Report on:

Surplus Evaluation Consulting Services

For the Maryland Insurance Administration

Project #D80R92000007

October 30, 2009

INVOTEX GROUP

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ABBREVIATIONS AND ACRONYMS

ACL	**Authorized Control Level**
AMT	**Alternative Minimum Tax**
ASC	**Administrative Services Contracts**
BCBSA	**BlueCross BlueShield Association**
CareFirst	**Refers to the CareFirst group of companies, including CFI, its affiliates, and their respective subsidiaries and equity investee companies**
CFBC	**CareFirst BlueChoice, Inc.**
CFI	**CareFirst, Inc.**
CFMI	**CareFirst of Maryland, Inc.**
DISB	**District of Columbia Department of Insurance, Securities, and Banking**
ERM	**Enterprise Risk Management**
FEP	**Federal Employee Program**
GHMSI	**Group Hospitalization and Medical Services, Inc.**
HMO	**Health maintenance organization**
HRBC or HORBC	**Health Organization Risk-Based Capital**
MIA	**Maryland Insurance Administration**
MIEAA	**Medical Insurance Empowerment Amendment Act of 2008**
NAIC	**National Association of Insurance Commissioners**
PPFSC	**Plan Performance and Financial Standards Committee**
RBC	**Risk Based Capital**
SBP	**Service Benefit Plan Administrative Services Corporation**
TAC	**Total Adjusted Capital**
UCL	**Unpaid Claims Liability**

TAB 1

1. SUMMARY OF FINDINGS AND RECOMMENDATIONS

Findings:

1. CareFirst has a unique affiliation company structure and related Intercompany Agreement; while apparently adequate to meet the group's administrative and operational needs, the company's complex structure – as approved by regulators years before to enable a multi-plan affiliation arrangement – creates an inefficient means to manage risk and surplus resulting in the necessity that both CFMI and GHMSI carry relatively more surplus than would otherwise be the case. It also means that the determination of an appropriate amount of surplus for the companies should be performed separately for each entity rather than on a consolidated basis.

2. As of year-end 2008, 62% and 24% of CFMI's and GHMSI's surplus, respectively, was attributable to their equity investments in CFBC. This CFBC-attributable portion of the surplus is not readily accessible because there are substantial practical limitations on the ability of either company to receive dividends from CFBC or to otherwise monetize their investment in order to convert it to cash for payment of claims.

3. At year-end 2008, CFMI and GHMSI held amounts of surplus that are comparable on a relative basis to their nonprofit Blue Cross Blue Shield plan peers. GHMSI's surplus on a relative basis is near the higher end of the peer group, whereas CFMI's is near the lower end.

4. Milliman's 2008 analysis on behalf of CareFirst determined a targeted surplus range for CFMI of 900-1200% ACL RBC, and for GHMSI of 750-1050% ACL RBC.

5. Invotex determined that Milliman's approach was reasonable; we did, however, have some differences of judgment as to certain assumptions, which resulted in an appropriate amount of surplus range as determined by Invotex of 825-1075% ACL RBC for CFMI, and 700-950% ACL RBC for GHMSI. Our range for both companies therefore is somewhat lower and tighter than that recommended by Milliman.

6. As of year-end 2008, CFMI's and GHMSI's actual reported surplus equated to 503% and 845% ACL RBC, respectively. Therefore, as of year-end 2008, CFMI

is below and GHMSI is within their respective targeted surplus ranges as determined by Invotex.

7. The appropriate amount of surplus range provides the underpinnings for a framework that can be used by the MIA going forward to evaluate if CFMI's and/or GHMSI's surplus is excessive on the one hand, or if below the targeted range on the other; the framework can prompt proactive steps on the part of the company and the MIA with regard to premium rate changes so as to enable these nonprofit health service plans to better maintain appropriate surplus levels.

8. Based on CareFirst's forecasts of results through year-end 2009, both CFMI's and GHMSI's RBC surplus ratios are not expected to change materially from year-end 2008 levels of 503% and 845%, respectively.

9. Inasmuch as both CFMI and GHMSI are below or within their respective appropriate amount of surplus range, there is no indication of excessive surplus on the part of either company.

10. The minimum surplus test of 8% of prior year premiums that is provided in § 14-117 of the Maryland Insurance Article serves its intended function as a regulatory minimum standard. However, as of year-end 2008 the resulting minimum amount equates to only 147% and 277% ACL RBC for CFMI and GHMSI, respectively, which is significantly below the lower end of the appropriate amount of surplus range as determined by our study. In the case of CFMI, it is even below 200% ACL RBC, the point at which regulatory intervention would be indicated based on the RBC statute. For both companies, it is below the 375% ACL RBC threshold that would trigger heightened monitoring by BCBSA.

11. An updated analysis of targeted surplus ranges every 3-5 years should be considered. More frequent analyses may be appropriate based on unusual events or circumstances that may arise. For example, once the outcome of national health care reform efforts is known, an updated or supplemental analysis may be warranted.

12. Apportionment of surplus attributable to a particular jurisdiction – as is required in MIEAA – is a concept that has no financial meaning, applicability, or relevance and should be reconsidered. This is because surplus is non-divisible and exists for the protection of the entire enterprise and all of its policyholders. In the case of CareFirst and with respect to the DISB's consideration of the surplus of GHMSI

in the context of the MIEAA, the most practical scenario may be one in which both the MIA and the DISB agree as to whether there is an excess surplus and, if so, to what extent, and GHMSI then submits a plan calling for that excess surplus to benefit existing subscribers over a reasonable time frame, presumably through temporary deferrals of rate increases or similar means. In this manner, the benefits would then be allocated back by jurisdiction and by group or subscriber in close proportion to the sources of recent contributions to surplus.

13. Invotex identified certain recommended changes, summarized below, to Maryland insurance laws, regulations and/or practices for the MIA's consideration resulting from our study.

Recommendations:

1. The MIA should consider requiring nonprofit health service plans to periodically assess an appropriate targeted surplus range in light of their unique facts and circumstances and the current environment and to submit their analyses to the MIA. See pages 62-63.

2. As part of the MIA requirements, management should annually file an assertion that the nonprofit health service plan is within the appropriate targeted surplus range as that may be approved by the MIA (e.g., an approved process or range amount, to be determined by the MIA); that the analysis has been subjected to appropriate levels of governance; and that management is responsible for the underlying assumptions. See page 63.

3. While analysis of targeted surplus ranges is inherently complex, the MIA should encourage nonprofit health service plans to submit analyses that are sufficiently complete and understandable for the MIA to review; in some cases, it may be appropriate for the plans to also use supplemental alternative methodologies that are less complex and which may more transparently convey the process, analysis, and conclusions. See page 63-64.

4. The MIA should consider if the language of Maryland Insurance § 14-117 is sufficient to embrace a longer-term view for protection of policyholders. See page 65.

5. The MIA should consider changes to regulations or practices that will assure that the MIA will work proactively with nonprofit health service plans in approving rates sufficient to maintain surplus within the targeted surplus range. See page 65.

6. We recommend that the MIA require CareFirst to update its analysis of targeted surplus ranges every 3-5 years. The MIA should also reserve its right to request an updated analysis and/or to perform its own analysis at any juncture given the facts and circumstances of the companies and the environment as they may exist at the time. See page 68.

7. The MIA should anticipate the timing of the effective date for the NAIC's new HORBC trend test as an accreditation standard and when Maryland law will be amended to comply with that standard. Within 1-2 years of that date, the MIA should alert nonprofit health service plans of the pending change so that they may consider the impact on their analysis of targeted surplus ranges. See page 74-75.

8. The MIA should also require nonprofit health service plans to notify the MIA if the BCBSA RBC requirements change to incorporate a similar trend test, or if they change in any way that might potentially impact an evaluation of targeted surplus ranges for the company. See page 74-75.

9. The MIA should consider if § 14-117 should be changed in light of the issues presented regarding the extent of surplus of CFMI and of GHMSI that is attributable to their respective investments in CFBC. See page 77-78.

10. The minimum surplus test of 8% of prior year premiums that is provided in § 14-117 of the Maryland Insurance Article serves its intended function as a regulatory minimum standard. However, as of year-end 2008 the resulting minimum amount equates to only 147% and 277% ACL RBC for CFMI and GHMSI, respectively, which is significantly below the low end of the appropriate amount of surplus range as determined by our study. In the case of CFMI, it is even below 200% ACL RBC, the point at which regulatory intervention would be indicated based on the RBC statute. Therefore, we believe that the law should be modified to provide better protection for Maryland subscribers. See page 78-79.

11. Whether their evaluation is based on a detailed analysis such as that performed in 2005 and 2008 by Milliman, or by a more judgmental extrapolation or otherwise in intervening years, we recommend that the MIA obtain CareFirst management's representations annually asserting their responsibility for the determination of a

targeted surplus range, the amount of that range expressed as a percentage of ACL RBC, whether that has changed from the prior year and, if so, why, where the company's surplus is currently relative to the targeted range, and whether notable changes have been made in the manner in which that has been determined, or in the governance over that process by management and applicable committees of the board. See page 84-85.

12. We recommend that the MIA consider changes to laws, regulations, and/or practices that would adopt a Pennsylvania-like model that would result in the MIA and nonprofit health service plans working proactively together to include or approve, as appropriate, risk and contingency factors in filed rates so as to enable the plans to maintain appropriate levels of surplus. See page 86-87.

13. CareFirst and the MIA should discuss and consider whether a restructuring of the companies within the CareFirst group would not only reduce or eliminate inefficiencies in risk and surplus management, but provide other benefits as well such as further streamlining operations. There certainly are numerous factors that would have to be considered, but our study did identify the affiliation relationship itself, liquidity related to investments in CFBC, and certain provisions of the Intercompany Agreement that can give rise to inefficiencies from a risk/surplus perspective. See page 76-78.

TAB 2

2. ASSIGNMENT

Invotex was engaged by the State of Maryland to provide surplus evaluation consulting services to the MIA. The Scope of Work, as defined by the Request for Proposals for Surplus Evaluation Consulting Services No. D80R92000007 dated January 27, 2009, includes the following:

1. Recommend the appropriate amount of surplus for CFMI and GHMSI on an individual and on a consolidated basis; the recommendation should address how, in determining the appropriate amount of surplus, surplus earned in more than one jurisdiction should be apportioned so as to insure that subscribers of a health benefit plan issued or delivered in the State of Maryland are adequately protected.

2. Develop an analytical framework, methodology and/or identify additional criteria which may be used by the Commissioner to evaluate whether surplus is "excessive" for CFMI and GHMSI on an individual and consolidated basis.

3. Recommend whether the evaluation of the surplus levels of CFMI and GHMSI should be made on an individual basis, on a consolidated basis, or both, and the appropriate frequency of such evaluation.

4. Evaluate whether CFMI and GHMSI subscribers enrolled in health benefit plans issued or delivered in the State of Maryland are adequately protected by a surplus in an amount equal to the greater of: (1) $75,000; and (2) 8% of their respective total earned premium received in the immediately preceding calendar year.

5. Research and identify risk based capital requirements established by other states for comparable nonprofit health plans.

6. Recommend the appropriate risk based capital requirements for CFMI and GHMSI on an individual basis and on a consolidated basis.

7. Recommend any appropriate changes in law, including but not limited to administrative regulations.

8. Provide testimony relating to and/or in support of Invotex's findings and recommendations at a public hearing, or before the General Assembly, as needed.

As our work progressed, so did developments in the District of Columbia relative to its Medical Insurance Empowerment Amendment Act of 2008, referred to herein as MIEAA. At the request of the MIA, we attended the DISB's public hearing held on September 10, 2009; we participated in meetings with the DISB's advisors from Rector & Associates; and we have addressed certain matters pertaining to the application of MIEAA to the facts and circumstances involving GHMSI based on our knowledge of the company gained over the course of our work on behalf of the MIA.

TAB 3

3. STRUCTURE OF REPORT AND APPROACH

Our report begins with a **Background** section that describes pertinent aspects of CareFirst including about CFMI and GHMSI specifically, and a section on how the **Evaluation of the Surplus of Insurers** is generally made in the insurance and regulatory communities.

We then include a section on **Peer Analysis**, which compares certain financial attributes of CFMI and GHMSI to a group of similar nonprofit Blue Cross Blue Shield plans.

While peer analysis can support a view as to the adequacy of reported surplus, it is not by itself determinative because it does not sufficiently examine the unique risk profile of the subject companies. CareFirst engaged Milliman to perform studies of targeted surplus ranges for both CFMI and GHMSI. A significant aspect of our engagement on behalf of the MIA was to make an **Assessment of Milliman's Study**, which follows the section on Peer Analysis. We assessed the actuarial modeling work performed on CFMI's and GHMSI's behalf by Milliman, including key assumptions underlying Milliman's work.

As a part of our assessment of Milliman's work, we performed our own **Risk Assessment** which identified some additional risks that were not quantitatively considered by Milliman in their analysis, and for which we considered potential adjustments to Milliman's targeted surplus ranges.

With adjustments to Milliman's targeted surplus ranges based on our assessment of their work and our risk assessment, we derived what we believe to be an **Appropriate Amount of Surplus for CFMI and GHMSI.** Our determination is made on a quantitative basis expressed as a range of ACL RBC for both companies but also includes certain principles that we have brought forward for the MIA's consideration. Our determination of a framework for the MIA's consideration was partially influenced by the results of a similar effort made by the Pennsylvania Insurance Department several years ago involving Blue Cross and Blue Shield plans operating in that state which is described in the following section on **RBC Requirements of Other States and the NAIC.**

With our determination made of an appropriate amount of surplus for CFMI and GHMSI, we then make an **Assessment of Current Surplus Requirements in Maryland** and

consider if, in light of our study, those requirements (greater of $75,000 and 8% of prior years' earned premium) appear to be sufficient to protect Maryland subscribers.

Resulting recommendations to change those requirements for the MIA's consideration follow in sections pertaining to **Appropriate Risk Based Capital Requirements**, and a **Suggested Methodology for the MIA**. The latter section considers the appropriateness of a consolidated evaluation of an appropriate amount of surplus for CFMI and GHMSI taken together versus stand-alone evaluations for each of the entities, as well as the frequency of such evaluations.

Lastly, we address specific questions put forth to Invotex by the MIA pertaining to the notion of **Apportionment** of surplus as a possible means to enhance the protection of Maryland subscribers to nonprofit health service plans operating in more than one state.

Throughout this report, recommendations for the MIA's consideration relating to potential changes in laws, regulations or regulatory practices have been placed in a text box and in italics – like this paragraph – for ready identification.

Unless otherwise noted, financial amounts included herein are based on statutory-basis financial statements as filed with regulatory authorities.

In performing our work, we were provided access to requested documentation by the MIA and by CareFirst, as well as to Milliman's reports and supplemental information regarding their approach and underlying model and assumptions. We interviewed a number of CareFirst executives and staff, as well as staff of Milliman, in order to obtain a more complete understanding of various matters. We gratefully acknowledge their cooperation and the courtesies that they extended to us in the course of our work.

TAB 4

4. BACKGROUND REGARDING CAREFIRST

In order to address the issues pertinent to Invotex's engagement, it is necessary to first understand certain information about CareFirst, its organizational structure, and its operating characteristics and nuances. Such aspects can have a pervasive impact on the manner in which the company operates and how it is managed, as well as on its risk profile, and are therefore relevant to an evaluation of the surplus of CFMI and GHMSI. In particular, there are issues involving the affiliation, corporate structure, and certain operational agreements that, in our view, present some inherent inefficiencies in managing risk and surplus across the enterprise. In other words, these issues make it necessary for each of CFMI and GHMSI to carry more surplus than would otherwise be the case, all other factors being equal.

CareFirst's Mission and Business: CareFirst "provide[s] a comprehensive array of health insurance and managed care products and services primarily through indemnity health insurance, health maintenance organization (HMO) coverage and health benefits administration. Other products and services include preferred provider and point-of-service networks, fee-for-service arrangements, third-party administrator services and other managed care services."[1]

CareFirst's stated mission is "to provide health benefit services of value to customers across the region comprised of Maryland and the National Capital Area."[2] To fulfill its mission, CareFirst's stated commitment is to:

- "Offer a broad array of quality, innovative insurance plans and administrative services that are affordable and accessible to our customers;
- Fairly address the needs of customers in each of the jurisdictions in which we operate;
- Conduct business responsibly as a nonprofit health service plan, to ensure the plan's long-term financial viability and growth;
- Collaborate with the community to advance health care effectiveness and quality;

[1] Consolidated Financial Statements and Other Financial Information, CareFirst of Maryland, Inc. and Subsidiaries, Years Ended December 31, 2008 and 2007 with Report of Independent Auditors, p. 6.
[2] http://www.carefirst.com/media/html/Mission.html.

- Support public and private efforts to meet needs of persons lacking health insurance;
- Foster health systems integration and health care cost containment to benefit people in areas we serve, and
- Promote respect, fairness and opportunity for our associates."[3]

CFMI and GHMSI, as nonprofit health service plans operating in Maryland, also have the following statutory mission pursuant to Maryland Insurance Code §14.102:

> "(c) Mission.- The mission of a nonprofit health service plan shall be, in accordance with the charter of the nonprofit health service plan, to:
>
> (1) provide affordable and accessible health insurance to the plan's insureds and those persons insured or issued health benefit plans by affiliates or subsidiaries of the plan;
>
> (2) assist and support public and private health care initiatives for individuals without health insurance; and
>
> (3) promote the integration of a health care system that meets the health care needs of all the residents of the jurisdictions in which the nonprofit health service plan operates."

CFI is a licensee of the BCBSA, which provides CFI with numerous benefits, including:

- The right to use BLUE CROSS and BLUE SHIELD in its trade name and/or corporate name;[4]
- The right to use BLUE CROSS and BLUE SHIELD and their design service marks in the sale, marketing and administration of health care plans and related services;[5]
- The ability to be associated with BCBSA's recognizable brand;

In addition:

- The BlueCard system allows CareFirst to compete in the national accounts market;

[3] http://www.carefirst.com/media/html/Mission.html.
[4] Blue Cross License Agreement, p. 2; Blue Shield License Agreement, p. 2.
[5] Blue Cross License Agreement, pp. 1-2; Blue Cross License Agreement, pp. 1-2.

- BCBSA has a national network of plans that can invest in systems and collect patient and claims data information nationally, which it can then make available to all of its Plans;
- BCBSA provides a governmental relations function to its licensees; and
- Being a part of the BSBSA affords the licensees such as CFI with access to lower vendor pricing (e.g., better pricing from firms such as IBM because many Blues contract with IBM).

Another view of the benefits of BCBSA membership is to consider the impacts of the loss of the license on subscribers and the company. In that regard, CareFirst has advised us of the following impacts:

Effects of License Termination on the Public: Automatic termination of the License Agreements permits CFMI and GHMSI to continue to function as nonprofit health service plans and CFBC to continue to function as a for-profit HMO, but they would have to replace the Blue Brands with other service marks, and undergo disconnection from Blue Cross Blue Shield systems. Such a loss of Blue Cross and Blue Shield coverage would deprive subscribers in the District, Maryland and Northern Virginia of significant benefits. CareFirst has represented to us that those benefits include the following:

- Up to 2.9 million CFMI and GHMSI members would lose access to the Blue Cross and Blue Shield provider networks outside of the Service Area, that comprise approximately 90% of all hospitals and 80% of all doctors in the United States, as well as to the Blue Cross and Blue Shield provider networks outside the United States. These networks enable traveling Blue Cross Blue Shield members to obtain health care services without significant up-front payments, and at significant discounts. Last year these discounts amounted to approximately $1.1 billion for CFMI and GHMSI members.
- CareFirst members in the District, Maryland and Northern Virginia would also lose the significant benefits of nationwide access to the Blue Distinction Centers, which are carefully screened quality providers of Transplant, Cancer Care, Cardiac Care and Bariatric Surgery. Blue Distinction Centers provide better health outcomes at lower cost.

- CFBC members would lose access to the Away From Home Care program, which provides health benefits to retirees, students and others residing away from home.

Effects of License Termination on the Plans: CareFirst and its 5,400 employees would also suffer serious consequences from loss of the Blue Cross and Blue Shield Brands. For example:

- CFMI and GHMSI cover approximately 530,000 federal employees under the Federal Employee Program ("FEP"), representing approximately 18% of their total enrollment. In 2007 CareFirst received approximately $2.0 billion from the federal government in connection with its participation in FEP. Although the federal employees would not notice a change, CFMI and GHMSI would lose these revenues and subscribers. Jobs associated with serving these federal employees could also be lost.

