (e.g, general liability, workers' compensation, and business property). The Company maintains adequate fidelity coverage in line with DC Code § 31-3405.

STATUTORY DEPOSIT

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

TERRITORY AND PLAN OF OPERATION

The Company conducts business in the District of Columbia as a hospital and medical services corporation licensed and regulated by DISB, pursuant to the Medical Insurance Empowerment Amendment Act of 2008 (DC Code 31-3501 et seq.), which amended the Hospital and Medical Services Corporation Regulatory Act of 1996, effective April 9, 1997. The Company writes comprehensive medical, vision, Medicare Supplement, Federal Employees Health Benefit Program (FEHBP), and provides administrative services to certain customers under self-insured agreements. Other products and services include preferred provider and point of service networks, third-party administrator services, and other managed care services. These products and services are provided to individuals, businesses, and government agencies primarily in the Washington, D.C., Metropolitan area, Virginia, and Maryland. The Company is a licensee of the BlueCross BlueShield Association and markets its products under the BlueCross BlueShield trade name.

The Company contracts with various health care providers, including hospitals, nursing homes, home health care facilities, alcohol and drug treatment facilities, pharmacies, physicians, and dentists, as participating providers to render services to subscribers of health care plans administered by the Company.

The significant lines of business and total revenues for the Company are presented below based on the 2023 statutory financial data filed by the Company with the Department:

| Line of Business | Total Revenues | Percentage of Total |
|--------------------------------------|-----------------------|----------------------------|
| Comprehensive (hospital and medical) | \$ 1,071,509,790 | 26.33% |
| Medicare Supplement | 27,394,444 | 0.67% |
| Dental Only | 116,267,997 | 2.86% |
| Vision Only | 19,778,666 | 0.49% |
| FEHBP | 2,807,410,701 | 68.99% |

| | | |
|------------------|-------------------------|-------------|
| Long-Term Care | 74,860 | 0.00% |
| Other Health | 2,925,232 | 0.07% |
| Health Subtotal | 4,045,361,690 | 99.40% |
| Other Non-Health | 24,229,303 | 0.60% |
| Totals | <u>\$ 4,069,590,993</u> | <u>100%</u> |

REINSURANCE

Reinsurance Agreement

Effective February 1, 2019, First Care, Inc., CFMI, and GHMSI entered into a reinsurance agreement. Under the terms of the agreement, CFMI and GHMSI desire to reinsure the risk associated with their stop loss insurance products to First Care. CFMI and GHMSI shall pay to First Care all premiums received for writing stop loss insurance coverage, less any reasonable costs related to the administration of the stop loss policies. First Care shall reinsure any and all claims incurred by CFMI and/or GHMSI for the provision of stop loss insurance coverage to eligible employer groups. CFMI and GHMSI shall submit claims on a monthly basis, and intercompany cash settlements shall be due, and payable, within thirty (30) days of the end of each month in which the debt was incurred, or in which the obligation of indebtedness arose.

Stop Loss Reinsurance Agreement Among CFBC, CFMI, GHMSI

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

ACCOUNTS AND RECORDS

The Company's statutory home office is located at 840 First Street NE, Washington, D.C., 20065. This also serves as the primary location of the Company's books and records. This satisfies the requirements of Section 31-3431 of the District of Columbia Official Code, which requires that a domestic health maintenance organization maintain its principal office within the District and shall keep its books, records, or files without the permission of the Department.

The Company's accounting procedures, practices, account records, and supporting data were reviewed and tested to the extent deemed necessary. A review of the Company's Information Technology General Controls and General Application Controls was also performed as required by the Handbook. The review did not disclose any significant deficiencies in these records.

FINANCIAL STATEMENTS

The following financial statements are based on the statutory financial statements filed by the Company with the Department and present the financial condition and results of operations as reported by the Company for the period ending December 31, 2023. The examination does not attest to the fair presentation of the financial statements included herein. If, during the course of the examination, an adjustment was identified, the impact of such adjustment would be documented separately following the Company's financial statements.

Admitted Assets, Liabilities, Capital and Surplus
Statement of Revenue and Expenses
Statement of Changes in Capital and Surplus
Notes to the Financial Statements
Analysis of Changes in Surplus Resulting from the Examination
Comments on Financial Statement Items

Financial statements are the responsibility of the Company's management. The accompanying "Comments on Financial Statement Items" (if any) should be considered an integral part of the financial statements.