- Claims administration and processing services for FEP are handled centrally by the Service Benefit Plan Administrative Services Corporation ("SBP"). SBP is jointly owned by GHMSI (which owns 90%) and by BCBSA (which owns 10%). However, CareFirst's loss of the Blue Cross and Blue Shield licensure would result in BCBSA owning 100% of SBP and would deprive GHMSI of significant revenues. In 2007, SBP received approximately $83 million in reimbursements from the federal government for SBP operations.

- CFMI and GHMSI would almost certainly also lose revenues associated with their approximately 375,000 national account members representing 13% of their total enrollment. A "national account" is a group with members located in other parts of the country who are served by Blue Plans other than CFMI and GHMSI. Since CFMI and GHMSI would no longer have access to the nationwide Blue Cross Blue Shield provider network, many of these national accounts presumably would choose to transfer their business to another Blue licensee. In 2008 these national account revenues were estimated to be as much as $1.3 billion. Jobs associated with serving these customers could also be lost.

- CFMI and GHMSI would lose the ability to tap into significant cost savings from the national contracts that BCBSA has negotiated on behalf of all Blue Cross and Blue Shield Plans with more than 50 strategic partners, including IT, telecommunications, professional services, marketing, shipping, and more.

- Pursuant to another provision in the License Agreements, CareFirst would be subject to a termination fee of approximately $259 million, which would be used to build a new Blue Cross and Blue Shield presence in the Service Area.

Being a licensee of BCBSA also brings certain obligations and responsibilities to the CareFirst affiliated group of companies, including certain restrictions as to CareFirst's market territory, and the need to maintain certain financial strength measures. CareFirst's market territory includes the state of Maryland, the District of Columbia, and portions of Northern Virginia (the cities of Alexandria and Fairfax; the town of Vienna; Arlington County; and the areas of Fairfax and Prince William Counties in Virginia lying east of Route 123). As a result, CareFirst's operations are subject to regulation by state insurance regulators in three jurisdictions: Maryland, Virginia, and the District of Columbia. CFI and CFMI are domiciled in Maryland and therefore the MIA is their primary regulator with respect to financial and holding company matters. GHMSI and CFBC are domiciled in the District of Columbia and therefore the DISB is the primary regulator with respect to their financial matters. The insurance regulators in Maryland, Virginia and the District of Columbia also oversee and regulate market conduct of insurers with respect to the sale and marketing of insurance products and services within their respective jurisdictions.

As of the end of 2008, the CareFirst affiliated group had 1,839,000 contracts.[6] In 2007, the combined market share for CareFirst's service area was 42%. That figure was projected to increase to 43% in 2008 and to hold at that level for 2009.[7]

CareFirst's Organizational Structure: CareFirst's products and services are offered primarily through two nonprofit health service plans, CFMI and GHMSI; a for-profit regional health maintenance organization subsidiary[8], CFBC, which is co-owned by CFMI and GHMSI through equity ownership in 60%/40% shares, respectively; and other subsidiaries. Under CFI, a not-for-profit parent company, the group engages in business as CareFirst BlueCross BlueShield.[9]

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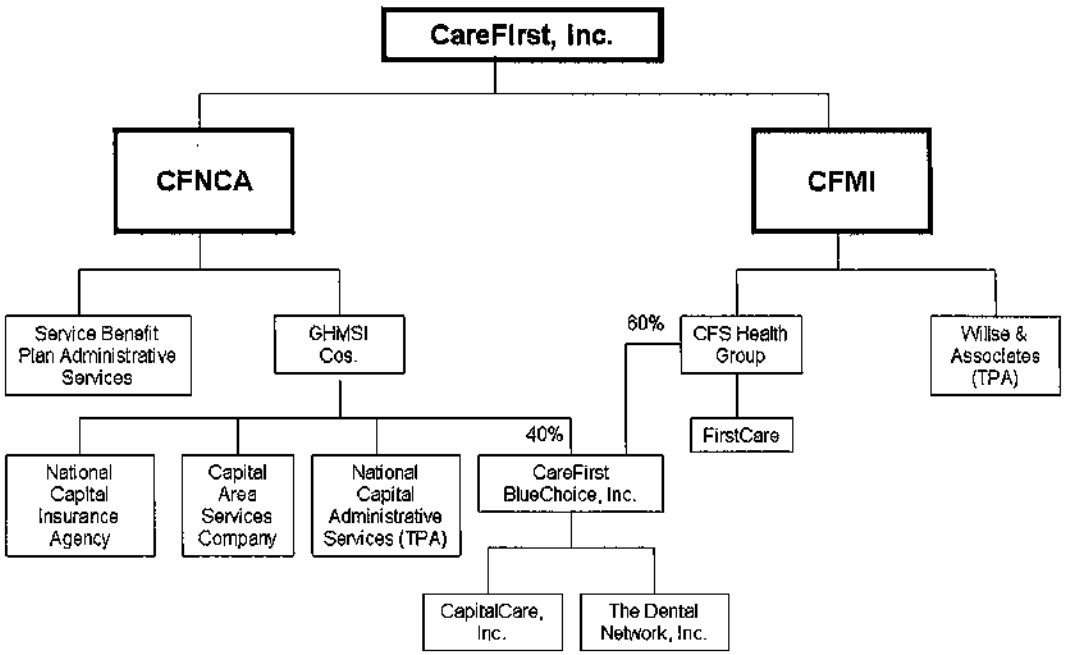
[6] CareFirst, Inc. and Affiliates Underwriting Gain & Loss Report By Market Segment, December 2008 Year-To-Date Actual.

[7] Briefing Book for Standard and Poor's Ratings Group, 2008 Update for CareFirst, Inc., November 2008, p. 4.1.

[8] Consolidated Financial Statements and Other Financial Information, CareFirst of Maryland, Inc. and Subsidiaries, Years Ended December 31, 2008 and 2007 with Report of Independent Auditors, p. 6; http://www.carefirst.com/company/html/AboutUsHome.html.

[9] Consolidated Financial Statements and Other Financial Information, CareFirst of Maryland, Inc. and

An organization chart of the CareFirst group of companies is as follows (in the chart, CFNCA refers to CareFirst of the National Capital Area, or GHMSI):



Note - Other Non-operating entities include for CFNCA Access America, Inc., for CFMI Green Spring Mental Health Services, Inc., Columbia FreeState Dental Plan, Inc., Patuxent Medical Group, Inc. and for BlueChoice TDN Administrative Services, LLC.

The following chart provides high-level financial data and a sense of magnitude, i.e., where within the organization premiums, assets and surplus are reported. This data is provided for CFMI, GHMSI and CFBC as the underwriting companies within the group; the other affiliates, including CFI, are quite small in comparison.

GHMSI	
Net Premiums Written ($000)	$ 2,815,214
Net Admitted Assets ($000)	$ 1,772,935
Surplus ($000)	$ 686,780

CFMI	
Net Premiums Written ($000)	$ 1,833,811
Net Admitted Assets ($000)	$ 1,149,945
Surplus ($000)	$ 394,251

40%

CFBC	
Net Premiums Written ($000)	$ 1,743,314
Net Admitted Assets ($000)	$ 645,508
Surplus ($000)	$ 406,675

60%

The above data is based on statutory reporting as of and for the year ended December 31, 2008.

Subsidiaries, Years Ended December 31, 2008 and 2007 with Report of Independent Auditors, p. 6.

Historical Developments of CareFirst: In an evaluation of the surplus of CFMI and/or GHMSI, it is useful to understand not just the current organizational structure, but how that structure came about, how GHMSI's and CFMI's surplus accumulated, and over what time period.

Prior to 1998, GHMSI and CFMI were unaffiliated and separate licensees of BCBSA operating in neighboring territories. GHMSI, also then known as Blue Cross Blue Shield of the National Capital Area, had as its licensed marketing territory the District of Columbia, Montgomery and Prince George's counties in Maryland, and certain parts of Northern Virginia. CFMI was then known as Blue Cross and Blue Shield of Maryland, and its marketing territory included the remainder of the State of Maryland, i.e., excluding the counties of Montgomery and Prince George's.

In the early 1990s, GHMSI's failed international expansion effort and under-performing investments in non-core businesses, combined with accelerating competition in the national capital region, left the company in financial distress. Surplus dropped to precipitously low levels, even after obtaining statutory accounting relief to report GHMSI's home office at market value rather than at book value (depreciated cost). Significant losses were incurred, largely due to extraordinary charges associated with restructuring and the write-down of bad assets. Administrative expense levels were abnormally high relative to industry standards. Total cash and investments were dangerously low, and bank debt surpassed $30 million. Surplus was further propped up through the contribution of surplus notes from Blue Cross and Blue Shield-affiliated entities in amounts that ultimately grew to $60 million.[10] (Surplus notes essentially are loans that are subordinated to policyholder obligations and therefore allowed for statutory purposes – but not for GAAP – to be reported as a component of surplus rather than as a liability.)

GHMSI's surplus in the early 1990s is summarized below ($ in millions):[11]

	1990	1991	1992	1993
Preliminary surplus	$ 36.2	$ 21.9	$ (27.8)	$ (57.1)
Excess value of real estate	79.4	80.1	60.8	55.1
Surplus note			15.0	55.0
Reported surplus	$ 115.6	$ 102.0	$ 48.0	$ 53.0

[10] Report of Goldman Sachs to GHMSI's Board of Trustees dated August 7, 1996, p. 34.
[11] Derived from copies of Annual Statements of GHMSI that were filed with state insurance regulators.

Thus, and with the financial backing of other Blue Cross and Blue Shield Plans and with the approval of its insurance regulator, GHMSI was able to report surplus levels that were adequate, albeit barely, compared to mandated minimums. But with that funding also came the requirement to reconstitute GHMSI's Board to include the involvement of CEOs of a half-dozen other BCBS Plans. GHMSI's regulatory and financial difficulties ultimately culminated in 1993 with the reconstitution of its board and replacement of senior management.

New management terminated GHMSI's involvement in non-core areas, improved collections on accounts receivable, improved liquidity ratios and investment balances, significantly reduced headcount (from 3,479 FTEs at year-end 1992 to 1,954 FTEs at mid-year 1995), stemmed the slide in enrollment with new products and more competitive premiums, and renegotiated provider contracts.[12] As a result, GHMSI was able to return to financial viability.

CFMI experienced its own problems. From 1986 through 1988, CFMI – then known as Blue Cross and Blue Shield of Maryland – incurred operating losses of $110 million and its surplus declined dramatically from $67 million to $27 million. Reflecting these losses and reduced surplus, a 1987 examination by the MIA found that it had achieved a deficit position of $1.2 million. Between 1985 and 1989, its reported surplus declined precipitously from $122 million to $16 million, and its subsidiary companies had incurred total losses of $120 million. During this same time span it made capital infusions of more than $170 million to its HMO and noninsurance subsidiaries that had lost in excess of $120 million.[13]

The fact that the surplus of GHMSI and CFMI were both at very low levels in the early 1990s is pertinent in other sections of this report relating to the apportionment of surplus by jurisdiction inasmuch as it creates, from a practical perspective, a more recent beginning point in time from which the surplus in those companies that exists today has since been accumulated. In other words, analysis of the sources of surplus that exist today would not have to look further back beyond the early 1990s.

[12] Report of Goldman Sachs to GHMSI's Board of Trustees dated August 7, 1996, pp. 35-36.
[13] Fourth Interim Report on U.S. Government Efforts to Combat Fraud and Abuse in the Insurance Industry, U.S. Permenant Subcommittee on Investigations, June 1995, pp. 29-36.

In early 1996, management and GHMSI's Board discussed the possibility of CFMI as a potential merger partner. The potential advantages that were discussed included that as integrated companies, the best practices of each plan could be maintained and duplicate functions could be eliminated; the Blue Cross Blue Shield trademark would be maintained; and new products could be enabled on a more accelerated basis.

GHMSI and CFMI filed for regulatory approval of a business affiliation, which was consummated in 1998. CFI was incorporated on January 16, 1998, to become the not-for-profit parent of CFMI and GHMSI. These affiliated entities collectively engaged in business going forward as CareFirst BlueCross BlueShield.[14]

The Intercompany Agreement: The affiliation gave rise to the need for certain intercompany agreements in order to conduct business smoothly, efficiently, and minimize risk. Most notable for purposes of this study is an intercompany agreement which has been updated from time to time, as follows:

- Amended and Restated Intercompany Agreement, March 22, 2000
- Second Restated Intercompany Agreement, September 21, 2006
- Third Restated Intercompany Agreement, January 1, 2009 (the "Intercompany Agreement")

The Intercompany Agreement is most germane to this study inasmuch as it provides a means to utilize enterprise-wide resources to stem risk. The Intercompany Agreement by and among CFI, CFMI, GHMSI and their subsidiaries (i.e., including CFBC) provides that, in the event of a surplus shortfall or inability to pay claims or other obligations by one party to the agreement, the others will fund the shortfall, through loans, capital contributions, or other means. The only apparent limitations to this intercompany funding are if the proposed payment would "(1) cause such Providing Party's [surplus] to fall below or further below its statutory or regulatory [surplus] requirements or BCBSA Surplus Requirements; or (2) cause such Providing Party not to be in compliance with any statute, regulation or order applicable to such Party, or any requirements of BCBSA, or to violate any specific legal prohibition regarding the transfer, including but not limited to the requirement that

[14] Consolidated Financial Statements and Other Financial Information, CareFirst of Maryland, Inc. and Subsidiaries, Years Ended December 31, 2008 and 2007 with Report of Independent Auditors, p. 6.

intercompany transfers of assets must be 'fair and reasonable' in accordance with D.C. Code Section 31-706, and Sections 7-702 and 7-703 of the Maryland Insurance Code."[15] Therefore, each entity must, to some degree, consider the financial viability of the other in their evaluation of intercompany affairs.

The existence of the Intercompany Agreement and its requirement that the affiliates cross-guarantee each others' surplus and liquidity is relevant to the consideration of group risk and how that is managed across the enterprise. As written, it suggests that the enterprise-wide resources of the CareFirst group of companies are available to fund shortfalls wherever they may arise within the corporate group. Nonetheless, funding of such amounts would require regulatory approvals, possibly by several jurisdictions. No amounts have yet been funded to date, and therefore the ability to tap resources cross-entity and cross-jurisdiction is yet untested as to what constraints may be imposed, if any, or as to the timeliness in which approvals can be obtained.

The Intercompany Agreement also provides for discretionary funding among affiliates, i.e., funding that is not necessarily triggered by an adverse surplus or liquidity position. As written, this provision does not appear to be limited to any particular amounts, although successively higher levels of authority are required by management and by the various boards of directors at increasing dollar levels. We understand that, to date, there has been no discretionary funding between the CareFirst affiliates pursuant to the Intercompany Agreement.

The Intercompany Agreement was recently amended to require that any transfers of funds be subject to regulatory approval and that any transfers either be "legally permissible investments in subsidiaries, or documented loans which will be paid back to the transferor." Therefore, and should either CFMI or GHMSI need surplus relief from the other, that would have to be in the form of a surplus note which would require the entity loaning its funds to subordinate its rights to those of policyholders of the receiving party. Regulatory approval would involve a review of the facts and circumstances at the time and action by regulators of two states; there is no assurance that such regulatory approval would be granted.

[15] Third Restated Intercompany Agreement, p. 4.

The affiliation had various other implications for the management and operations of the new CareFirst group:

- From a governance perspective, and inasmuch as CFMI and GHMSI remained separate non-stock, non-for-profit entities, their boards remained separate and distinct from each other as well as from CFI's board, albeit with some overlapping membership.
- Management and staffing were re-aligned to a single team with the ultimate goal of seamlessly managing the combined operations of CareFirst.
- Operations and infrastructure became integrated over time to achieve efficiencies.
- HMO operations moved to a centralized platform using GHMSI's subsidiary, CapitalCare, Inc.,[16] subsequently renamed CFBC and which, upon valuation and regulatory approvals, became 60% owned by CFMI and 40% owned by GHMSI.

Cross-Jurisdictional Sales: From an operational perspective, CareFirst continued to serve subscribers in the combined service area in the following manner:

- GHMSI continued to sell in its original marketing territory – the District of Columbia, Montgomery and Prince George's counties in Maryland, and parts of Northern Virginia – but also began to sell some products in CFMI's traditional territory. Approximately 10% of GHMSI's subscribers are residents of the District of Columbia while the remaining 90% of subscribers are residents of Maryland or Virginia.[17] The FEP contract represents approximately 28% of GHMSI's total membership, and the large group, national account and FEP segments collectively account for approximately 79% of membership.[18]
- CFMI continued to sell in its original marketing territory – the State of Maryland excluding Montgomery and Prince George's counties – but also began to sell some products in GHMSI's traditional territory.
- CFBC became a new means for CareFirst to go to market across its entire newly-combined service area offering HMO products.

[16] Market Conduct Examination Report of the Health Business of CareFirst BlueChoice, Inc., p. 4 (http://www.mdinsurance.state.md.us/sa/documents/CareFirst813-01(1-14-03).pdf).
[17] Pre-Hearing Report, DISB Review of GHMSI Surplus Pursuant to the Medical Insurance Empowerment Amendment Act of 2008, D.C. Code § 31-3501 *et seq.*, August 31, 2009, p. 16.
[18] Standard & Poor's RatingsDirect, Group Hospitalization and Medical Services Inc. (d/b/a CareFirst BlueCross BlueShield), December 31, 2008, pp. 4-5.

The fact that GHMSI and CFMI began to sell outside of their traditional service areas gave rise to the notion of "cross-jurisdictional" sales, a matter which CareFirst discussed with regulators and then began to disclose in the Annual Statements and annual audited financial statements of CFMI and GHMSI. Cross-jurisdictional sales as described in this section of our report pertain to historical reporting by both plans of sales made in each others' service areas; they do not relate in any way to the subject of "apportionment," which is described in a subsequent section of this report. Based on those disclosures, a summary of cross-jurisdictional activity within the CareFirst group is as follows:

Revenue and Impact to Surplus From Cross-Jurisdictional Sales

		Risk		Non-Risk		TOTAL	
Year	Line Items	CFMI Sales Outside Historic CFMI Service Area	GHMSI Sales Outside Historic GHMSI Service Area	CFMI Sales Outside Historic CFMI Service Area	GHMSI Sales Outside Historic GHMSI Service Area	CFMI Sales Outside Historic CFMI Service Area	GHMSI Sales Outside Historic GHMSI Service Area
YTD	Revenue ($000)	34,412	187,010	-	-	34,412	187,010
06/30	Impact to Surplus ($000)	2,505	8,336	1,263	(1,142)	3,768	7,194
2008	Contracts (actual)	21,449	41,635	44,115	30,950	65,564	72,585
	Revenue ($000)	73,360	330,857	-	-	73,360	330,857
2007	Impact to Surplus ($000)	5,352	6,751	(113)	3,163	5,239	9,914
	Contracts (actual)	22,132	40,200	20,047	30,677	42,179	70,877
	Revenue ($000)	77,916	242,429	-	-	77,916	242,429
2006	Impact to Surplus ($000)	7,340	7,725	1,679	1,658	9,019	9,383
	Contracts (actual)	24,520	34,723	19,864	19,810	44,384	54,533
	Revenue ($000)	80,077	189,518	-	-	80,077	189,518
2005	Impact to Surplus ($000)	2,758	(3,401)	59	1,639	2,817	(1,762)
	Contracts (actual)	24,600	23,300	19,600	10,800	44,200	34,100
	Revenue ($000)	81,582	118,763	-	-	81,582	118,763
2004	Impact to Surplus ($000)	5,270	4,492	(905)	1,141	4,365	5,633
	Contracts (actual)	25,800	18,000	16,900	10,400	42,700	28,400

Source: CFMI Statutory Financial Statements, 2004 - 06.30.2008

Through 2007, cross-jurisdictional sales were recorded as premiums by the entity writing the contract and the resulting underwriting activity stayed on that entity's books, albeit with footnote disclosure so that regulators could monitor the volume.

Beginning in 2008, and with regulatory approval, a Quarterly Earnings Redistribution Agreement between CareFirst of Maryland, Inc. and Group Hospitalization & Medical Services, Inc. was entered into by and between CFMI and GHMSI whereby any such cross-jurisdictional sales from January 1, 2008 forward are effectively 100% reinsured from the entity that made the cross-jurisdictional sale back to the entity in whose traditional (pre-affiliation) service territory is the principal office or residence of the contracting group or individual. In other words, even though CFMI may have issued a contract in Montgomery County, Maryland, the net underwriting experience related to that contract would ultimately be reported on GHMSI's books through reinsurance accounting as if

GHMSI had written that business itself. The converse would also be true for business written by GHMSI in CFMI's traditional territory post-2007.

A summary of such cross-jurisdictional sales which were made in 2008 and effectively reinsured back is as follows:

Cross-Jurisdictional Sales Reinsured for CFMI and GHMSI For 2008

Year Ended Dec. 31, 2008 ($000)	CFMI	GHMSI
Premiums assumed	$ 386,713	$ 68,439
Premiums ceded	(68,439)	(386,713)
Premiums, net	318,274	(318,274)
Cost of care assumed	317,320	53,934
Cost of care ceded	(53,934)	(317,320)
Cost of care, net	263,386	(263,386)
General and administrative expenses assumed, net	55,601	
General and administrative expenses ceded, net	-	(55,601)
Net loss assumed by CFMI	**$ (713)**	**$ -**
Net loss ceded to CFMI	**$ -**	**$ 713**

Sources: Statutory Annual Statements, CFMI, 2008;
Statutory Annual Statements, GHMSI, 2008.

Effort to Convert to For-Profit Status: A historical perspective of CareFirst would not be complete without some mention of the company's efforts in 2001-2003 to convert to for-profit status and the proposed acquisition by WellPoint. While the proposed transaction did not occur, we do observe that much of its underlying rationale related to greater access to capital to address risks and resource needs to compete and deliver services effectively. Some of those issues continue to be relevant in the context of the MIA's current evaluation of GHMSI's and CFMI's surplus.

TAB 5

5. EVALUATION OF THE SURPLUS OF INSURERS

Generally speaking, insurers evaluate their surplus needs considering various factors, including the following:

- Minimum statutory requirements, e.g., 200% ACL RBC;
- Market expectations, primarily represented by the degree of financial soundness necessary to maintain a financial strength rating from a rating agency consistent with the insurer's targeted market and strategic goals;
- Internal analyses of the company's risks and surplus needs in light of its operational and risk profile and how those may be subject to change based on plans or forecasts or by the existence of anticipated as well as unanticipated risks.

The lowest of the foregoing thresholds is the minimum statutory requirement which, by definition, is a precarious place for an insurer to be. A minor slip would trigger regulatory action. Moreover, and even at higher levels, adverse publicity and possible ratings downgrades could cause reputational issues; informed policyholders or groups may opt to move their business elsewhere. In the case of accident and health insurers, such actions can result in what is known as "adverse selection" which could exacerbate the impact of matters that are already contributing to a deteriorating financial condition. Contract holders who are most apt to move are those who, relatively speaking, are healthier and more able to find coverage elsewhere at a satisfactory price and without restrictions because of pre-existing limitations. That leaves the insurer with a smaller base of business that is less profitable, comprised of relatively more contract holders who are prone to more and larger claims in the short term. For these reasons, insurers do not want to be at, near, or be seen as heading in the direction of minimum surplus levels.

The relationship between financial strength of an insurer and its ability to withstand both anticipated and unanticipated risks has long been recognized – by the industry, its regulators, rating agencies, brokers, informed consumers, and others. The manner in which that relationship has been addressed has changed dramatically over time. In fact, risk management by insurers is very much still an evolving area for which many hard lessons are still being learned as seen, for example, in the adverse effects wrought by the

recent credit crisis and ensuing recession and the efforts at the federal, state and NAIC levels to consider necessary marketplace, financial reporting, and regulatory reforms.

History of Capital and Surplus Requirements: For many years and through the 1980s, insurers were largely subjected to static minimum capital and surplus requirements. A flat amount typically would be required for an insurer to become licensed, and varying other flat amounts might be required depending on the lines of business it was authorized to write. So, for example, one company writing $5 million annually in premium and another writing $500 million in premium could have been subjected to the same minimum capital requirement, e.g., in the $1-2.5 million range. Some states also required an additional amount based on claim volume, for example, an amount at least equal to three months of claim payments. A more sophisticated regulatory requirement to evaluate surplus based on the unique risk profile of each company simply did not exist in those days.

Low and static capital and surplus requirements, combined with the effects of business practices of some insurers and other deficiencies in regulation resulted in a spate of insurer insolvencies in the late 1980s, initially related primarily to property/casualty insurers, and then involving some larger life insurers in the early 1990s. Accident and health insurers were not immune; indeed, GHMSI itself came very close to insolvency, and CFMI experienced financial difficulties of its own. It was also in this time frame that Blue Cross and Blue Shield of West Virginia became the first (and to date, only) BCBSA licensee to enter liquidation proceedings. These developments spawned investigations by the U.S. Congress and the U.S. General Accounting Office. Blue Cross and Blue Shield plans specifically were investigated by a Senate Permanent Subcommittee chaired by Sam Nunn, D-GA. The result was increased activity by the states and by the NAIC to develop a stronger and more uniform system of state-based regulation.

Risk Based Capital: The centerpiece of those efforts was the NAIC's Financial Regulatory Standards Accreditation Program, an initiative that is still ongoing and evolving with further refinements to standards which are adopted and with which each accredited state is then expected to comply. Foremost among those regulatory standards at the time was the advent of risk-based capital requirements for insurers.

Risk based capital was initially developed in two different formats, one for property/casualty insurers and another applicable to life/health insurers. The resulting

formulas and related model laws were approved in 1993 and became part of the NAIC's accreditation standard requirements shortly thereafter. Over the ensuing years, a separate Health Organizations Risk Based Capital framework was developed which was adopted by the NAIC in 1998. According to the NAIC Model Laws, Regulations and Guidelines, Volume III, many states have since either adopted the Model Act or have similar or related legislation.[19]

Risk based capital is a means by which the amount of capital and surplus of an insurer can be evaluated in large measure against its own risk profile. That profile considers the company's size, the types of business it writes, its invested asset profile, and other risk-related characteristics. Generally speaking, company-specific data for the reporting entity, such as the dollar value by classification of its investments in fixed maturities, are multiplied by various factors which have been determined and approved by the NAIC based on industry experience. In the case of investments in fixed maturities for example, the industry factors are determined by the NAIC based on studies of bond default experience going back over an extended period. The idea is to determine an amount that the company should retain in capital and surplus that, based on prior industry experience, would then appear to be sufficient to guard against future defaults on the company's bonds, assuming that the company's ultimate default rate is no greater than the relevant period of past industry experience.

The NAIC's RBC formula produces such values to address the following risk categories:

- Affiliates risk
- Asset risk, e.g., unaffiliated stocks, bonds, other invested assets
- Property and equipment assets
- Asset concentration
- Underwriting risk / experience fluctuation risk / other underwriting risk

[19] These states include: Arizona, Arkansas, Colorado, Connecticut, DC, Georgia, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Nebraska, Nevade, New Hampshire, New Jersey, North Carolina, North Dakota, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Dakota, Texas, Utah, Virginia, Washington, West Virginia, and Wyoming (NAIC Model Laws, Regulations and Guidelines, Volume III, pp. 315-15 – 315-18.

- Credit risk, e.g., from reinsurers, intermediaries, loans and advances to providers, and other health care-related receivables
- Business risk, e.g., medical costs paid through ASC arrangements[20]

The NAIC's formula does not simply sum the foregoing measures; rather, there is a covariance adjustment that, in effect, recognizes that some of these risks are independent of each other and that not all risks will develop adversely at the same time. Thus the final RBC results after the covariance adjustment is less than the sum of the parts. It should be noted, however, that the covariance adjustment itself is based on a broad, industry-wide assessment as to which risks are interdependent and to what degree. The experience of any particular company may be quite different than that which is assumed through the factors underlying the NAIC's RBC model.

Accompanying the RBC formula itself is a model law developed by the NAIC. Of specific interest to the situation at hand involving CareFirst is the Risk Based Capital (RBC) for Health Organizations Model Act which was adopted by the NAIC in 1998. Maryland has since adopted the key provisions of that model, which are now included as MD ANN. CODE Ins § 4-301 to 4-314 (1995/2001). Therefore, CFI, including CFMI and GHMSI, must meet those requirements.

The critical part of the model law and the enabling Maryland statute is that it drives regulatory action; as the reporting entity's capital and surplus falls through successively decreasing threshold levels, increasing levels of regulatory intervention are triggered. If that process proceeds to the lowest threshold, the statute would require the insurance commissioner to take over control of the company. Those thresholds are as follows:

- Company Action Level RBC = 200% of ACL RBC; the company must submit a plan that identifies the matters that contributed to the action level event, propose corrective action, provide certain financial projections including supporting assumptions, and identify the quality and/or problems associated with various aspects of the company's business.

[20] NAIC Health Risk-Based Capital Report, 2008, p. i.

- Regulatory Action Level RBC = 150% of ACL RBC; in addition to the filing of a plan, the regulator may examine the company and/or its plan to the extent necessary, and can issue corrective orders.

- Authorized Control Level (ACL) RBC = amount as determined pursuant to the RBC formula and instructions; in addition to the preceding levels of regulatory action, the regulator may, if deemed to be in the best interests of policyholders, cause the company to be placed under regulatory control and provided that the Authorized Control Level event alone is sufficient grounds to do so.

- Mandatory Control Level RBC = 70% of ACL RBC; provides that the regulator shall place the company under regulatory control and that the Mandatory Event Level event alone is sufficient grounds to do so.

It is important to understand why the NAIC included this series of increasingly more stringent action levels within the RBC Model Act. It was necessary to provide time, much more so than would ever have been possible under the prior law and static minimum surplus requirements, for regulators to intervene and approve corrective actions and for those actions to bear fruit before the company slipped into insolvency. It was well-recognized by working group members at the time that adverse trends and conditions impacting insurers could not be cured overnight; that where premium rate and underwriting changes are concerned it can often take many months for improvements to be reflected and accreted into operating results. As a result, the thresholds that "trigger" involvement by regulators had to be set at levels substantially above pre-existing minimums so as to provide additional time for the benefits of regulatory intervention to take hold.

Limitations of RBC: While RBC was a significant development in the financial regulation of insurers, it does have limitations which may be significant in interpreting the adequacy of capital and surplus for a particular company:

- While the RBC formula is based in part on company-specific reported amounts, they are applied against risk factors that are anchored in industry experience, which may prove to be quite different from the company's ultimate experience.

- Although the RBC factors are based on past industry experience regarding adverse investment and underwriting cycles, there is no assurance that the

industry's future experience will be no worse than its past experience over relevant time frames. (Indeed, the recent credit crisis and recession has resulted in significant credit spread widening in late 2008, at unprecedented levels).

- There are certain risks that do not necessarily lend themselves to modeling as part of a standard, industry-wide format and which therefore may not be adequately reflected in RBC, if at all. In particular, the following risks are currently not captured in the RBC formula: catastrophe risk, operational risk and the risk of spread widening for investments in bonds.[21] Moreover, the NAIC's RBC is not currently targeted toward a particular statistical level of safety (unlike Solvency II in Europe where the Solvency Capital Requirement would be defined as the amount of economic capital required to be held to limit the probability of ruin to 0.5%).[22]

Nonetheless, the NAIC's RBC initiative has enhanced the regulatory monitoring of the financial condition of insurers.

It should be noted that during the NAIC's development of RBC, repeated warnings were made by working group members that RBC was developed solely as a means to differentiate inadequately capitalized insurers from others. It was not the intent, nor did the working group seek to test, whether the formula would be effective in differentiating between adequately capitalized insurers. In fact, the model act includes language admonishing insurers from making announcements in any form about its RBC or that of its competitors.

Nonetheless, and as a practical matter, it has been our experience that it is not atypical for those in the industry, and even regulators themselves, to compare companies on the basis of RBC inasmuch as it is the only uniform, industry-wide, publicly-available and simply-grasped measure that purports to express the financial strength of insurers on a relatively common basis, adjusted however imperfectly for a company's scale and operational/risk profile.

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[21] Vaughan, Therese M., The Implications of Solvency II for U.S. Insurance Regulation, February 2009, p.12.

[22] Vaughan, Therese M., The Implications of Solvency II for U.S. Insurance Regulation, February 2009, p.4.

That said, RBC is not the only measure to be considered – just the only publicly-available and standardized industry-wide measure. There are other means to assess the adequacy of an insurer's surplus that are relevant to the MIA's interests in the CareFirst matter. These include the work of rating agencies, and internal risk modeling by insurers.

BCBSA Licensing Requirements: In addition to minimum surplus requirements per Maryland statute, CFI must also comply with Membership Standards adopted by BCBSA. Such standards were first adopted by BCBSA to become effective as of December 31, 1994.[23] Such time period immediately followed the financial difficulties involving GHMSI, CFMI and BCBS-WV as well as the related congressional investigations. Thus, just as the NAIC responded to criticism with its financial regulatory standards, BCBSA responded in kind with more stringent membership standards of its own. Albeit for different reasons, both sought to raise the bar and reduce the risk of future insolvencies.

Compliance with these standards is monitored by BCBSA's Plan Performance and Financial Standards Committee. However, the committee does not have authority to grant or terminate a plan's license and/or its membership in BCBSA. Rather, the committee makes a determination as to compliance with the standards and then recommends action to be taken to BCBSA's Board of Directors which may accept, reject or modify the recommendation. With some exceptions contained in license agreements, a plan's "licenses and membership may only be terminated on a three-fourths or greater affirmative plan and plan weighted vote."[24]

BCBSA's standards require a plan such as CFI, as the primary BCBSA license holder of the CareFirst group of companies, to furnish to BCBSA a calendar year-end Health Risk-Based Capital Report as defined by the NAIC. Depending on the reported RBC levels, there are certain implications with respect to a plan's compliance with the BCBSA standard that it be "operated in a manner that provides reasonable financial assurance that it can fulfill its contractual obligations to its customers."[25] Criteria to determine compliance include liquidity measures, compliance with state-mandated capital and surplus requirements, and RBC amounts. With respect to RBC, the trigger levels and

[23] Guidelines to Administer Membership Standards Applicable to Regular Members, p. 3.
[24] Guidelines to Administer Membership Standards Applicable to Regular Members, p. 4.
[25] Guidelines to Administer Membership Standards Applicable to Regular Members, p. 20.

licensing implications relative to that standard require the plan to maintain capital and surplus greater than or equal to 200% of the NAIC's ACL RBC after covariance; noncompliance would subject the plan to immediate termination of its BCBSA license and membership.[26]

Monitoring by the Association: Intensified monitoring by the Association begins when RBC falls below 375% (the BCBSA Early Warning Level). For some Plans which are part of large holding company structures (CareFirst falls into this category), additional monitoring procedures can be initiated when RBC falls below 500%.[27] However, if the primary licensee (CFI in this case) has greater than 500% ACL RBC, it could have a subsidiary or affiliate whose individual company RBC is as low as 300% ACL RBC without triggering intensified monitoring by BCBSA.

CareFirst has advised us that such monitoring procedures include the following:

- Initial inclusion of a Blue Plan by the Plan Performance and Financial Standards Committee (PPFSC; a standing BCBSA Board committee comprised of nine member Plan CEOs and three independent members) in intensified monitoring generally occurs when a Plan's HRBC ratio falls below 375%. A Plan may also be included in intensified monitoring if its liquidity levels fall below two months of claims and administrative expenses for two consecutive quarters. In every case the PPFSC considers the Plan's current and projected HRBC and liquidity ratios as well as the specific circumstances of the situation.

- Upon action by the PPFSC, a letter is sent to the Plan's CEO with follow-up copies to the Plan's Board of Directors explaining the reasons for the PPFSC's action and next steps. This letter offers, at the Plan's option, a meeting by PPFSC representatives with the Plan's Board. The PPFSC's action is also reported to the BCBSA Board.

- A Plan included in intensified monitoring is required to provide BCBSA with an action plan on how it intends to improve its surplus position, and cooperate with requests from BCBSA for additional financial information, financial forecasts, and on-site visits with company management. Further, the Plan is required to

[26] Guidelines to Administer Membership Standards Applicable to Regular Members, p. 20.
[27] February 8, 2007 memorandum from Lester C. Schott, Associate Commissioner Examination and Auditing re: CareFirst of Maryland Surplus Analysis, p. 2.

provide BCBSA with an annual certification for adequate accounting for unpaid claim liabilities, actuarial liabilities and related items issued by a qualified, independent actuary. Finally, the Plan is required to make certain disclosures to providers, accounts and direct pay subscribers, including its year-end audited balance sheet.

- BCBSA uses all available information to make an informed assessment of the Plan's progress in correcting the situation and ability to remain in compliance with the licensure minimum capital requirement. If this assessment is negative and the Plan's surplus or liquidity continues to worsen, the PPFSC may elect to move the Plan to a higher level of intensified monitoring. Generally this occurs when a Plan's HRBC ratio falls below 300% or 1.5 months of liquidity, but again there are subjective considerations. At this level of intensified monitoring the process indicated above is repeated and may include more frequent on-site visits by BCBSA as well as a mandatory meeting with the Plan's Board of Directors.

- At any point in the process, the PPFSC may request a meeting with the Plan's regulator.

- In order to retain its license from BCBSA to use the BLUE CROSS and/or BLUE SHIELD Brands, a Plan must maintain an HRBC ratio of at least 200%, the "Licensure Minimum" capital requirement. If a Plan's HRBC ratio were to fall below 200%, BCBSA's Board of Directors (composed of the CEOs of the Plans) would commence actions to terminate that company's license to use the Blue Brands.

BCBSA's guidelines note the following caveat with respect to the use of RBC as a measure of surplus adequacy:

> "The HRBC calculation was designed by the [NAIC] to estimate the minimum statutory level of required capital and is used by BCBSA to determine compliance with BCBSA's minimum HRBC requirement, established PPRP monitoring thresholds and other requirements and protocols. Given that the HRBC calculation is a retrospective formula, it does not take into account the potential impact of future events (developing market challenges or constraints, investments in technology, unexpectedly high claims, changes in business mix, potential acquisitions or divestitures, etc.) that may have a significant impact on the HRBC of a Plan. Additional capital may be needed to protect against events not

otherwise accounted for in the HRBC formula and BCBSA encourages Plans to maintain surplus well above the required HRBC minimum. HRBC was not designed, calibrated or intended for use in determining excess levels of capital."[28]

We agree with the caveat; HRBC does have certain limitations. Furthermore, and based on our own monitoring of actions of the NAIC's working groups involved in development of RBC and HRBC over the years, it is true that these regulatory tools were not developed with a focus on determining excessive levels of capital and surplus.

Influence of Rating Agencies in Determining Surplus Levels: Rating agencies have played an important, influential and evolving role relative to the insurance industry. The role of rating agencies has also been subjected to increasing levels of scrutiny, both by the NAIC and by federal agencies such as the Securities and Exchange Commission. The Nationally Recognized Statistical Rating Organizations that are both registered with the SEC and extensively involved in ratings of insurers are as follows:

- A.M. Best Company, Inc.
- Fitch, Inc.
- Moody's Investors Service, Inc.
- Standard & Poor's Ratings Services

Each of these rating agencies uses industry research and proprietary models in developing their own assessments either of an insurer's strength and claims-paying ability and/or of the credit standing of the insurer or its debt-issuing parent or affiliates. We understand that the agencies utilize an extensive peer analysis. We also understand that their models, which continue to evolve, address the significant risks facing the enterprise, such as credit, market, liquidity, reserving (setting the unpaid claim liability amount) and operational risks.

Capital adequacy is certainly a consideration for rating agencies. For example, FitchRatings' "Criteria Report" for analyzing the credit quality and financial strength of

[28] Guidelines to Administrer Membership Standards Applicable to Regular Members, p. 20.

U.S. heath insurance and managed care companies includes a financial review.[29] One of the four main segments of the financial review is an assessment of capital adequacy.[30]

The rating agencies assign a rating based upon their assessment of the company's financial strength. The work of the rating agencies is less transparent in that their models remain proprietary whereas the NAIC's RBC formula is publicly available. Some criticisms have been made about the rating agencies, e.g., with regard to their ability or willingness to change ratings on a timely basis in response to developments involving a company. Nonetheless, in our experience the rating agencies play an undeniably important role within the insurance industry:

- Agents, brokers and consultants often look to ratings to assure their clients that their insurance business is being placed with financially sound companies.
- Insurers consider each others' ratings, for example, in evaluating reinsurance and counterparty risks.
- Even regulators themselves monitor changes in ratings inasmuch as the rating agencies offer an additional perspective and may have more resources and/or be timelier in responding to new developments at a company or within the industry.
- While insurers must comply with regulatory requirements, they are very attuned to the expectations of rating agencies and how those expectations change over time; insurers spend a considerable amount of time and attention in attending to the data and information needs of rating agencies and in explaining their strategies and operations to analysts so as to attain the highest rating possible in light of its market and competitive situation.