Statement of Assets, Liabilities, Capital and Surplus

December 31, 2023

| | |
|---|-------------------------|
| Bonds | \$ 1,105,565,165 |
| Preferred stocks | 1,500,000 |
| Common stocks | 73,580,253 |
| Cash, cash equivalents and short-term investments | 207,083,989 |
| Other invested assets | 787,056,840 |
| Subtotals, cash and invested assets | 2,174,786,247 |
| Investment income due and accrued | 11,837,603 |
| Uncollected premiums and agents' balances | 342,291,727 |
| Accrued retrospective premiums and contracts | 99,283,439 |
| Amounts recoverable from reinsurers | 56,058,319 |
| Other amounts receivable under reinsurance contracts | 3,264,897 |
| Amounts receivable relating to uninsured plans | 46,558,457 |
| Current federal and foreign income tax recoverable and interest thereon | 5,691,688 |
| Guaranty funds receivable or on deposit | 4,759,655 |
| Receivables from parent, subsidiaries and affiliates | 11,111,791 |
| Health care and other amounts receivable | 842,047,008 |
| Aggregate write-ins for other than invested assets | 709,208 |
| Total assets | \$ 3,598,400,039 |

Liabilities, Capital and Surplus

| | | |
|--|-----------|------------------------------------|
| Claims unpaid (Note 1) | \$ | 401,732,257 |
| Accrued medical incentive pool and bonus amounts | | 5,297,501 |
| Unpaid claims adjustment expenses (Note 1) | | 11,358,747 |
| Aggregate health policy reserves (Note 2) | | 638,946,329 |
| Aggregate health claim reserves | | 465,584 |
| Premiums received in advance | | 23,154,151 |
| General expenses due or accrued | | 57,463,249 |
| Net deferred tax liability | | 19,747,931 |
| Ceded reinsurance premiums payable | | 2,561,677 |
| Amounts withheld or retained for the account of others | | 26,293,503 |
| Remittances and items not allocated | | 748,949 |
| Borrowed money | | 196,582,777 |
| Amounts due to parent, subsidiaries and affiliates | | 204,310,502 |
| Payable for securities | | 409,484 |
| Liability for amounts held under uninsured plans | | 46,256,288 |
| Aggregate write-ins for other liabilities | | 200,693,817 |
| Total liabilities | | 1,836,022,746 |
| Unassigned funds (surplus) | | 1,762,377,293 |
| Total capital and surplus | | 1,762,377,293 |
| Total liabilities, capital and surplus | \$ | <u><u>3,598,400,039</u></u> |

Statement of Revenue and Expenses
For the Year Ended December 31, 2023

| | |
|--|------------------------------|
| Net premium income | \$ 4,014,723,744 |
| Change in unearned premium reserves and reserve for rate credits | 1,884,776 |
| Aggregate write-ins for other health care related revenues | 28,753,170 |
| Aggregate write-ins for other non-health revenues | 24,229,303 |
| Total revenues | <u>4,069,590,993</u> |
| Hospital/medical benefits | 2,203,742,493 |
| Other professional services | 370,350,390 |
| Outside referrals | 43,109,470 |
| Emergency room and out-of-area | 114,340,290 |
| Prescription drugs | 955,867,998 |
| Incentive pool, withhold adjustments and bonus amounts | 7,086,335 |
| Subtotal hospital and medical expenses | <u>3,694,496,976</u> |
| Net reinsurance recoveries | 94,190,771 |
| Total hospital and medical | <u>3,600,306,205</u> |
| Claims adjustment expenses | 126,409,723 |
| General administrative expenses | 329,347,091 |
| Increase in reserves for life and accident and health contracts | (2,150,000) |
| Total underwriting deductions | <u>4,053,913,019</u> |
| Net underwriting gain or (loss) | <u>15,677,974</u> |
| Net investment income earned | 66,723,187 |
| Net realized capital gains (losses) less capital gains tax | (2,510,641) |
| Net investment gains | <u>64,212,546</u> |
| Aggregate write-ins for other income or expenses | 1,712,402 |
| Net income or (loss) after capital gains tax and before all other federal income taxes | 81,602,922 |
| Federal and foreign income taxes incurred | (22,038,689) |
| Net income (loss) | <u><u>\$ 103,641,611</u></u> |

Statement of Changes in Capital and Surplus

| | 2023 | 2022 | 2021 | 2020 | 2019 |
|--|-----------------|-----------------|-----------------|-----------------|-----------------|
| Capital and surplus, December 31, prior year | \$1,590,904,465 | \$1,639,097,545 | \$1,645,376,798 | \$1,440,051,604 | \$1,200,102,655 |
| Net income or (loss) | 103,641,611 | 88,606,928 | 81,342,303 | 162,259,069 | 98,769,488 |
| Change in net unrealized capital gains (losses) | 53,936,639 | (146,001,935) | (84,029,822) | 44,587,528 | 141,926,447 |
| Change in net deferred income tax | 10,242,437 | (1,492,866) | 1,862,067 | (27,482,588) | (66,297,348) |
| Change in nonadmitted assets | 12,716,423 | 31,853,695 | 38,021,449 | 19,709,743 | 54,678,717 |
| Dividends to stockholder | - | - | (20,000,000) | - | - |
| Aggregate write-ins for gains or (losses) in surplus | (9,064,282) | (21,158,902) | (23,475,250) | 6,251,442 | 10,871,645 |
| Capital and surplus, December 31, current year | \$1,762,377,293 | \$1,590,904,465 | \$1,639,097,545 | \$1,645,376,798 | \$1,440,051,604 |
| Exam adjustments | - | - | - | - | - |
| Capital and surplus, December 31, current year | \$1,762,377,293 | \$1,590,904,465 | \$1,639,097,545 | \$1,645,376,798 | \$1,440,051,604 |

Notes to Financial Statements

1. Claims Incurred and Unpaid Claims and Claim Adjustment Expenses

The Company pays fees based upon negotiated contractual fee schedules to medical providers that provide physician and hospital services. The Company also negotiates contractual agreements with certain physicians and medical management groups to provide health care and ancillary services to its members. In addition, the Company has a contractual agreement with a pharmacy benefit management company to provide pharmacy benefits to its members. Cost of care is recognized in the period in which members receive medical services. In addition to actual benefits paid, the cost of care includes the impact of accruals for estimates of reported and unreported claims, which are unpaid as of the balance sheet dates. The liability for medical claims payable is computed in accordance with generally accepted actuarial practices and is based upon past claims payment experience, together with other current factors, which, in management's judgment, require recognition in the calculation. The Company develops its estimates for care services incurred but not reported using an actuarial process that is consistently applied. The actuarial model considers factors such as time from the dates of service to claims receipt, claims backlogs, seasonal variances in medical care consumption, provider rate changes, medical care utilization, medical cost trends, membership volume, and demographics. Depending on the health care provider and type of service, the typical billing lag for services can vary significantly. Substantially all claims are known and settled within 12 months from the date of service.

The Company regularly reexamines its previously established unpaid claims estimates based on actual claim submissions and other changes in facts and circumstances. Due to the uncertainties inherent in the claims estimation process, it is at least reasonably possible that the actual claims paid could differ materially from the amounts accrued on the accompanying balance sheets.

2. Federal Employee Program

The Company participates in the Federal Employee Health Benefit Plan (FEHBP) with other BlueCross BlueShield plans. This program includes an experience-rated contract between the Office of Personnel Management (OPM) and BCBSA, which acts as an agent for the participating BlueCross BlueShield plans. In addition, each participating plan, including the Company, executes a contract with BCBSA that obligates each participating plan to underwrite FEP benefits in its service area. The BCBSA contract renews automatically each year, unless written notice of termination is given by either party. As of December 31, 2023, no written notice of termination has been given by either party. Premium rates are developed by BCBSA and approved by OPM annually. These rates determine the funds that will be available to the participating BlueCross BlueShield plans to provide insurance to federal employees that enroll with the BlueCross BlueShield FEHBP.