Company-Specific Models To Evaluate Capital And Surplus Needs: What others may do to evaluate an insurer's surplus – the NAIC or rating agencies, for example – should be secondary. What is far more important in our view is what a company and its board does to evaluate the amount of capital and surplus, to monitor changes in conditions that might impact that over time, and to assure that the insurer remains not only viable, but sustainable over the long haul notwithstanding that unexpected losses will surely occur

[29] FitchRatings Criteria Report, U.S. Health Insurance and Managed Care Rating Criteria, March 2, 2007, p. 6.
[30] FitchRatings Criteria Report, U.S. Health Insurance and Managed Care Rating Criteria, March 2, 2007, pp. 6-7.

and which may, however infrequently, be material to the company's financial condition and potentially threaten its financial soundness.

In such evaluations, there is much more involved than simple reliance on regulatory or industry measures of capital and surplus. Enterprise Risk Management, or ERM, encompasses a wide range of activities and involves the board and key financial and operating personnel throughout the company. Key aspects of ERM include the following:

1. Risk identification and monitoring
2. Risk assessment and prioritization
3. Risk mitigation
4. Risk appetite determination
5. Risk aggregation, measurement and reporting
6. Overarching governance through senior-level committees and board involvement

ERM is very much an evolving practice and different insurers are at different places along the learning and experience curve. CareFirst appears to be reasonably along the path based on our experience, and we have seen evidence that the company has processes in place that address each of these items at least to some degree. With respect to risk measurement, we have learned that CareFirst does not perform an economic capital or similar analysis directly; rather, it has engaged Milliman to provide an independent analysis of an appropriate range of surplus for GHMSI and for CFMI.

Milliman's work and our assessment thereon with respect to the subject CareFirst matter are discussed later in this report. Our view about the need for such company-specific models from a general perspective is that they are useful if not necessary, increasing in prominence within the industry, and increasingly being considered as an integral part of the ongoing process to enhance state insurance regulation. We also believe that the use of models should not supplant the use of good judgment and common sense. Models might purport to determine a single answer, but they are perhaps most valuable in sharpening the questions asked, and in providing more insight that must then be considered with the benefit of sound judgment and prudent governance.

In her paper to the Networks Financial Institute at Indiana State University, the NAIC's Chief Executive Officer evaluated *The Implications of Solvency II for U.S. Insurance Regulation.* She noted the following:

> "Model risk can be significant. Criticisms of internal models are rampant today, with critics focusing on the structure of the models..., the inputs into the model (tending to be too optimistic, because they relied too heavily on recent good experience), the assumption that the past can fully predict the future, the failure to account for extreme changes in correlations in times of turmoil, the tendency of the firms and their models to ignore certain risks that turned out to be important in retrospect, (e.g., liquidity risk)...
>
> ...there are many of us that have strongly believed that many of the directions towards internal models are theoretically correct, and yet we find ourselves in the position that empirical evidence actually indicates that the companies that would have been at the top of most professionals' lists of the best run, most sophisticated, entities with the most cutting edge risk management two years ago nonetheless have tended to be those that are now making the headlines and requiring the largest inflows of new capital, whether private or governmental."[31]

Comments such as these reflect the conservatism that is the inherent nature of insurance regulation in the U.S. and provide an apt context with which any review of such models performed for CareFirst should be reviewed, particularly in light of the recent experience of the credit crisis and recession and their lingering effects.

[31] Vaughan, Therese M., The Implications of Solvency II for U.S. Insurance Regulation, February 2009, pp. 15-16.

TAB 6

6. PEER ANALYSIS

Background on the Blue Cross Blue Shield Plans ("Blue Plans"): Part of our assignment called for us to perform peer analysis, i.e., to identify companies similar to GHMSI and CFMI and to compare their surplus and related metrics to that of the peer companies. The result of that analysis is summarized in this section. Just as there are unique aspects of the corporate structure and operations of CareFirst, so too there are nuances of other nonprofit Blue Plans that can diminish comparability across plans. Nonetheless, the analysis served as a diagnostic tool to ascertain if CFMI or GHMSI exhibited external signs of excessive surplus relative to their peers, and as a means to corroborate our final ranges of appropriate surplus amounts for both companies which were independently developed leveraging Milliman's analysis as described in the following section of our report.

The top 20 Blue Plans in the aggregate insure more than 94 million members[32] and thus have a strong presence within their respective regional health insurance markets. As of the end of the first quarter of 2009, CFI was ranked as the 11th largest of the 36 BCBSA licensees based on reported annual premium of the CareFirst affiliated group.

Blue Plans can differ dramatically in terms of size, geographical market coverage, product offerings, and organization type. They span from WellPoint, Inc., the largest and among the most diversified U.S. health insurers operating nationwide with 35 million members and $56 billion in annual premium, to BlueCross BlueShield of Vermont, a very small single-state nonprofit health insurer which writes only $429 million in annual premium albeit with a dominant 70% market share.

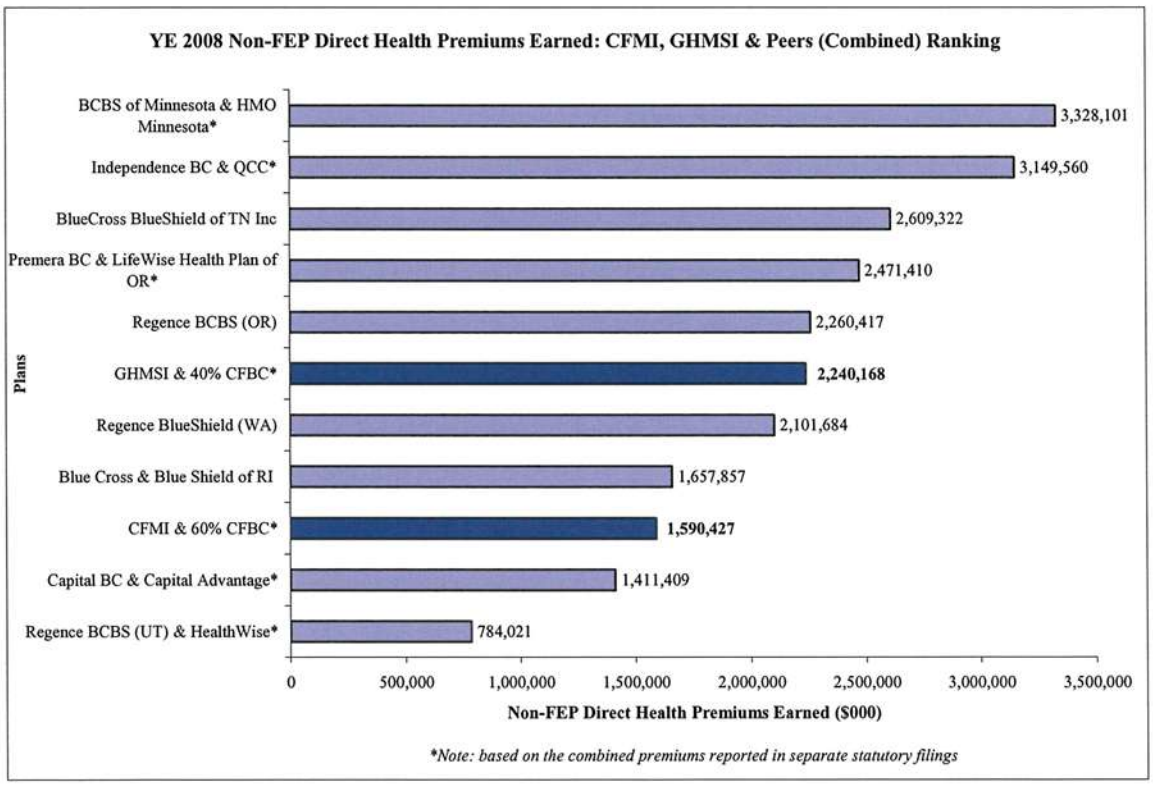
The nonprofit Blue Plan universe is similarly diverse. They consist of some of the largest Blue Plans – including Health Care Service Corporation, Highmark, Inc., Blue Cross Blue Shield of Michigan, Blue Cross and Blue Shield of North Carolina, Blue Cross and Blue Shield of Florida, and Horizon Blue Cross Blue Shield of New Jersey – as well as numerous mid-sized regional nonprofit and mutual insurers and small, often rural health insurers. Examples of the mid-sized regional plans include The Regence Group, Excellus BlueCross BlueShield, and Independence Blue Cross. Blue Plans also vary by the types

[32] BCBSA website.

and extent of business that they write, such as group versus individual coverage, and by lines of business, i.e., long term care, Medicaid, worker's comp, etc.

These important distinctions can have a significant impact on Blue Plan profitability and financial stability. For example, nonprofit Blue Plans with a high proportion of large group business have experienced pressure on earnings due to tightening pricing and fall-out from the economic downturn.[33] By contrast, Blue Plans with dominant market share in rural areas have fared better and have maintained stronger profitability.

Peer Group Selection: The following chart ranks CFMI and GHMSI on the basis of 2008 Non-FEP direct earned premiums along with those of other Blue Plans that we have determined to be in a representative peer group:



GHMSI and CFMI are mid-sized nonprofit Blue Plans and write significant amounts of group business as well as individual business. We have determined a peer group of Blue Plans with similar characteristics, comprised of mid-sized Blue Plans operating in competitive markets. We considered mid-sized Blue Plans as those ranging from $500

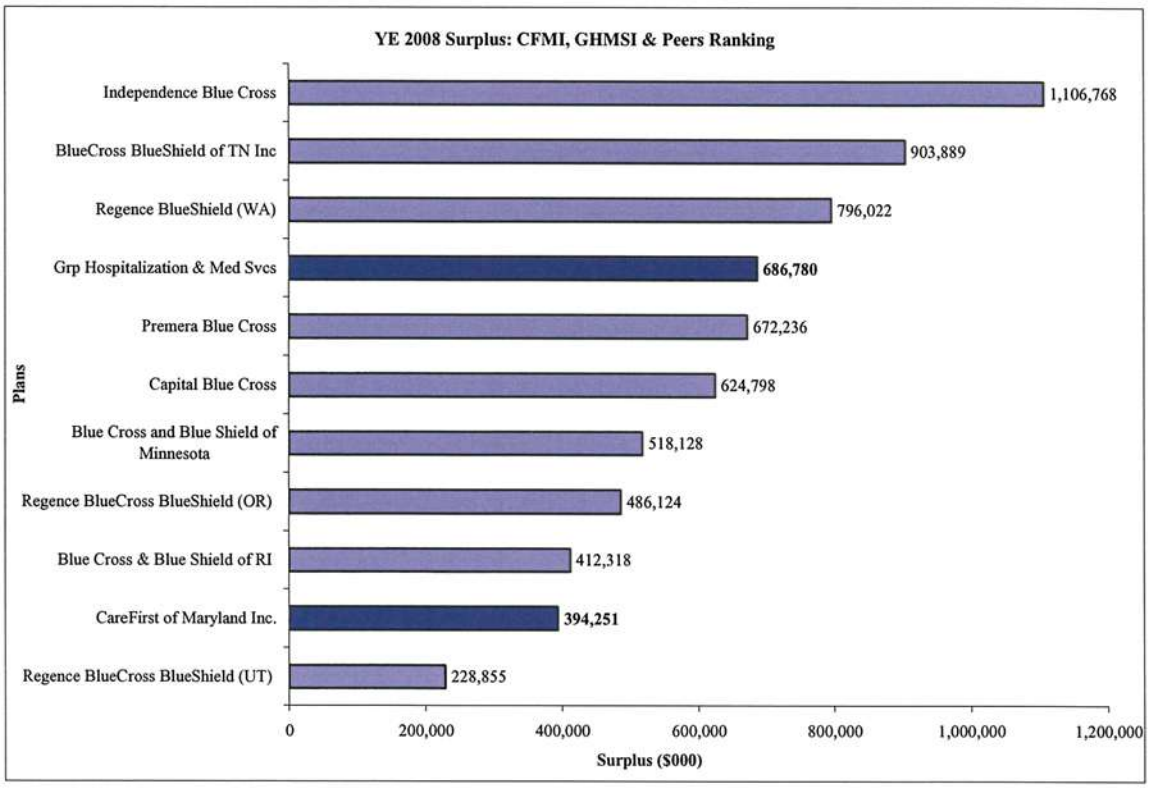
[33] AM Best Report August 2009.

million to $3.5 billion in Non-FEP health premiums earned (by operating entity), and a competitive market to exist if the Blue Plan's market share is less than 65% of total premiums written within its market territory. These peers have also been selected on the basis of their organizational form, as they are all nonprofit (or stock subsidiaries of larger nonprofit Blue Plans).

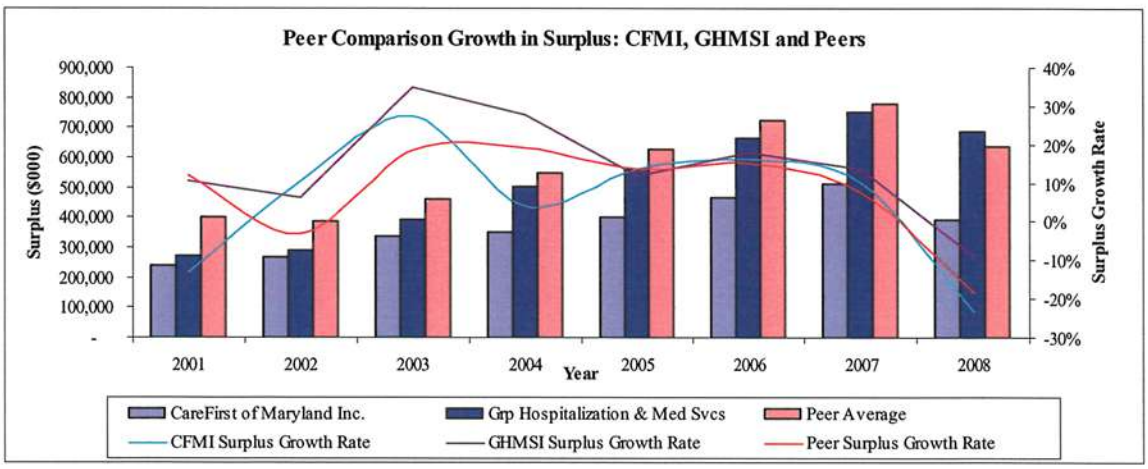
HMO premium was also factored into our peer selection given the importance of CFBC to CFI. When adding this as a consideration, some candidates such as QCC Insurance Company, Keystone Health Plan East, Inc. and Capital Advantage emerged as potential peers. These operating entities are subsidiaries of larger Blues Plans. Some of the businesses of these larger Blues Plans were not selected given their lower resemblance to CFMI and GHMSI (for example, Keystone Health Plan East, Inc. with $4 billion of premium in 2008 was excluded because approximately one half of that is Medicare business). While we included the QCC Insurance entity, we did not include other entities within the Independence Plans. Our rationale was similar to that which we applied across the various plans, which was to isolate entities that were most similar to those of the CareFirst group, and not dissect parts of entities with similar lines of business. As a result, the peers are a mixture of single entities and combined entities – but not separate lines of businesses within an entity.

Each peer generated premium in 2008 in a range considered comparable to CFMI and GHMSI (50% to 200%) and while their lines of business are not fully comparable, they compare closely to CFMI and GHMSI.

Peer Comparison Growth in Surplus – CFMI, GHMSI and Peers: The following chart compares surplus across the peer group of companies selected by Invotex with CFMI and GHMSI. In this chart, the surplus of a Blue Plan's HMO subsidiary is effectively included in surplus of the parent through statutory accounting principles; by those same principles, surplus of a Blue Plan's HMO affiliate is excluded from the parent's surplus. In the case of CFMI and GHMSI, surplus for each shown in the chart below includes their respective share of the surplus of CFBC and is as reported by CFMI and GHMSI in their year-end 2008 annual statements filed with regulatory authorities.



As can be seen above, CFMI is at the lower end of the peer group in terms of the absolute value of surplus. GHMSI is closer to the upper end, but does not appear to be an outlier based on this analysis. As the following table demonstrates, GHMSI's surplus had consistently been below the average of the peer group until 2008. At year-end 2008, GHMSI's surplus approximated the average for the peer group.



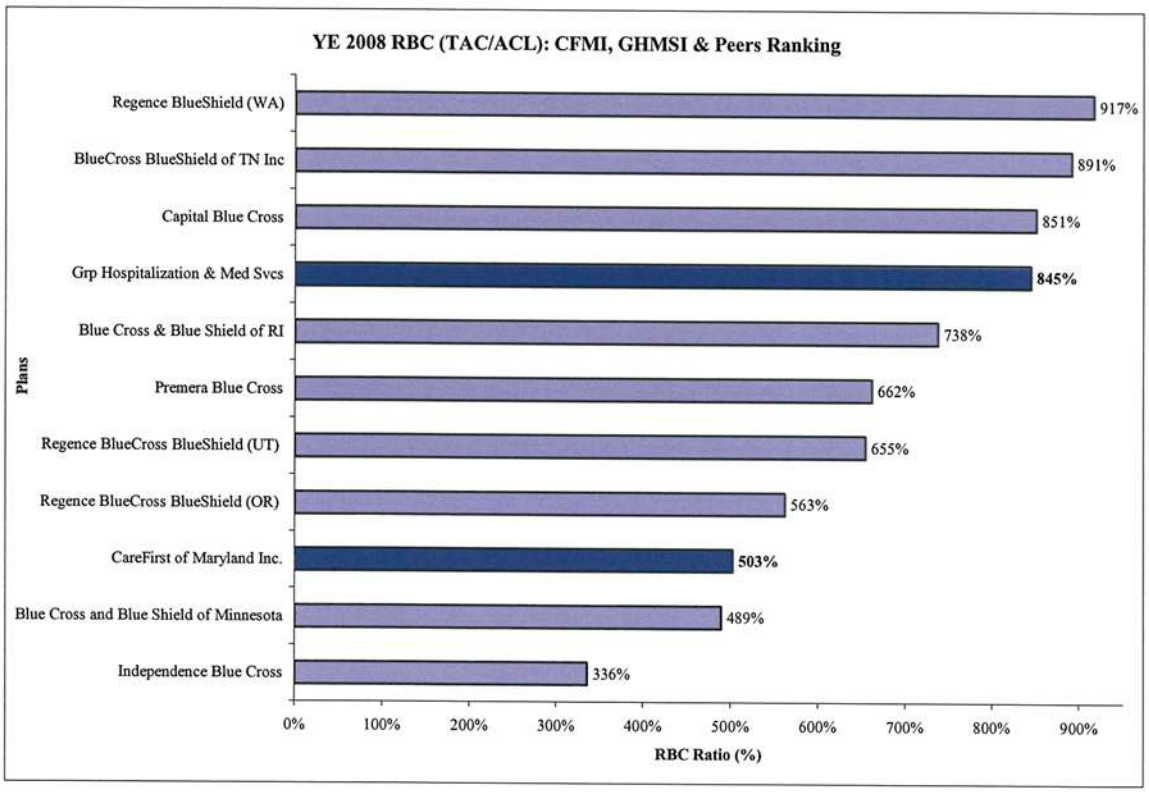
Surplus ($000)	2001	2002	2003	2004	2005	2006	2007	2008
CareFirst of Maryland Inc.	239,793	265,503	338,469	352,445	400,659	466,648	513,480	394,251
Grp Hospitalization & Med Svcs	273,984	290,773	392,008	501,014	560,967	663,006	753,559	686,780
CFMI Surplus Growth Rate	*-13%*	*11%*	*27%*	*4%*	*14%*	*16%*	*10%*	*-23%*
GHMSI Surplus Growth Rate	*10%*	*6%*	*35%*	*28%*	*12%*	*18%*	*14%*	*-9%*
Independence Blue Cross	689,628	707,106	840,917	1,038,534	1,186,958	1,411,621	1,490,401	1,106,768
BlueCross BlueShield of TN Inc	614,088	602,542	648,369	787,242	907,948	936,119	1,152,585	903,889
Regence BlueShield (WA)	411,644	345,639	500,955	618,116	716,582	880,928	924,880	796,022
Premera Blue Cross	328,989	311,613	373,072	445,991	525,447	661,486	783,895	672,236
Capital Blue Cross	610,662	518,779	515,477	564,309	658,120	794,006	797,570	624,798
Blue Cross and Blue Shield of MN	403,466	494,833	608,412	691,771	692,929	712,646	645,660	518,128
Regence BlueCross BlueShield (OR)	266,275	235,608	282,180	366,437	466,860	533,543	552,188	486,124
Blue Cross & Blue Shield of RI	*197,269*	*206,684*	*261,482*	*286,530*	*315,902*	*371,768*	*428,810*	*412,318*
Regence BlueCross BlueShield (UT)	99,892	83,280	124,639	159,482	179,389	215,554	237,721	228,855
Peer Average	*402,435*	*389,565*	*461,723*	*550,935*	*627,793*	*724,186*	*779,301*	*638,793*
Peer Surplus Growth Rate	*12%*	*-3%*	*19%*	*19%*	*14%*	*15%*	*8%*	*-18%*

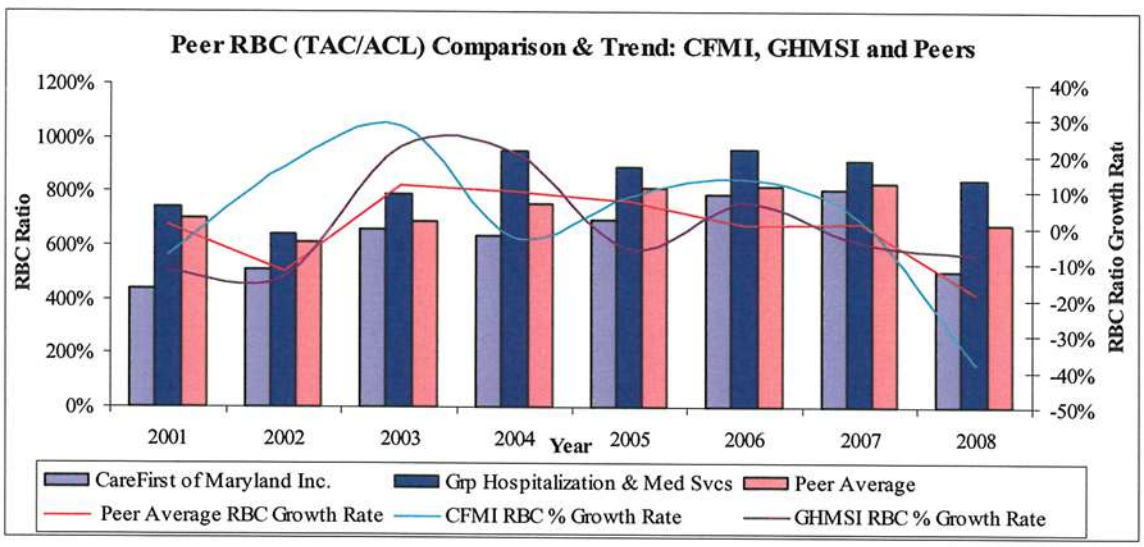
CFMI, GHMSI and their peers have grown their respective surplus positions substantially over the past eight years which helped to cushion the impact of capital losses that they experienced in 2008. Peer average surplus has grown at an average annual rate of 8% from 2001-2008 notwithstanding the $141 million (18%) reduction in surplus experienced in 2008 attributable to capital losses.

CFMI's 23% reduction (by $119 million) in surplus in 2008 exceeded that of its peers on a relative basis, caused by higher-than expected medical losses and the disruption in the global financial markets. In contrast, GHMSI's capital loss was less severe than that of CFMI and its peers both in percentage and dollars terms.

During the period of 2001-2007, both CFMI and GHMSI experienced a greater average annual growth rate than the peer group. CFMI's and GHMSI's surplus grew 114% and 175%, respectively, versus the peer group average of 94% during that period. Their surplus positions going into 2008 enabled CFMI and GHMSI to weather the adverse effects on surplus of mispricing and the financial crisis.

Peer RBC (TAC/ACL) Comparison & Trend: CFMI, GHMSI and Peers





RBC Ratio	2001	2002	2003	2004	2005	2006	2007	2008
CareFirst of Maryland Inc.	438%	513%	657%	638%	694%	790%	808%	503%
Grp Hospitalization & Med Svcs	744%	643%	787%	951%	893%	955%	916%	845%
CFMI RBC % Growth Rate	*-8%*	*17%*	*28%*	*-3%*	*9%*	*14%*	*2%*	*-38%*
GHMSI RBC % Growth Rate	*-12%*	*-14%*	*23%*	*21%*	*-6%*	*7%*	*-4%*	*-8%*
Regence BlueShield (WA)	746%	631%	746%	985%	1222%	1247%	1145%	917%
BlueCross BlueShield of TN Inc	1098%	1022%	1181%	1198%	1206%	1100%	1311%	891%
Capital Blue Cross	1409%	1031%	929%	926%	758%	771%	866%	851%
Blue Cross & Blue Shield of RI	452%	460%	548%	538%	614%	685%	762%	738%
Premera Blue Cross	420%	406%	433%	509%	565%	807%	814%	662%
Regence BlueCross BlueShield (UT)	664%	466%	652%	720%	822%	816%	773%	655%
Regence BlueCross BlueShield (OR)	446%	385%	478%	706%	964%	820%	745%	563%
Blue Cross and Blue Shield of Minnesota	689%	764%	819%	811%	753%	666%	596%	489%
Independence Blue Cross	361%	359%	392%	404%	413%	463%	458%	336%
Peer Average	*698%*	*614%*	*686%*	*755%*	*813%*	*819%*	*830%*	*678%*
Peer Average RBC Growth Rate	*1%*	*-12%*	*12%*	*10%*	*8%*	*1%*	*1%*	*-18%*

CFI is projecting that its consolidated RBC will decline by year-end 2009 based upon results through June 30, 2009, a function of its continued underwriting losses at CFMI and additional non-admitted assets. RBC on a weighted average basis for all nonprofit Blue Plans has also decreased recently, from 783% in 2007 to 700% in 2008.[34]

In 2008 the peer group experienced a downward trend in RBC from the period average high of 830% ACL RBC in 2007. In 2008, peer group RBC ranged from 336% ACL RBC (for Independence Blue Cross) to 917% (for Regence BlueShield - WA) and averaged 678% ACL RBC. GHMSI and CFMI fall within this range, although GHMSI (at 845% ACL RBC) is at the higher end, while CFMI (at 503% ACL RBC) is at the lower end of the range. Importantly, while GHMSI exceeds the peer average of ACL RBC, neither GHMSI nor CFMI appear, based on that measure, to hold surplus above the norm for the peer group.

In 2006, two of the 9 peers – BCBS Tennessee and Regence Blue Shield (WA) reported in excess of 1100% ACL RBC. By 2008, no peer reported RBC above 1000% ACL RBC. Nevertheless, three peers – Capital Blue Cross, BCBS Tennessee and Regence Blue Shield (WA) – maintained RBC in very close proximity to that of GHMSI. The remaining six peers reported RBC of 738% or less, with the majority (7 of 9 peers) in a solid RBC range of 563% or better. At RBC of 503%, CFMI is at the low end of its peers in 2008.

[34] Oppenheimer Equity Research Industry Update, Health Care/Managed Care, July 1, 2009.

One peer, Independence Blue Cross (IBC), is an outlier with 336% ACL RBC at December 31, 2008, a relatively low amount compared to our peer group. At that level, IBC is below the BCBSA Early Warning Monitoring Level of 375%.

Other Measures of Capital Adequacy:

Reserves / Surplus

Company	2004	2005	2006	2007	2008
CareFirst of Maryland Inc.	85.4%	72.5%	68.5%	51.3%	80.7%
Grp Hospitalization & Med Svcs	145.7%	138.4%	123.9%	100.4%	118.1%
CFMI and GHMSI Average	*115.6%*	*105.4%*	*96.2%*	*75.8%*	*99.4%*
Peer Average	*54.4%*	*53.7%*	*47.9%*	*45.8%*	*54.1%*

Premiums / Surplus

Company	2004	2005	2006	2007	2008
CareFirst of Maryland Inc.	376.36%	344.44%	299.90%	279.72%	463.82%
Grp Hospitalization & Med Svcs	405.66%	402.22%	370.51%	373.56%	399.55%
CFMI and GHMSI Average	*391.01%*	*373.33%*	*335.21%*	*326.64%*	*431.68%*
Peer Average	*294.56%*	*289.57%*	*274.57%*	*273.93%*	*333.73%*

Another means commonly used to evaluate surplus adequacy is operating leverage which is often measured on the basis of Net Premiums/Surplus and of Reserves/Surplus. In this context, "reserves" refers to unpaid claim liability; in the calculation of premiums/surplus in the above chart, "premiums" include that for the legal entity only – i.e., it excludes that of HMO affiliates – and include FEP premiums. On the basis of both of these measures of surplus adequacy, CFMI and GHMSI have higher leverage than their peers and this became more pronounced with CFMI's surplus decline in 2008.

Federal Employee Health Premiums Earned to Total Health Premiums Earned as of 06.30.09

Company	Total Health Prem Earned ($000)	FEP Prem Earned ($000)	Non-FEP Business ($000)	% Business FEP
CareFirst of Maryland Inc.	710,171	426,406	283,765	60%
Grp Hospitalization & Med Svcs	1,579,818	739,649	840,170	47%
CFMI & GHMSI Average	*1,144,995*	*583,027*	*561,967*	*53%*
Peer Average	*914,950*	*127,279*	*787,672*	*23%*

The higher leverage is thus attributed to the higher proportion of FEP business which is written by CFMI and GHMSI compared to the peer group. FEP business carries very

little underwriting risk, and if FEP premiums were excluded from the aforementioned premiums/surplus chart, CFMI and GHMSI would show less leverage than their peers.

Conclusions from Peer Review: Based solely on our peer analysis, it appears that CFMI and GHMSI have relative amounts of surplus comparable to their peers. GHMSI's surplus on a relative basis is near the higher end of the peer group, whereas CFMI's is near the lower end.

As discussed elsewhere in this report, the CareFirst group corporate structure and the terms of the Intercompany Agreement expose both GHMSI and CFMI to the risk of intercompany funding requirements should there be a shortfall in liquidity or surplus. The avenue that is provided for such cross-entity funding to occur is through the Intercompany Agreement, and any such funding would require repayment and regulatory approval, neither of which can be assured. Thus we viewed each of CFMI and GHMSI on a stand-alone basis, and on that basis their surplus appears comparable to their peers.

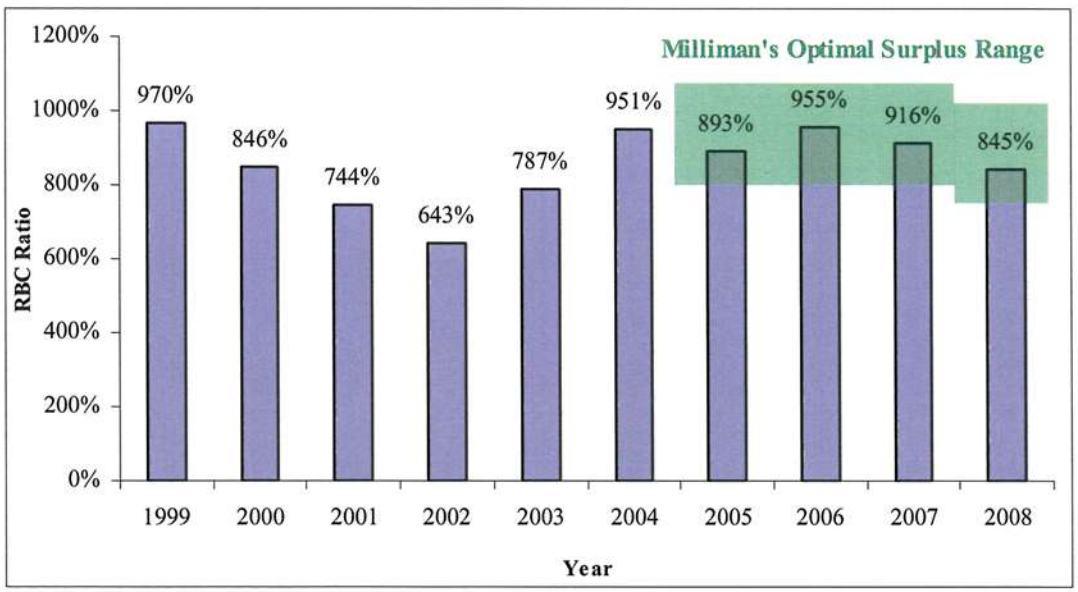
In sum, our peer review did not discern signs of excess surplus on the part of CFMI or GHMSI when viewed relative to their peers. Our peer review also serves to corroborate our selection of a targeted surplus range for CFMI and GHMSI, as described in later sections.

TAB 7

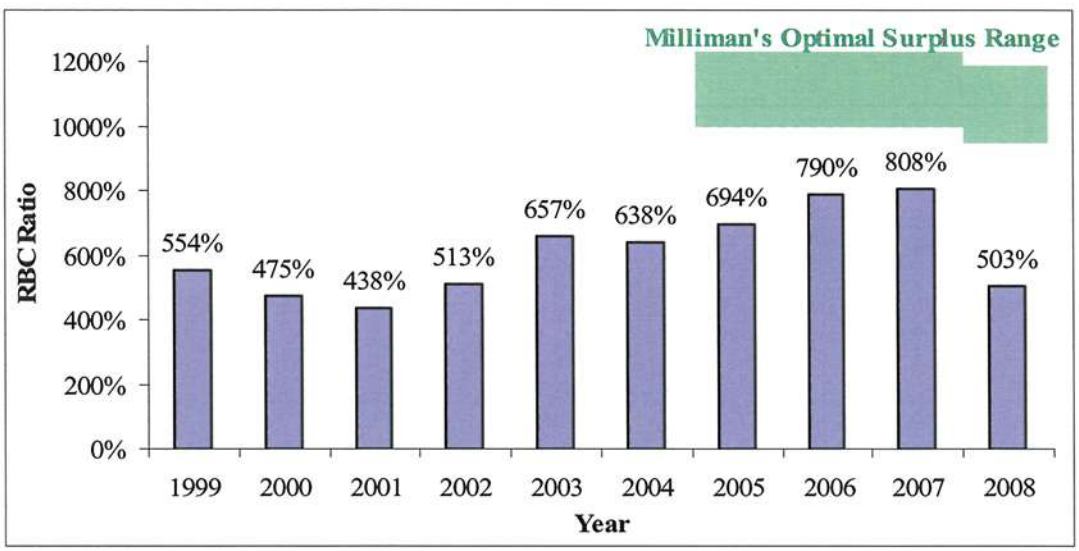
7. ASSESSMENT OF MILLIMAN'S STUDY

With respect to an internal review of surplus, CareFirst engaged Milliman to perform an independent assessment of an appropriate range of surplus. Milliman's first reports on the surplus levels of CFMI and GHMSI were issued in May and March 2005, respectively, followed by updated analyses for each plan, both issued in December 2008. Milliman's results, compared with the reported surplus levels of each plan, are as follows:

GHMSI Historical RBC Ratio with Milliman Recommended Ranges



CFMI Historical RBC Ratio with Milliman Recommended Ranges



The MIA provided us with Milliman's reports summarizing their analyses of the targeted surplus levels for CFMI and for GHMSI; such reports had been made public with CareFirst's permission. Milliman also provided us with confidential supporting documentation, and we were able to meet with Milliman's consultants at their offices in Wayne, PA on August 27-28, and again on October 12, 2009. In all respects, Milliman was cooperative and reponded to our questions.

The primary body of Milliman's work resulted in a frequency distribution leading to the likelihood of surplus loss at various confidence levels. This was accompanied by reviews of historical data of each of CFMI and GHMSI as well as of a set of peer Blue companies, determining the levels of underwriting losses over a period of several decades. This secondary analysis was used by Milliman as a reasonableness check against their more theoretical and forward-looking approach. Our summary focuses on the theoretical approach inasmuch as that is the methodology that drove Milliman's conclusions as to target surplus ranges.

The approach taken has been used by Milliman in other similar analyses involving other Blue Cross and Blue Shield plans, and is quite sophisticated. It is not the only approach that could have been used in this situation; we believe it is likely that other approaches could have been utilized to reach similar results. We focused on developing a sound understanding of the approach utilized by Milliman rather than developing a separate independent methodology. Milliman's approach and their conclusions as to the targeted surplus ranges for GHMSI and CFMI is the basis for CareFirst's management's assertions as to those ranges. By focusing on Milliman's work directly we were able to ascertain whether the approach relied upon by CareFirst's management and the underlying assumptions were reasonable. In addition, our approach provided certain efficiencies to the project in that we were able to leverage Milliman's ability to re-run their model so as to test variances from use of alternate assumptions selected by Invotex, and to more directly compare and analyze the results.

Milliman made use of Monte Carlo Simulations, a tool that selects a large number of random numbers and backs into values (in this case the amount of loss over a loss cycle), each with an associated probability. The tool is useful in integrating a number of random variables, in this case categories of risk, when it is difficult to combine them

algebraically. The alternative approach is to use a Scenario Model, or Deterministic Model. The advantages of Monte Carlo include having a mathematical and repeatable basis for any conclusions, and in having a likelihood associated with each outcome. The disadvantages include the need to select a probability distribution for each risk category, and the overall complexity and the lack of transparency in the assumptions and methodology. A scenario model is simpler to understand but may appear to be more judgmental. Both approaches rely on selecting the appropriate risks and sizing them in a reasonable way.

Assumptions Utilized in Milliman's Analysis: Certain key high-level assumptions are utilized by Milliman in their analyses:

- Surplus Floor: Milliman is setting the bar at 200% or 375% ACL – in other words, they aim for a surplus target range that is high enough so that at the remote end the company is assured that it will not trigger regulatory action or lose the use of the BCBSA trademarks (200% of ACL RBC) or otherwise incur intensive monitoring or other sanctions by the BCBSA (375% of ACL RBC).

- Trend Test: As described later in this report, we note that Milliman did not consider the NAIC's new HORBC trend test trigger for Company Action Level, i.e., ACL RBC between 200% and 300% with a combined ratio greater than 105%. When we brought the new trend test to Milliman's attention, they confirmed that they had not previously evaluated its impact. At our request, they did so, and informed us that as long as BCBSA does not modify the loss of trademark threshold from the current 200% of surplus level, the impact of the trend test on Milliman's analysis would be minimal. In the absence of a change in the loss of trademark standard, Milliman would assign the new trend test a confidence level at about the 95th percentile, rather than the 98% that they applied to the 200% threshold in their current analysis. Milliman tested the impact of a 300% threshold with 95% confidence, and concluded that it would not affect their target surplus range for either GHMSI or CFMI. If, on the other hand, BCBSA were to adopt a loss of trademark policy for companies that were to fail the trend test, Milliman believes that the surplus target range would need to be increased to reflect the impact of that standard. Therefore Milliman would propose that the surplus target ranges should be re-evaluated if BCBSA were to adopt such a change.

While the new trend test will be included in year-end 2009 filings, it will have no effect until Maryland's HORBC requirement is changed. The corresponding NAIC model law is still being revised, at which time a seasoning period takes place and only then could it be considered for adoption as an NAIC accreditation standard (although Maryland would not have to wait for that to occur to implement the trend test). States have several years to adopt new accreditation standards, thus it may be a number of years before the trend test is in effect in Maryland. Our view is that it is appropriate for the evaluation of the appropriate amount of surplus for CFMI and GHMSI to exclude consideration of the new trend test until 1-2 years prior to the date by which it is expected to be enacted in Maryland. Thus, we have proposed no adjustments to Milliman's targeted surplus ranges relative to the trend test.

- Loss Distributions: Many of the probability-of-loss distributions for the 12 key risks are based on Milliman's collective judgment and other assumptions are based on company-specific analysis. All of the 12 key risk categories are assumed to be independent of each other except for premium rate adequacy and UCL adequacy.

- Inclusion of CFBC's Business: The direct business of each of CFMI and of GHMSI and their respective proportionate share of CFBC were treated as a single combined business segment, a simplification which assumes that funds from one segment (e.g., CFBC) are available for the other segment (e.g., either CFMI or GHMSI as applicable). As described further in this report, we do not believe that assumption is completely realistic given certain structural and regulatory restrictions involving these companies. As a consequence, we have included an additional margin in our determination of an appropriate amount of surplus for both of CFMI and GHMSI.