The excess of gross premiums for the life of the program over the charges for the life of the program is considered the special reserve under the contract between OPM and BCBSA. Each year, OPM also allocates additional funds to a contingency reserve that may be utilized by the participating plans in the event that funds set aside from annual premiums are insufficient or fall below certain prescribed levels

by OPM. Funds available to each participating BlueCross Blue Shield plan, including the special reserve and the contingency reserve, are held at the U.S. Treasury, including amounts unused from prior periods. Any funds that remain unused upon termination of the BCBSA contract, after the claims run out and reimbursement of allowable administrative expenses, would be returned to OPM for the benefit of the FEHBP. BCBSA has reported the amounts being held in the special reserve as \$6,571,115,000 and \$5,982,672,000 as of September 30, 2023, and December 31, 2022, respectively. BCBSA has also reported the amounts being held in the contingency reserve as \$7,870,240,000 and \$10,160,838,000 as of September 30, 2023, and December 31, 2022, respectively. Amounts incurred in excess of the total reserves held at the U.S. Treasury for the FEHBP would not be reimbursed to the Company.

Based upon formulas developed by BCBSA, the Company has recorded its allocable share of the special reserve being held by OPM as an asset, with an equivalent amount recorded as a rate stabilization reserve. The amounts are included in health care and other amounts receivable and aggregate health policy reserves, respectively. These amounts are \$632,685,000 and \$634,131,000 as of December 31, 2023, and 2022, respectively.

FEP revenue earned was \$2,807,411,000 and \$2,532,475,000 for the years ended December 31, 2023, and 2022, respectively.

3. Commitments and Contingencies

CFMI and the Company entered into an intercompany agreement that requires CFMI or the Company, or their respective affiliates, to provide the financial resources necessary to satisfy the respective statutory or regulatory reserve requirement, subject to specific limitations, if either CFMI or the Company or their respective affiliates fail to meet or maintain their respective statutory or regulatory reserve requirement as required by law, or if such transfer of financial resources is needed to satisfy any other legally enforceable obligation.

The Company, along with the BCBSA and all of the other BCBSA licensees, has been named as a defendant in multiple suits that make up the Blue Cross Blue Shield Antitrust Litigation. This matter is part of a multi-district litigation combining several antitrust cases, brought by two putative nationwide classes of plaintiffs, health plan subscribers, and providers, which challenge the exclusive service areas outlined in the BCBSA license agreements. The Company has been cooperating in the joint defense with the BCBSA. During 2022, the remaining balances of the insurance recoverable and the settlement liability related to the subscriber cases were settled. Various subscribers have exercised their right to opt out of the class and file separate lawsuits. Those claims continue to be assessed, but liability on them is not probable or estimable at this time.

On May 25, 2023, the Blue Plans and plaintiff representatives, representing providers and seeking provider classes, reached an agreement on certain settlement terms and parameters, subject to final negotiation and approval. The parties have not agreed on terms for a final agreement. Any proposed settlement for the provider class is subject to court approval. The Company concluded that it was probable that a loss was incurred and the amount of loss was reasonably estimable. The receipt of the

insurance proceeds was also considered probable. As a result, the Company recorded an insurance recoverable of \$5,289,000 and a settlement liability of \$34,296,000. The insurance recoverable is recorded as a non-admitted other amounts receivable, and the settlement liability is recorded as aggregate write-ins for other liabilities.

In the jurisdictions in which the Company is licensed to conduct business, guaranty associations have been created for the purpose, among others, of protecting insured parties under health insurance policies when a health insurer becomes impaired or insolvent or fails. The Company is contingently liable for assessments in any calendar year in order to provide any required funds to carry out the power and duties of the associations. These associations levy assessments, up to prescribed limits, on all member insurers in a particular state on the basis of the proportionate share of the premiums written by member insurers in the line of business in which the impaired, insolvent, or failed insurer is engaged. Some states permit member insurers to recover assessments through full or partial premium tax offsets.

On March 1, 2017, the Commonwealth Court of Pennsylvania ordered long-term care insurer Penn Treaty Network America Insurance Company and one of its subsidiaries to be liquidated. The insolvency resulted in a retrospective premium-based guaranty fund assessment against the Company from 2017 to 2021. A portion of the assessment was recognized as premium tax credit and applied to reduce the 2022 and 2023 premium tax liability. As of December 31, 2023, the balance of the discounted premium tax credit receivable is \$4,760,000 and is expected to be realized incrementally through 2031.

A reconciliation of the recognized premium tax credit receivable is as follows:

| | |
|---|-------------|
| Assets recognized from paid and accrued premium tax offsets and policy surcharges as of January 1, 2023, | \$5,913,000 |
| Decreases: | |
| Premium tax offset applied | (1,153,000) |
| Assets recognized from paid and accrued premium tax offsets and policy surcharges as of December 31, 2023 | \$4,760,000 |

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

Analysis of Changes in Surplus Resulting from the Examination

The following is a reconciliation of capital and surplus between what was reported by the Company and as determined by the examination. There were no changes to the Company's surplus as a result of

this Examination.

| | | | |
|--|-----------------|-----------------|------------------------|
| Capital and surplus, December 31, 2023 – per Annual Statement | | | \$1,762,377,293 |
| | | | Increase (Decrease) |
| | Per | Per | In Capital and |
| | Company | Examination | Surplus |
| Total assets | \$3,598,400,039 | \$3,598,400,039 | \$ - |
| Total liabilities | 1,836,022,746 | 1,836,022,746 | \$ - |
| Capital and surplus, December 31, 2023 – per examination | | | \$1,762,377,293 |

COMMENTS ON FINANCIAL STATEMENT ITEMS

As a result of the examination, no adverse findings affecting the financial statements, or material changes to the financial statements were identified.

SUBSEQUENT EVENTS

A restructuring of CareFirst entities took effect on January 1, 2025 in order to achieve greater operational efficiency. The following changes were included in the restructuring:

1. Dissolution of Capital Area Service Company, Inc. (“CASCI”): CASCI has no operations and is not anticipated to operate in the future.
2. Merger of CFAI and CFDSNP: CFAI has not renewed its contract with CMS for 2025 and will no longer sell individual HMO product. CFDSNP will administer the run-out period under CFAI’s 2024 contracts with CMS.
3. Movement of CFBC Subsidiaries: CFBC moved the ownership of its Medicare Advantage and Medicaid subsidiaries under CFMI instead of CFBC. The Medicare and Medicaid Companies will no longer be included in CFBC’s RBC calculations. There will be no member impact from the movement of these companies within the holding system.
4. Movement of National Capital Insurance Agency (“NCIA”): CareFirst transferred 100% of the membership units of NCIA from CFH to CMC.

Effective January 1, 2025, CFI CFMI, GHMSI, CFH, and CMC entered into a new holding company system intercompany agreement, which superseded and replaced the previously mentioned ‘Administrative Services Agreement’. The new agreement, per the Company, permits any CareFirst company to provide administrative services to other companies and charge direct and indirect costs as well as a market-based service fee.

On September 3, 2024, CMC entered into a five-year loan agreement with CFMI, GHMSI, and CFBC to increase the liquidity of CFMI, GHMSI, and CFBC. Under the terms of the agreement, CMC can

provide up to \$300,000,000 in total funds, and each of CFMI, GHMIS, and CFBC, in its sole discretion, may borrow in \$5,000,000 increments up to the total loan amount. As of December 31, 2024, CMC provided loans in amounts of \$45,000,000, \$0, and \$0 to CFMI, GHMSI, and CFBC, respectively. This new loan agreement replaced the previously mentioned loan agreement between CFMI and GHMSI with CFBC, which was paid off by CFBC on August 30, 2024, and terminated.

SUMMARY OF RECOMMENDATIONS

As a result of the financial examination, no material report findings or recommendations were made.

CONCLUSION

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

Acknowledgment is made of the cooperation and assistance extended by the Company's officers and employees during the course of the examination.

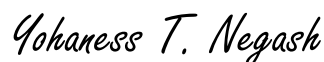
SIGNATURES

In addition to the undersigned, Financial, IT, and Actuarial Examiners with the firm Baker Tilly US, LLP, representing the Department, also participated in the examination.

Respectfully submitted,



Jessie L. Adamson, CFE, CISA
Examiner-In-Charge
Baker Tilly, Inc.
Representing District of Columbia, Department of Insurance,
Securities and Banking



Yohaness Negash, CFE, CFE (Fraud), PIR, CIA, CISA
Examination Manager
District of Columbia, Department of
Insurance, Securities and Banking