- Intercompany Agreement: The intercompany surplus guarantee provision of the Intercompany Agreement was not explicitly considered by Milliman, either as a risk to either of CFMI or GHMSI on the one hand, or as a contingent source of funds on the other. Milliman's view is that if either GHMSI or CFMI were to experience financial difficulty, the other likely would as well at the same time; consequently, there wouldn't be an excess of surplus in one company that could be tapped to offset a deficit in another. Milliman also is concerned that regulatory approvals that would be required to effectuate the needed surplus transfer would

be delayed if forthcoming at all, despite prior regulatory approvals of the Intercompany Agreement. Indeed, the Intercompany Agreement was recently amended to require that any transfers of funds be subject to regulatory approval and that any transfers either be "legally permissible investments in subsidiaries, or documented loans which will be paid back to the transferor." Therefore, and should either CFMI or GHMSI need surplus relief from the other, that would have to be in the form of a surplus note which would require the entity contributing the funds to subordinate its rights to those of policyholders of the receiving party. Regulatory approval would involve a review of the facts and circumstances at the time and action by regulators of two states; there is no assurance that such regulatory approval would be granted.

- Effects of Income Taxes on Loss Scenarios: The loss amounts being modeled are not reduced for the effect of federal income tax. Milliman's analysis and their application of downside scenarios through pro forma financial statements aim to demonstrate that, if GHMSI/CFMI started with the indicated targeted surplus and the projected risks/losses developed, that GHMSI and CFMI (taken separately) would stay above the BCBSA RBC requirement over the down cycle. In those pro formas, the projected losses are not tax-effected because CFI made an election with its 2008 consolidated return to forego the carryback period that it would otherwise have been entitled to as a result of losses generated in 2008. We further understand that similar elections could again be made in the future for a variety of reasons. . As a result, CFI will not be carrying back losses and instead will recognize a tax benefit going forward as taxable gains are realized. Our view is that management's position to not tax effect the scenarios has some merit; nonetheless, we believe that it is reasonable to expect some years when, if losses occurred, the company would be able to report a tax benefit. Inasmuch as the determination of a surplus range is a long-term view, we therefore have included an adjustment to tax-effect the loss scenarios at 10%, which is half of the 20% AMT rate to which the company is currently subject.

- Risk Categories: The analytical portion specifically considers only 12 risk categories, although the Milliman report discusses others. As described in the Risk Assessment part of this report, Invotex has identified certain other risks that do not appear to have been addressed, at least quantitatively, by Milliman's

analysis. The 12 specific key risk categories considered in Milliman's analyses are as follows:

1. Premium rate adequacy. This is a very broad category and covers risk of premium and fee revenue being less than medical and administrative costs, an outcome that can occur for a wide variety of reasons. Milliman's analysis was based on several specific causes of inadequate rates.
2. Adequacy of estimates in the unpaid claims liability (UCL). This risk was considered to be interdependent with premium rate adequacy risk, i.e., if trend assumptions proved to be too low both rates and UCL would likely be short.
3. The impact of overall changes in interest rate levels on the values of bonds that might need to be liquidated prior to their maturity dates to pay claims. For example, if interest rates were to increase, the market value of bonds in the portfolio would decrease, causing a loss to occur if such bonds would need to be sold prematurely.
4. Bond portfolio impairment. This risk category represents the potential loss of value from bond issuers defaulting on either principal or interest payments.
5. Market value of the equity portfolio. This is the risk that stock values in the equity portfolio may decline in comparison to the longer term anticipated appreciation.
6. Loss of commercial business. If a block of business is lost, the fixed expenses (overhead) being covered by either premiums or ASC fees could not be eliminated quickly and would lead to losses until overhead is brought in line with ongoing business levels.
7. Loss of FEP indemnity business. This risk is similar to the loss of commercial business, but is treated separately by Milliman due to the scale of CareFirst's FEP business.
8. Loss of FEP Service Center business. GHMSI has a contract with BCBSA to process claims for its own FEP business and that of other Blue plans and maintains a dedicated processing facility for this purpose. If the contract is terminated it will take time to eliminate the underlying costs.
9. Loss of Blue Card income. This risk is similar to the loss of FEP Service Center business, but the lost business would come from accounts controlled by other Blue plans other than FEP.

10. Other business risks (ASC default, disputes). The risk in this category contemplates a credit loss on the ASC business. CareFirst pays claims on its ASC business and is reimbursed at the end of each month for those claims paid. This risk category also includes the potential that CareFirst could lose disputes with customers or providers that exceed the normal historical amounts.
11. Catastrophic events. This contemplates events such as excessive claim costs that result from an epidemic or pandemic or from an act of terrorism or natural disaster. It also includes some provision for events such as federal health care reform activities that could produce losses to the companies.
12. Unanticipated growth and development. This could relate to the need for information system enhancements due to new reporting or compliance requirements from government entities, or the need for major and unanticipated product development costs resulting from competitive or regulatory pressure.

The foregoing risk categories contribute to Milliman's targeted surplus range in varying degrees; the impact of some risks is more prominent than that of other risks in the determination of overall surplus needs. Milliman's analysis did not include a separate calculation for each risk; therefore, there was no ready ability to determine the relative proportion of surplus need that was attributable to each respective risk category. In response to our request, Milliman re-ran their model multiple times, in each instance excluding a different risk category; in each calculation, the difference between the model result with all categories and the model result excluding the subject category was determined. From those indications, we were able to determine that the principal risk categories driving the determination of a large majority of the targeted surplus needs were premium rate adequacy, unanticipated growth and development, catastrophic events, and bond interest rates, and in that order for both of CFMI and GHMSI.

Monte Carlo Model and Pro Formas: Milliman's use of a Monte Carlo model resulted in a single frequency distribution of possible loss amounts using a table expressing loss amounts and associated probabilities for each of the 12 considered risks. As indicated above, the first two risks (premium rate adequacy and UCL adequacy) were treated as dependent, thus a separate UCL adequacy frequency was constructed for each random number range selected for premium rate adequacy. The process required selection of 12

random numbers for each iteration, one for each risk, in order to provide a single data point for the overall frequency distribution.

The risk category tables were generally balanced, in the sense that favorable as well as unfavorable deviations were considered, so an increase to surplus was a possible outcome. In constructing the table for each risk category, Milliman performed analyses using company and industry history supplemented by considerable professional judgment. Other tables could have been devised and different sets of risks could have been considered either simplifying or expanding the analysis, but we found the process and judgments made by Milliman to be generally reasonable.

The model does not presume that all 12 risks occur simultaneously, although that outcome could conceivably be an extreme outcome in the distribution tail. In each run of the model calculation, each risk is given a random chance of occurrence based on its distribution and likely impacts.

The conclusion in Milliman's work was expressed as a range to be targeted. The selections of the points, or probability levels, in the Monte Carlo table were judgmentally determined. In their analysis, Milliman used the 90th, the 95th, and the 98th percentiles. The 90th and 95th percentiles were used in conjunction with the 375% BCBSA RBC requirement and the 98th percentile was used for the 200% ACL RBC level.

The Milliman analysis included a set of pro forma financial statements using a set of standardized assumptions, only varying the ones affected by a specific loss-of-surplus amount. This served to translate specific loss of surplus amounts into sets of income statements and determined the beginning surplus that would be required to assure that the surplus at the end of the loss cycle would still be above the targeted level. This provided a more tangible illustration of particular loss levels and how, if achieved, those loss levels would still keep surplus of each of CFMI and GHMSI above the aforementioned ACL RBC and BCBSA RBC action thresholds.

Analysis of Underlying Assumptions by Key Risk Category

1. Premium Rate Adequacy

Milliman's approach considered several specific causes of deviations of actual versus intended margins in rates. The standard deviation for each category was determined and these were combined into a probability distribution for the combination by calculating the standard deviation of the category under the assumption that it was a normal distribution. The categories used are as follows:

a. Secular trend, based on historical variation in medical cost trends since 1986 and adjusted for trend leveraging based on CareFirst's actual mix of deductibles and stop loss coverage.
b. Random fluctuation, based on observed actual versus expected (resulting from application of typical rating algorithms) claim levels.
c. Operational trend miss, primarily network contracting changes. The assumptions for this were judgmental, but contemplate actions by the company that would affect claim costs such as changes to the claim adjudication logic or changes in provider payment arrangements, but that wouldn't have been anticipated when the rates were developed. This component was based on actuarial judgment.
d. Other premium rate miss components, including adverse selection and underwriting results, again based on judgment.

As a computational convenience, components were assumed by Milliman to be normally distributed and independent. However, the distributions are not quite normal since they are fundamentally based on the distribution of claims, which is skewed (there can't be negative claims but on the positive side there is virtually no maximum). These specific components of premium rate adequacy do not consider certain other risks; for example, new product types may require assumptions about member behavior that cannot be determined from historical data. A recent example is the company's losses from "consumer driven" products that required estimates on the degree of utilization reduction resulting in greater cost participation by patients. Another example is the required estimation of utilization reduction resulting from various care management protocols. This type of risk was considered in the unanticipated growth and development category, but it does not appear to have been explicitly dealt with by Milliman.

2. UCL Estimation

Milliman assumed that misses in UCL estimation were related to misses in trend. The inter-relationship was accomplished by constructing a separate probability distribution for each range of trend miss. Milliman assumed that the two risk categories are partially dependent. However, the dependency assumption could be challenged since misses are often also related to unanticipated large claims, older large claims distorting calculated completion factors, operational events such as changes to the claim systems, or unexpected changes in the speed of claim processing and resulting changes in claim backlog levels. We have reviewed the actual CareFirst estimated versus actual UCL estimates over a period of time to test the Milliman assumption and have a proposed adjustment to the Milliman range based on alternative assumptions.

3. Impact on Bond Portfolio Values of Interest Rate Changes

Milliman assumed that a portion of the bond portfolio would need to be liquidated if extreme losses occurred. There is a risk that changing interest rates could affect the liquidated value compared to the book value. The selected assumptions appear reasonable for the environment existing at the time the Milliman report was prepared, but not in a more normal economic climate. Therefore we have proposed adjustments to the Milliman range based on modifying the assumptions to reflect a more normal economic environment.

4. Bond Impairment

This risk category recognizes the exposure to principal and interest defaults. The assumptions appear to be reasonable.

5. Equity Portfolio Values

Since changes in market value of equity investments directly impact surplus, Milliman developed assumptions to recognize the risk of changes. These assumptions appear reasonable. They are based on deviations from the trend line of the S&P 500 index over three-year periods starting in 1950.

6. Loss of Business Impact – Separately for Commercial (including ASC), FEP Indemnity, FEP Service Center Business, and Blue Card

These categories are for the risk of losing business segments that produce revenue that contribute to covering overhead. It is assumed that two years are required to reduce overhead expenses to reflect the loss of revenue. The specific assumptions appear to be reasonable.

7. Other Business Risks

Two specific categories were identified. First was the risk that ASC business would default on reimbursing claims that had already been paid for ASC accounts. We established alternate assumptions that we felt were more reasonable and have proposed range adjustments based on these alternative assumptions. Second was the risk that CareFirst would lose a dispute over an issue that might affect a segment of its customer base. The assumptions for this second category seem reasonable.

8. Catastrophic Events

The Milliman assumptions included a provision for a 2.5% (of risk premium) base line allowance with 100% probability plus the contingent impact of other catastrophes. We do not agree with the 2.5% base provision and have developed alternate assumptions resulting in an additional proposed adjustment.

9. Provision for Unidentified Development and Growth

An important risk included in this category is the need for Information Technology development that is unanticipated and imposed on CareFirst from external requirements. It is our view that funding for some of these incremental enhancements, albeit unexpected, is embedded in the ongoing corporate budget. A risk that appears to be under-recognized in this aspect of Milliman's analysis is that of under-pricing a new product, such as Consumer Driven Health, as was discussed earlier. As a result, we proposed adjustments based on our own selection of alternative assumptions for both of these risks, the results of which partially offset each other.

10. Other Adjustments

Invotex made additional adjustments to the targeted surplus levels recommended by Milliman relating to risks that were not directly considered by Milliman in the computational aspects of their Monte Carlo model. These adjustments pertain to the following:

- Operational Risk – the risk that CFMI or GHMSI would fail to adequately perform certain operational functions that would result in loss or additional costs.
- Pricing Strategy Risk – the potential adverse impact of a particular pricing strategy, such as pricing new business at a discount.
- Rate Regulation Risk – the inability to implement needed rate increases on a timely basis or in sufficient amounts due to regulatory intervention.
- Probability Distribution – in some circumstances, Milliman assumed a normal distribution; Invotex adjusted for a somewhat skewed distribution.
- Pension Plan – the risk of additional funding to CFI's defined benefit pension plan due to reduction in the plan's asset values.
- CareFirst BlueChoice – the risk of limitations in movement of funds between CFBC and either of CFMI or GHMSI.
- Guaranty Fund Risk – the risk that failure of an unaffiliated insurer could result in CFMI and/or GHMSI having to pay assessments from state guaranty funds.
- Tax-effecting of Loss Scenarios – as previously discussed, we have included an adjustment to tax-effect all loss scenarios in the model at 10%, which is half of the 20% AMT rate to which the company is currently subject.

Other Needs for Surplus: In addition to providing a backstop to guard against the adverse effects of anticipated and unanticipated risks, surplus of an insurer can also be used to finance certain long-term investments and expenditures. In the case of CareFirst, the company has embarked on an ambitious plan that, among other objectives, aims to transform the current multiple-system architecture and drive the collection, analysis and use of data to optimize the delivery of health care rather than simply paying claims which has been a primary focus in the past. The company's capital expenditures and related operating expense forecast is approximately $500 million from 2008 through 2011, some of which can be seen in the following chart as increases in capital expenditures in 2008 and are projected to continue into 2009 (consolidated amounts for CFI, $ in thousands):

CareFirst Capital Expenditures

Year	$ in Thousands
2000	$ 62,079
2001	61,170
2002	43,814
2003	43,817
2004	45,748
2005	43,108
2006	50,408
2007	76,633
2008	94,961
Projected 2009	165,000

Source: *CareFirst Inc, excluding DE capital expenditures*

The data above supports the view that there is a sizeable amount of capital expenditures that occurs annually for CareFirst, given the nature of the company's size and business. For 2000 through 2007, such expenditures averaged $53 million. To that extent, and as a practical matter, there is a sizeable amount for such capital expenditures as well as related operating expenses that is provided in the company's ongoing operating budget and for which a special provision in surplus would not be needed.

In addition, the company's ongoing strategic initiative aims to produce substantial benefits which will result in improved customer reach and service and at lower cost in future years. Thus there should be benefits that will inure to surplus beginning in 2011. Inasmuch as we believe a long-term view should be taken in determining targeted surplus ranges, the short-term surplus drain should later be offset by future additions to surplus, and we therefore have not included any adjustment to Milliman's range relating to CareFirst's planned capital expenditures.

TAB 8

8. RISK ASSESSMENT

Surplus of an insurer exists for the protection of policyholders, i.e., it provides an added cushion to guard against the following:

- Financial reporting risks – that, for whatever reason, assets are overstated or liabilities are understated
- Other than financial reporting risks – that events or circumstances may occur in the future that may adversely affect the company

We gave consideration to a universe of risks to which insurers typically become subject, and focused on those key risks that appeared to be most pertinent to a nonprofit health service plan. In considering this potential "risk universe" we applied our own professional experience and judgment as we utilized the following sources:

- Information obtained from CareFirst relating to the company's identification of its own key risks
- A risk universe obtained from CareFirst based on information from BCBSA which detailed risks applicable to Blue Cross and Blue Shield plans generally
- The results of an analysis prepared by a joint NAIC working group comprised of state insurance regulators and representatives of the Federal Reserve which compared risks across the banking and insurance sectors

In our analysis, we sought to determine whether or to what degree the key risks we identified were included in the NAIC's RBC formula for health insurers, as well as in the modeling of an optimal target surplus range that was performed for CFMI and GHMSI by Milliman. In doing so, we identified certain key risks which did not appear to be adequately addressed in one or both of those measures from a quantitative perspective. In that regard, the following risks are notable:

- Retirement plan and other benefit funding: CFI has a defined benefit plan that provides benefits to employees who were hired prior to 2009; employees hired after that date are covered by an enhanced 401(k) plan. CFI also maintains additional supplemental benefit plans and provides certain post-employment health and medical benefits. In 2008, the benefit plans experienced the turmoil in

the markets: assets valued at $480 million at the beginning of the year lost $116 million in value during 2008 notwithstanding that employer contributions increased ten-fold from the prior year to $89 million in 2008. By the end of the year the plans' unfunded status had increased by $83 million to $107 million. Such exposures are not considered in the NAIC's RBC formula. In Milliman's targeted surplus range analysis, the risk of material additional funding requirements for pension plans is encompassed in their public report narrative within a much broader category for catastrophic events. Nonetheless, we saw no explicit assumptions pertaining to this risk in their more detailed non-public analysis supporting that report. We adjusted Milliman's reported ranges of targeted surplus for both CFMI and GHMSI to provide for the risk of need for additional pension funding.

- Health Care Reform: The nation is facing potentially significant health care reforms, the outcome of which is uncertain. The impacts could be significant to health insurers such as CareFirst, with changes in the market and demand for products and services, in the composition and delivery of those products and services, in pricing and rate adequacy, in technology and knowledge management, and more. Such risks are not covered by the NAIC's RBC formula. Milliman acknowledges the risk that health care reform presents to health insurers including nonprofit health service plans like CFMI and GHMSI, and points to the provision that they have included in their model for catastrophic risk as providing for those risks, at least to some extent. They also represented to us that if they were to update their studies today, they would include a greater provision for such risk than they did when they performed their most recent studies for CFMI and GHMSI in late 2008. In our view, the outcome of reforms is too unpredictable at this juncture and we do not propose any related adjustments to Milliman's ranges. However, depending on the ultimate outcome, CareFirst and the MIA may need to revisit the indicated targeted surplus ranges earlier than may otherwise have been necessary.

- Regulatory Risk: As a nonprofit health service plan, both CFMI and GHMSI are regulated at the state level, with three state insurance departments involved in overseeing various matters. There is variation in the reach of the three jurisdictions' respective regulatory regimes (e.g., while both Maryland and the District of Columbia have prior rate approval authority, they vary as to the means by which they exercise that authority). Virtually all aspects of the companies and

their operations are subject to regulatory requirements and scrutiny, ranging from products and forms, premium rates, conduct in the marketplace, holding company and intercompany activities and transactions, financial aspects including surplus and the composition and valuation of assets and liabilities, and more. Such a highly regulated environment can impair the companies' ability to take certain actions as it might otherwise desire. Many actions require regulatory approval which may be denied, or may be approved only with limitations or additional conditions. The regulatory approval process often takes a considerable period of time, the length and unpredictability of which can cost the companies, e.g., as they must continue to use premium rates that may be inadequate while they await regulatory approval for increases. Accordingly, we have included an adjustment to Milliman's range to provide for these risks.

The adjustments that we made to Milliman's targeted surplus ranges for both CFMI and GHMSI relating to the foregoing items have been included in our summary analysis which is included in the *Assessment of Milliman's Study* section of this report.

TAB 9

9. APPROPRIATE AMOUNT OF SURPLUS FOR CFMI AND GHMSI

The MIA has asked Invotex to recommend the appropriate amount of surplus for CFMI and GHMSI on an individual and on a consolidated basis and, in so doing, to address how surplus earned in more than one jurisdiction should be apportioned so as to insure that subscribers of a health benefit plan issued or delivered in the State of Maryland are adequately protected.

We believe that the approach to determining an appropriate amount of surplus for Maryland's nonprofit health service plans should focus on a range of surplus that is adequate and reasonable for them to hold taking into consideration the following:

- The plan's business and its risk profile
- Its size and operations
- Its anticipated business plans and forecasts
- An appropriate degree of conservatism, consistent with sound financial regulatory oversight of any insurer

Considerable judgment is involved as the facts and circumstances of each insurer are unique, and no "bright-line" tests exist. Furthermore, insurers are subjected to prevailing winds in the marketplace which usually differ somewhat – sometimes materially – from expectations; therefore, it is important to give recognition to a range of targeted surplus to provide room for such fluctuations.

While much of regulatory considerations are "rules-based," e.g., how to compute RBC, we also considered certain qualitative aspects which we suggest to the MIA as possible "principles" to consider in its own efforts to evaluate an appropriate range of surplus for CFMI and GHMSI, as follows:

- Recognizing that § 14-117 of the Maryland Insurance Article tasks the Commissioner with the determination of appropriate surplus amounts for nonprofit health service plans, the determination of an appropriate range of surplus and operating the company within that range is first and foremost the responsibility of the company's management; in making his determination, the

Commissioner may consider the process, assumptions and results of management's analysis.

The MIA should consider requiring nonprofit health service plans to periodically assess an appropriate targeted surplus range in light of their unique facts and circumstances and the current environment and to submit their analyses to the MIA.

- It is appropriate for management and the board to consider obtaining expert advice and benefit from the experience of others in such matters, but they should also participate proactively in the determination and evaluation of key assumptions and findings, and acknowledge responsibility for the results. As the history of CFMI, GHMSI, and many other insurers illustrate, risk is very real and can have severe adverse consequences. It would not be unreasonable for the regulator to request certain assertions by management relative to their determination of a targeted surplus range not unlike those that are included in Section 16D of the NAIC's Annual Financial Reporting Model Regulation relating to management's reporting on internal controls. Moreover, the company's process to evaluate targeted surplus ranges should be subjected to oversight through appropriate measures of governance, for example, by an Audit Committee of the Board of Directors.

As part of the MIA requirements, management should annually file an assertion that the nonprofit health service plan is within the appropriate targeted surplus range as that may be approved by the MIA (e.g., an approved process or range amount, to be determined by the MIA); that the analysis has been subjected to appropriate levels of governance; and that management is responsible for the underlying assumptions.

- Should the regulators have a view different than that of company's management about the "appropriate amount of surplus," then that should be taken up with management so that the company may have the opportunity to consider the regulator's view and determine whether it is appropriate for the company to amend their range. Such a process would be similar to that of an auditor addressing a potential adjustment to a client's financial statements. Management should be encouraged to continue its efforts over time to evaluate surplus targets

and to continually improve upon its analysis. The existence of regulatory oversight should not have the aim or the effect of preempting management from those responsibilities.

- The process that the company undertakes to evaluate its surplus should be transparent and understandable to the company's regulators and, to the maximum extent possible, understandable to the public.

> *While analysis of targeted surplus ranges is inherently complex, the MIA should encourage nonprofit health service plans to submit analyses that are sufficiently complete and understandable for the MIA to review; in some cases, it may be appropriate for the plans to also use supplemental alternative methodologies that are less complex and which may more transparently convey the process, analysis, and conclusions.*

- A targeted amount of surplus should be expressed as a range of amounts in recognition of the degree of variability that is inherent in the risks underlying the business.

- Expressing the range in terms of the NAIC's ACL RBC metric adjusts, to some degree, for changes in the company's risk profile.

- The range should be determined with a longer-term outlook, i.e., based on risks that are reasonably foreseeable to exist going forward and through the next 5-10 years. Because of this long-term view, it should not be necessary for the company or the MIA to review the targeted surplus ranges annually; rather, a review every 3-5 years would seem more appropriate. However, more frequent intervals might be necessary based on facts and circumstances surrounding the company at the time, and external environmental factors. An example of the latter would be the potential outcome of the current national debate over health care reform and the significance of the related potential impacts to CFMI and GHMSI.

- If significant reductions to existing surplus levels are indicated upon management or regulatory review, they should be implemented gradually over time so as to minimize adverse marketplace reactions and any other unintended consequences.

In determining a fair and equitable manner to distribute any excess levels of surplus, the Commissioner should consider such potential consequences and the longer-term impact on policyholders.

The MIA should consider if the language of Maryland Insurance § 14-117 is sufficient to embrace a longer-term view for protection of policyholders.

- A regulatory framework to evaluate a nonprofit health insurer's surplus should result in a more proactive process to identify and address situations when surplus may be excessive, but also to work with the company to approve rates that will maintain surplus within the appropriate targeted range.

The MIA should consider changes to regulations or practices that will assure that the MIA will work proactively with nonprofit health service plans in approving rates sufficient to maintain surplus within the targeted surplus range.

In the following section of this report, we discuss how Pennsylvania addressed the issue of potential excess surplus of nonprofit Blue Cross Blue Shield plans. We believe that, at a conceptual level, Pennsylvania's "sufficient operating range of surplus" is synonymous with the "appropriate amount of surplus" that Maryland seeks with regard to CFMI and GHMSI. Therefore, we have adopted a three-tiered approach similar to Pennsylvania's model to illustrate our conclusions as to the surplus of CFMI and GHMSI.

Under the Pennsylvania model, a plan with surplus within the sufficient range would not need risk and contingency factors included in its filed rates. (While we are uncertain how this is actually being implemented in Pennsylvania, our view is that, even for a plan in the sufficient range, some risk and contingency factors may be necessary to enable the plan to stay in that range depending upon its current and anticipated growth trends.) A plan with surplus below the sufficient range would be able to include risk and contingency factors in its filed rates. For a plan with surplus above the sufficient range the plan would be required to justify the surplus level or, if excessive, to provide a plan to the department describing how it would reduce surplus to within the sufficient range within a reasonable period of time.

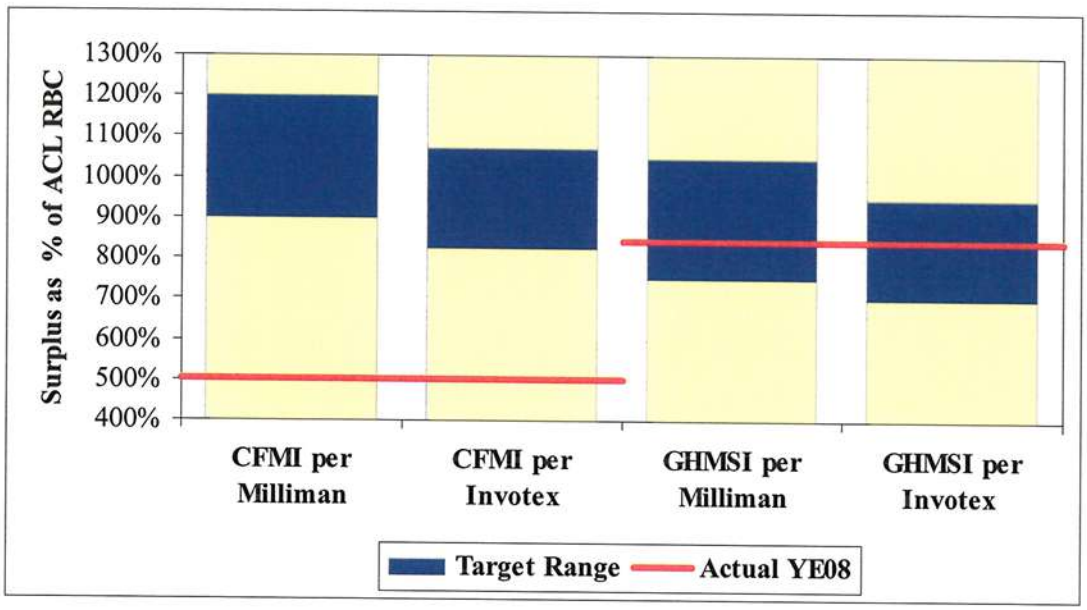
For each of CFMI and GHMSI, we determined an appropriate amount of surplus based on the following inputs:

- The optimal range of surplus as determined by Milliman for each plan
- Our own adjustments to Milliman's optimal range to address our views about certain assumptions utilized by Milliman and to address certain other risks that were not quantitatively considered in Milliman's analysis.
- Consideration of the risk universe impacting Blue Cross Blue Shield plans to challenge the existence of risk that may not have been adequately addressed either in HRBC or in Milliman's work
- Peer analysis, i.e., comparison of certain financial metrics of CFMI and GHMSI to similar nonprofit Blue Cross Blue Shield plans.

Using these inputs and professional judgment, we then determined an appropriate amount of surplus for each company, expressed as a range and as a multiple of ACL RBC. Our results for each company as compared to the targeted surplus range per Milliman's reports as well as to the amount of surplus reported by each company at December 31, 2008 as a percentage of ACL RBC are as follows:

	CFMI		GHMSI	
	Low	High	Low	High
Per Milliman	**900%**	**1200%**	**750%**	**1050%**
Per Invotex	**825%**	**1075%**	**700%**	**950%**
Company Reported, Year-End 2008	**503%**		**845%**	

A graphical representation of this data follows:



CFMI and GHMSI have unique risk profiles and operating environments leading to a different set of targeted surplus range for each company. CFMI has greater risk exposure from ASC business and operates in a more rate-regulated environment. The two companies also differ in their proportion of business in FEP and their investment portfolio composition.

For both CFMI and GHMSI, the range as determined by Invotex is somewhat lower and narrower than that recommended by Milliman which is attributed to differences of professional judgment regarding some of the assumptions underlying the model. As of December 31, 2008, CFMI's surplus was significantly below the low end of the amount determined by Invotex as the appropriate surplus range, whereas GHMSI's surplus was comfortably within its appropriate surplus range. Therefore, and based on our analysis, neither company is exhibiting indications of excessive surplus as of year-end 2008.

An outcome of the changes that we made to Milliman's assumptions is that the range became somewhat narrower, and therefore, perhaps, more meaningful from the standpoint of the companies and the MIA alike. Boundaries can provide less guidance to management and to regulators the further apart they are because there may be too much

room for fluctuations and less incentive for proactive intervention by management as well as by regulators.

The indicated ranges of an appropriate amount of surplus for both CFMI and GHMSI carry with them certain caveats. They are based on Milliman's model and their work, as well as on the assumptions that were developed and agreed upon by Milliman and CareFirst. The ranges developed by Milliman are based on an assumption that pricing margins will continue to be included in premiums at the general levels that exist today. Additionally, the resulting ranges have been amended by the adjustments made by Invotex as discussed herein. The ranges have been developed based on data for industry cost trends and experience over many years as well as perceived risks that currently exist but have not been observed historically. In a statistical sense, if CFMI and GHMSI are operating within their respective appropriate range of surplus, there is a low probability that risks will manifest themselves to such a degree that will cause either plan's surplus to fall below the 375% BCBSA RBC requirement and even lower risk that either plan's surplus would fall below the 200% current ACL RBC requirement. That said, there is "tail risk" present, i.e., there is a small but real possibility that larger losses or adverse surplus impacts could result, the magnitude or timing of which is not predictable. Moreover, all risks have not been modeled; certain high severity/low probability risks are very real, but considered so remote and variable that there is no practical way to size and/or provide for them through surplus.

We believe that these ranges will have longer-term utility to CareFirst and to the MIA and will not need updating every year.

We recommend that the MIA require CareFirst to update its analysis of targeted surplus ranges every 3-5 years. The MIA should also reserve its right to request an updated analysis and/or to perform its own analysis at any juncture given the facts and circumstances of the companies and the environment as they may exist at the time.

In the section of our report entitled "Suggested Methodology for the MIA," we describe why we believe that the appropriate manner to evaluate surplus for CFMI and GHMSI is on a separate company basis, not on a consolidated basis. Therefore, the above range of targeted surplus per Invotex has been determined separately for each of those two companies.

In the section of our report entitled *Apportionment*, we describe why we believe that is not a concept that will better protect Maryland subscribers. However, we have also included in that section some regulatory means to accomplish similar objectives for the MIA's consideration.

TAB 10

10. RBC REQUIREMENTS OF OTHER STATES

Pennsylvania: To date, Pennsylvania stands out in terms of how it has addressed the issue of potential excess surplus of nonprofit Blue Cross Blue Shield plans. An extensive inquiry was led by the Pennsylvania Insurance Department from 2002-2005 that involved public hearings, submission of testimony by interested parties, and extensive analyses of the information put forth on the record. The Pennsylvania commissioner's Determination and Order provided for a unique sufficient operating range of surplus for each of that state's regulated plans, measured as a multiple of ACL RBC, as follows:

- An upper level of surplus, labeled by the Pennsylvania Insurance Department as 'inefficient,' "which means it is presumptively inefficient and potentially excessive."[35]
- A second or middle level called 'sufficient' surplus.
- A final and lower level labeled 'efficient,' "which means the Plan does not face solvency issues from routine fluctuations from factors like underwriting results and return on investment. A lower bound for what is efficient is not identified and may differ for each Blue Plan and be dependent upon the circumstances causing a Blue Plan to push toward a lower operating range. "[36]

We believe that, at a conceptual level, Pennsylvania's framework is an appropriate starting place for Maryland to consider as a methodology to perform its own evaluation of CFMI's and GHMSI's surplus. That said, we have some concern with Pennsylvania's use of the terms "efficient," "sufficient" and "inefficient" to define levels of surplus inasmuch as there is much – maybe too much – technical thinking that is embodied in a single word of common usage that will likely then mean different things to different audiences. Nonetheless, Pennsylvania pioneered some thinking about a hierarchy of surplus levels for nonprofit health service plans and what actions are appropriate by the company and/or by the regulator as reported surplus moves among those levels.

[35] 2007 Statement of Surplus Levels for Blue Cross and Blue Shield Plans (http://www.ins.state.pa.us/ins/lib/ins/whats_new/2004bc/Surplus_Statement_for_2007.pdf).
[36] 2007 Statement of Surplus Levels for Blue Cross and Blue Shield Plans (http://www.ins.state.pa.us/ins/lib/ins/whats_new/2004bc/Surplus_Statement_for_2007.pdf).

As defined by Pennsylvania, at levels of surplus below the sufficient range, a plan would not necessarily "face solvency issues from routine fluctuations." While that may imply a satisfactory place for a nonprofit health service plan to be, insurers often face a variety of causes of non-routine fluctuations, often at the same time. Moreover, insurers don't typically aspire to simply avoid immediate solvency problems with their regulators; they aspire to be growing and sustainable businesses, an outcome that is beneficial for the company, its management and employees, but most importantly for its policyholders or subscribers. The more sustainable the business is, the greater the protection that is provided to subscribers over the long term. Among other things, the need for growth and sustainability requires companies to make investments in people, technologies, and methodologies and to innovate so as to compete more effectively. It also makes it necessary that they hold amounts of surplus greater than what is needed to merely avoid potential short-term solvency problems.

The irony is that levels of surplus defined by Pennsylvania as "efficient" in one sense, i.e., that less surplus is being put to use, also may make the company itself "inefficient" in another sense – it won't be able to go very far or very fast backed by only modest amounts of surplus. While there may be no apparent short term solvency concerns, the company may not be well positioned to sustain itself over the long term. Its relative inability to react as quickly or as effectively to both risks and opportunities can lay the seeds for solvency problems in the future.

Issues with vocabulary aside, we believe that the notions of a "sufficient" operating range of surplus brought forward by Pennsylvania, the concept of an "appropriate amount of surplus" that Maryland seeks with regard to CFMI and GHMSI, and an "appropriate target surplus range" recommended through Milliman's reports are aligned. In each case, they comprise a range of surplus amounts that is well above minimum levels and which provide the opportunity for the company to grow and to withstand a reasonable amount of variability over the long term while at the same time providing an upper end above which the possible existence of excessive surplus can be considered. The key is determining the appropriate amounts to define the lower and upper ends of that range, which will vary by company, and may even vary somewhat over the long term for a given company.

Under the Pennsylvania model, a plan with surplus within the sufficient range would not need risk and contingency factors included in its filed rates. (While we are uncertain how this is actually being implemented in the Pennsylvania model, our view is that, even for a plan in the sufficient range, some risk and contingency factors may be necessary to enable the plan to stay within that range given its current and anticipated growth trends.) For a plan with surplus below the sufficient range the plan would be able to include risk and contingency factors in its filed rates. For a plan with surplus above the sufficient range the plan would be required to justify the surplus level or, if excessive, to provide a plan to the department describing how it would reduce surplus to within the sufficient range and within a reasonable period of time.

In our discussions with the Pennsylvania Insurance Department, we learned the following:

- The three-tiered RBC range model that resulted from their department's efforts has significantly reduced the level of concern expressed by various interested parties as to the existence or measurement of potential excess surplus.
- The range model has enhanced the working relationship between the Pennsylvania Insurance Department and their regulated BC/BS plans in that the Department now more proactively works with the plans to approve risk and contingency factors to help keep the plans within the sufficient range of surplus. In other words, the model works both ways; it is not used solely as a tool to identify and work toward reduction of excessive surplus amounts.
- There appears to have been no adverse market reaction to the adoption of the three-tiered RBC model range.

The Pennsylvania approach and the three-tiered model range concept that it embraces appears to be effective, easy to administer, and a transparent means to balance the goals of financial soundness and community responsibility. The part that is neither easy nor transparent is the work that underlies the determination of benchmark values that distinguish between sufficient and other amounts of surplus based on the unique facts and circumstances for each particular plan. Our understanding is that those were based on extensive analysis and judgment by the Pennsylvania Insurance Department; however, there is no publicly available information as to exactly how they were derived other than

the narrative Determination and Order which describes the Department's analysis in general terms.

Other States: Other states have had some activity relative to the issue of excess surplus, but not to the same comprehensive degree as was done in Pennsylvania. Activity in other states includes the following:

State	Activity
Michigan	**Surplus is excessive if it is > 5x ACL RBC based on the NAIC formula (5 x 200%=1,000%); if excessive, must file plan to reduce surplus.**
Hawaii	**If a nonprofit's net worth > 50% of prior year's total health care expenditures plus operating costs, must refund excess to subscribers. Law was not renewed as of June 30, 2006.**
New Hampshire	**Capped nonprofit contingency reserves (a component of surplus) at 20% of premium income; not enforced, and plan converted to for-profit.**
Rhode Island	**No provision by law; United Healthcare of New England was found to have excess surplus, but it is part of UnitedHealth Group and relies on significant sharing of resources across the group.**
North Carolina	**"Current North Carolina law specifically caps BCBSNC's ability to build 'contingency reserves' (a component of surplus), although the law does not limit the plan's ability to accumulate surplus…BCBSNC is allowed to build up contingency reserves until that level reaches six times the average monthly expenditures for claims, administrative and selling expenses. Once that level is reached, the plan is no longer able to allocate extra funds to the contingency reserve pool, but it may continue to accumulate surplus."[37]**

[37] The Lewin Group: "Considerations for Regulating Surplus Accumulation and Community Benefit Activities of Pennsylvania's Blue Cross and Blue Shield Plans," prepared for The Pennsylvania General Assembly Legislative Budget and Finance Committee, p. 11.

NAIC Activity: The NAIC recently added a trend test to the HORBC calculation similar to that which is currently required for the property/casualty RBC formula. Under the current HORBC formula, Company Action Level is not triggered until the RBC ratio (total adjusted capital divided by authorized control level RBC) dips below 200%. With the addition of the new trend test, Company Action Level could also be triggered at higher RBC ratios, i.e., between 200% and 300%, if the company was also experiencing a negative trend defined as a combined ratio of greater than 105%.

We understand that the new trend test will be included in RBC filings beginning with year-end 2009. The corresponding changes to the Health Organizations Risk-Based Capital Model Act is also being modified, and we understand that the NAIC's intent is that, with the inclusion of the trend test, the act will be submitted for recommendation as an NAIC accreditation standard.

We note that Milliman's reports on the targeted surplus ranges for CFMI and GHMSI did not consider the new trend test. In their analysis, Milliman sought to determine targeted surplus ranges such that there would be a very high probability that Company Action Level would not be triggered, but that assessment was made based only on the existing BCBSA requirement of 200% ACL RBC.

We raised the issue of the new trend test with representatives of Milliman, who informed us that as long as BCBSA does not modify the loss of trademark threshold from the current 200% of surplus level, the impact of the trend test on Milliman's analysis would be minimal. In the absence of a change in the loss of trademark standard, Milliman would assign the new trend test a confidence level at about the 95th percentile, rather than the 98% that they applied to the 200% threshold in their current analysis. Milliman tested the impact of a 300% threshold with 95% confidence, and concluded that it would not affect their target surplus range for either GHMSI or CFMI. If, on the other hand, BCBSA were to adopt a loss of trademark policy for companies that were to fail the trend test, Milliman believes that the surplus target range would need to be increased to reflect the impact of that standard. Therefore Milliman would propose that the surplus target ranges should be re-evaluated if BCBSA were to adopt such a change. We have evaluated the need to consider the new trend test in the section of our report entitled *Assessment of Milliman's Study*.

The MIA should anticipate the timing of the effective date for the new trend test as an accreditation standard and when Maryland law will be amended to comply with that standard. Within 1-2 years of that date, the MIA should alert nonprofit health service plans of the pending change so that they may consider the impact on their analysis of targeted surplus ranges.

The MIA should also require nonprofit health service plans to notify the MIA if the BCBSA RBC requirements change to incorporate a similar trend test, or if they change in any way that might potentially impact an evaluation of targeted surplus ranges for the company.

TAB 11

TAB 11

11. ASSESSMENT OF CURRENT SURPLUS REQUIREMENTS IN MARYLAND

Section 14-117 of the Insurance Article contains the surplus requirements for nonprofit health service plans operating in Maryland. On the one hand, it specifies the minimum surplus that must be maintained as an amount equal to the greater of $75,000 and 8% of the total earned premium for the immediately preceding calendar year; on the other, it provides a threshold point (when surplus exceeds the "appropriate risk based capital requirements") to cause the Commissioner to hold a hearing to determine whether surplus is unreasonably large.

For purposes of § 14-117, assets do not include "stock of an affiliate or subsidiary of the plan if the stock has not been issued in accordance with a public offering or is not publicly traded on a recognized stock exchange." However, it goes on to say that, "notwithstanding subparagraph (ii)2 of this paragraph, 'assets' includes stock of an affiliate or subsidiary of a nonprofit health service plan to the extent that the Commissioner determines that the stock has a value that could be made available for the payment of claims and losses." [emphasis added]

This final phrase is important in the context of CFMI's and GHMSI's equity investments in CFBC. At December 31, 2008, CFMI's and GHMSI's surplus and the portion of their surplus that is comprised of the undistributed earnings of CFBC are as follows:

CFBC Portion of Surplus For CFMI and GHMSI 2008

	CFMI	GHMSI	
Total surplus as of 12/31/08 - CFBC	$ 406,675,383	$ 406,675,383	*(a)*
Equity ownership of CFBC	60%	40%	*(b)*
	$ 244,005,230	$ 162,670,153	
Total surplus as of 12/31/08	$ 394,250,693	$ 686,779,718	*(a)*
Portion of surplus comprised of the undistributed earnings of CFBC	62%	24%	

Sources: *(a) Annual Statement for YE 2008, Five-Year Historical Data, p. 28, line 4.*
(b) Consolidated Financial Statements, CFMI and Subsidiaries, Dec.31, 2007 and 2008, p. 6.

With respect to the notion that CFMI's and GHMSI's investment in CFBC "could be made available for the payment of claims and losses," we note the following:

- The statutory test is two-pronged and based not just on surplus, but also on a concern over the existence of liquid assets to pay claims.

- 62% and 24% of CFMI's and GHMSI's surplus as of December 31, 2008 is comprised of their respective equity in the undistributed surplus of CFBC.

- Other than an initial dividend of approximately $31 million paid to GHMSI in 2002 as part of an initial effort to balance the equity ownership and distribution at 60/40% for CFMI and GHMSI respectively,[38] CFBC has since paid no dividends. Assets that might be used to pay dividends are kept at CFBC and support its surplus for the protection of its own policyholders. CFBC's board would presumably authorize a dividend only in an amount considered to be excessive relative to CFBC's risks and financial profile. At December 31, 2008, CFBC reported surplus level stood at 737% RBC ACL.[39]

- Another way to tap the value of CFMI's/GHMSI's stock in CFBC is for one or both of them to sell some or all of their CFBC shares, a process that has considerable restrictions imposed by CFI and which may take time inasmuch as CFBC's shares are not traded on an exchange and would presumably require a private placement. CFMI or GHMSI could buy CFBC shares from each other, subject to CFI and regulatory approvals, the latter of which could take considerable time.

- CFBC is a for-profit HMO domiciled in the District of Columbia and is governed by a board largely comprised of CareFirst executives. As an HMO, it is not subject to § 14-117 and the provisions therein that provide for the Commissioner to determine whether its surplus is unreasonably large.

Therefore, CFMI's and GHMSI's investments in CFBC which are comprised of their respective equity in CFBC's undistributed surplus may not be readily available for the payment of claims of CFMI or GHMSI. Nonetheless, we acknowledge that CFBC is an entity with substantial value. We have discussed this matter with staff of the MIA to seek an interpretation as to whether CFMI's and GHMSI's respective investments in CFBC should be excluded from their surplus for purposes of determining compliance with § 14-

[38] Annual Statement for the Year 2000 of the CareFirst BlueChoice, Inc., p. 25.
[39] Calculations are from the STAT financials, page 28, line 14 (total adjusted capital) divided by line 15 (authorized control level risk based capital). Data extracted from SNL.

117. The MIA informed us that (1) it should be included, and (2) that the issue raised by Invotex may give rise to a need to change the wording of § 14-117.

The MIA should consider if § 14-117 should be changed in light of the issues presented regarding the extent of surplus of CFMI and of GHMSI that is attributable to their respective investments in CFBC.

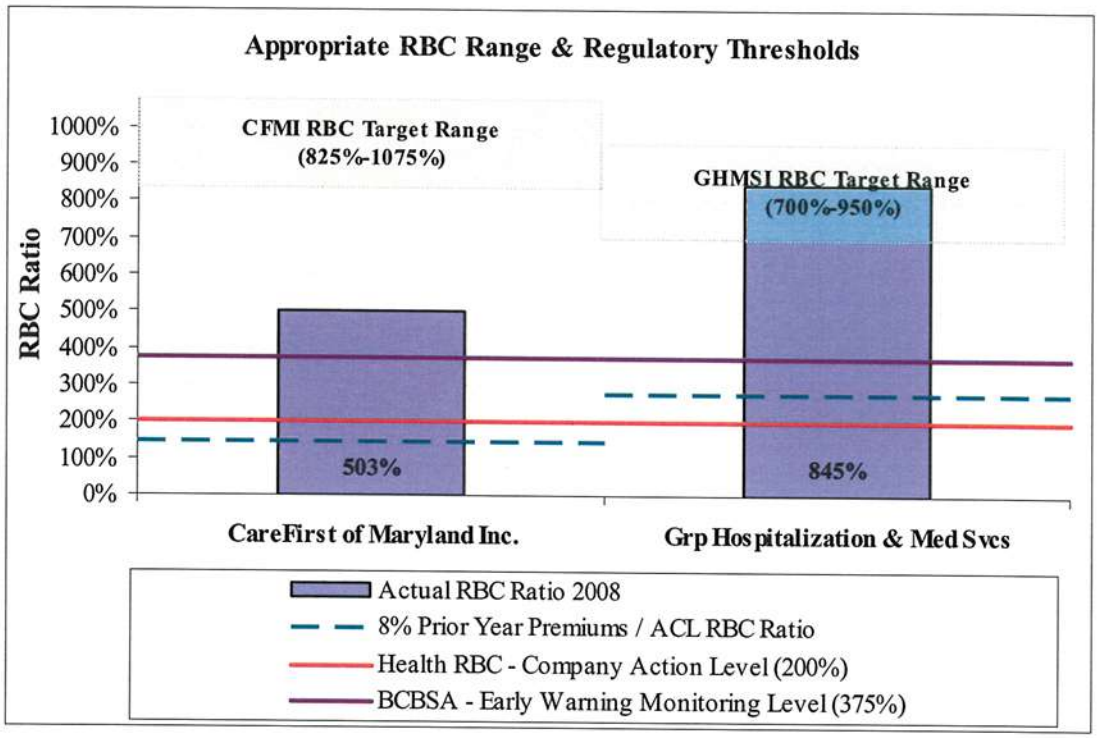
CareFirst and the MIA should discuss and consider whether a restructuring of the companies within the CareFirst group would not only reduce or eliminate inefficiencies in risk and surplus management, but provide other benefits as well such as further streamlining operations. There certainly are numerous factors that would have to be considered, but our study did identify the affiliation relationship itself, liquidity related to investments in CFBC, and certain provisions of the Intercompany Agreement that can give rise to inefficiencies from a risk/surplus perspective.

Application of the minimum surplus test of § 14-117 to CFMI and GHMSI results in the following:

Applications of Minimal Surplus Tests

	CFMI		GHMSI	
	2007	2008	2007	2008
Assets	$ 1,135,067	$ 1,149,945	$ 1,699,544	$ 1,772,935
less liabilities	621,587	755,695	945,985	1,086,155
Surplus	$ 513,480	$ 394,250	$ 753,559	$ 686,780
Net premiums written	1,387,307	1,833,811	2,713,086	2,815,214
Change in unearned prem	48,989	(5,195)	101,944	(71,219)
Total earned premium	$ 1,436,296	$ 1,828,617	$ 2,815,030	$ 2,743,995
8% of total earned prem	$ 114,904	$ 146,289	$ 225,202	$ 219,520
Required surplus level	**$ 111,959**	**$ 114,904**	**$ 196,523**	**$ 225,202**

To determine whether Maryland subscribers are adequately protected by those regulatory minimum requirements, we look to the appropriate amounts of surplus as determined by Invotex and as previously described in this report. As can be seen below, for both CFMI and GHMSI, the regulatory minimum is substantially below the amount indicated by even the lowest amount of our range. Thus, it is our opinion that the minimum requirements of § 14-117(b) do *not* adequately protect Maryland subscribers.



The minimum surplus test of 8% of prior year premiums that is provided in § 14-117 of the Maryland Insurance Article serves its intended function as a regulatory minimum standard. However, as of year-end 2008 the resulting minimum amount equates to only 147% and 277% ACL RBC for CFMI and GHMSI, respectively, which is significantly below the low end of the appropriate amount of surplus range as determined by our study. In the case of CFMI, it is even below 200% ACL RBC, the point at which regulatory intervention would be indicated based on the RBC statute. Therefore, we believe that the law should be modified to provide better protection for Maryland subscribers.

TAB 12

12. APPROPRIATE RISK BASED CAPITAL REQUIREMENTS

The phrase, "appropriate risk based capital requirements" is germane to CFMI and GHMSI inasmuch as both are nonprofit health service plans licensed in the State of Maryland and subject to § 14-117 of the Maryland Insurance Code, which states in part, as follows [emphasis added]:

> "(e) (1) The surplus of a corporation authorized under this subtitle may be considered to be excessive only if:
>
> (i) the surplus is greater than the appropriate risk based capital requirements as determined by the Commissioner for the immediately preceding year; and
>
> (ii) after a hearing, the Commissioner determines that the surplus is unreasonably large."

Current RBC requirements that pertain to nonprofit health service plans in Maryland emanate from the NAIC's Health Organization's Risk Based Capital formula and the related Model Act and pertain to minimum levels of surplus that must be held in order for an insurer to avoid heightened regulatory scrutiny. At or just above a minimum amount of surplus, the company's exposure to even minor fluctuations could result in regulatory action and solvency problems. Therefore, we do not believe that the minimum RBC requirement based on 200% ACL is a logical threshold for the MIA to use to trigger the need for a public hearing to evaluate whether surplus is "unreasonably large." To the contrary, at that level a company is barely able to avoid heightened regulatory scrutiny.

Likewise, § 14-117 does not appear to expect that there is a "bright-line" test that would be sufficient to differentiate a point at which surplus becomes unreasonably large. Rather, it calls for a public hearing to air the facts and circumstances, and the use of judgment by the Commissioner to make a determination as to whether or not surplus is unreasonably large and, if so, to what degree.

We believe that the concept of an "optimal surplus target range" as described in Milliman's reports for CFMI and GHMSI is consistent with the notion of "appropriate risk based capital requirements" expressed in § 14-117. The former measure is based on a range of surplus expressed in dollars; the latter converts that to a multiple of ACL RBC.

We have amended Milliman's results based on differences in professional judgment regarding some of the assumptions underlying their model to produce what we believe is an appropriate range of surplus for CFMI and for GHMSI, as follows:

	CFMI		GHMSI	
	Low	High	Low	High
Appropriate Range	**825%**	**1075%**	**700%**	**950%**

Thus, and if adopted by the MIA, reported surplus amounts that exceed these ranges would expose the companies to a call by the Commissioner for a public hearing and his determination, if such is the case, that their surplus is unreasonably large.

TAB 13

13. SUGGESTED METHODOLOGY FOR THE MIA

The MIA has requested that Invotex develop an analytical framework, methodology and/or additional criteria which may be used by the Commissioner to evaluate whether surplus is "excessive" for CFMI and GHMSI on an individual and consolidated basis, and to recommend whether the evaluation of the surplus levels of CFMI and GHMSI should be made on an individual basis, on a consolidated basis, or both, and the appropriate frequency of such evaluation.

Individual versus Consolidated Basis – CFMI and GHMSI: In evaluating whether the MIA's methodology should consider CFMI and GHMSI individually or on a consolidated basis there are various factors that we considered, including the following:

- For all practical purposes, CFMI and GHMSI operate as part of a cohesive group that faces the market and is managed as a single CareFirst enterprise.
- As a result, many of the risks that CFMI and GHMSI face are similar if not identical: for example, strategic risks would impact the entire enterprise, and pricing/underwriting risks would likely be similar across the enterprise inasmuch as pricing/underwriting decisions are made by a common management group (although some differences could arise between CFMI and GHMSI based on product differences and varying degrees of regulatory involvement in rate setting between jurisdictions).
- We are also mindful of the Pennsylvania case in which that state's commissioner determined in her review of surplus levels of four BCBSA licensees that the most appropriate way to analyze the operating characteristics and financial profile of each was on a consolidated basis.

The foregoing factors tend to favor the view that a consolidated approach is appropriate. On the other hand, we note the following:

- The ability of the CareFirst group of companies to move funds within the corporate structure is uncertain; unlike the Pennsylvania blues that have a parent-subsidiary relationship with entities within each group, CFMI and GHMSI are non-stock affiliates with no direct means to directly provide funding across the group to stem risk.

- There is a surplus guarantee in the Intercompany Agreement which can provide a source of funds in an emergency, but it cuts both ways; while one party to the agreement may be the beneficiary of its protection, that is at the expense of one or more other parties. Which party may need such benefits, when, and to what extent, is uncertain. Because of the interdependent nature of many risks that impact CFMI and GHMSI as well as CFBC, it is reasonably possible, if not likely, that if one of them was adversely impacted so as to trigger the guarantee that the others might also be experiencing similar difficulty which could preclude the ability of the other companies to make a transfer under the terms of the agreement. Additionally, payments to be made under the surplus guarantee would require regulatory approvals. Indeed, the surplus guarantee provision has not been triggered to date, and is therefore untested. For those reasons, Milliman made no provision for the surplus guarantee in their modeling of CFMI's or GHMSI's targeted surplus levels.

- Recent trends in financial services and lessons learned from the economic and credit crisis suggest an increased awareness of group risks and for regulatory supervision to be focused at that level. That means understanding the risks that can impact an entity that may emanate from its own affiliates and the ability to move sufficient funds on a timely basis within the group in response. Indeed, the risk-focused examination guidance of the NAIC indicates that examiners should be mindful of group risk and liquidity issues that may arise within a group of companies.

- CFMI and GHMSI are not domiciled in the same state which may present some unanticipated complications in resolving any need for cross-funding within the CareFirst group which might arise, at least in doing so on a sufficiently timely basis.

Weighing the pros and cons of separate versus consolidated evaluations of surplus for GHMSI and CFMI, our recommendation is that the MIA conform its approach to that brought forward by the NAIC's Risk Assessment Working Group and the resulting risk-focused examination approach: First understand the enterprise-wide profile of the CareFirst group and its risks that are presented on an intra-group basis to each legal entity in question. Having done that analysis (see *Background* section of this report) we find the organizational structure of CareFirst unique and in several ways problematic from the standpoint of the enterprise being able to avail itself of assets across the organization to

fend off risks wherever they arise within the organization. There are too many structural barriers, none of which can be overcome without regulatory approval from as many as three different jurisdictions. No assurance can be granted that such regulatory approvals will be forthcoming, or when, or with what additional conditions imposed. Therefore, we believe that only separate company evaluations of CFMI and GHMSI will best recognize the unique aspects of CareFirst's organizational structure and the limitations that exist in the company's ability to move funds within the group. We do note that separate evaluations were performed by Milliman (although those did combine CFBC's operations on a proportionate ownership basis with that of CFMI and GHMSI, a matter which we discuss below and in the section of our report entitled *Assessment of Milliman's Study*).

Inclusion of CFBC in the Surplus Evaluations: The question posed to us by the MIA as to separate versus consolidated evaluations related to CFMI and GHMSI. But in the course of our work, we noted another relationship within the CareFirst group that is worthy of similar discussion – CFBC. In its modeling of the premium rate adequacy and fluctuation risks of CFMI and GHMSI, Milliman included in its underlying data corresponding information in 60%/40% proportion, respectively, pertaining to CFBC. In other words, they effectively consolidated the exposures of CFMI and its share of CFBC, and of GHMSI and its share of CFBC. This appears logical in that, from an accounting perspective, whatever happens with regard to CFBC's surplus is picked up by CFMI and GHMSI in their respective 60%/40% ownership shares. However, it also assumes that there is free movement of funds within each of those pro forma consolidated groups. As we have described in the section of this report on the *Background Regarding CareFirst*, there are significant limitations on the movement of funds between CFBC and either of CFMI or GHMSI. Accordingly, we believe that prudent risk management would require both GHMSI and CFMI to carry some additional surplus in recognition that there are limitations on those movements of funds.

Frequency of Evaluations: To address the issue of how frequently the evaluations of nonprofit health plans are performed, we first identify differing levels of evaluation:

- First-level analyses would be those comparable to the study underlying this report, which required an in-depth process of evaluating information from the company and an independent assessment of work performed by the company and by its consultants in support of targeted surplus ranges. Absent evidence to the contrary such as sudden or unanticipated shifts in the business or the emergence

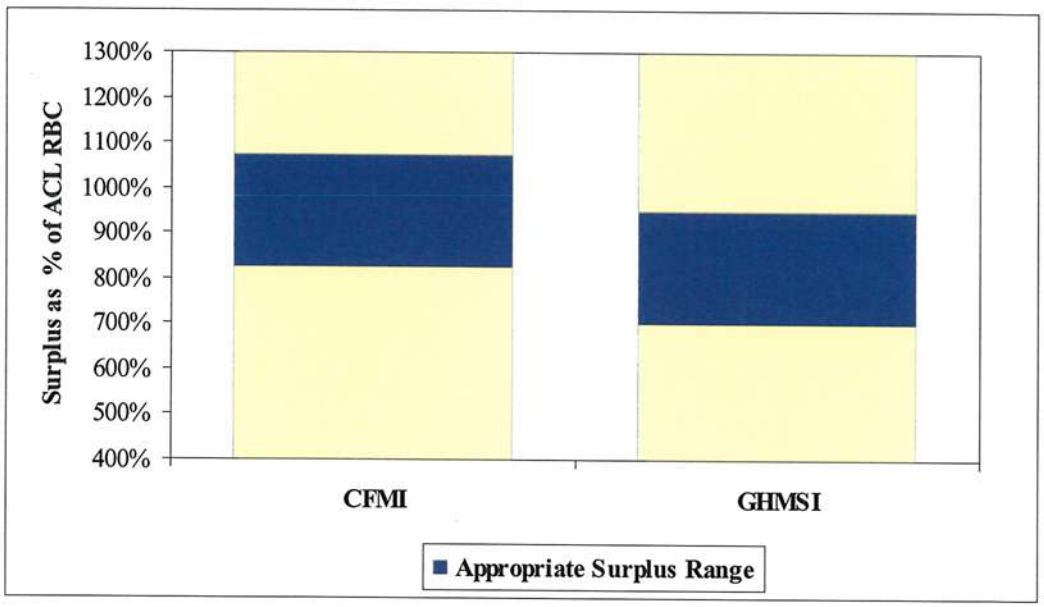
or manifestation of new and significant risks, such first-level analyses would not be necessary on an annual basis. For example, Milliman's first analysis of CFMI's and GHMSI's targeted surplus ranges was performed in 2005; their analysis was updated in 2008 and the resulting ranges shifted only slightly. We believe that a first-level review performed every 3-5 years should be sufficient, with the option to do so more frequently should events warrant – for example, to evaluate the impact of the outcome of national health care reforms on CFMI and GHMSI.

- Second-level analyses are based on the three-tiered RBC range developed herein and, as necessary, as updated by first-level reviews. The three-tiered RBC range model enables a quick annual review that can be done concurrent with the filing and analysis of the company's Annual Statement and its RBC Report.

Separate and apart from what the MIA does to evaluate targeted surplus ranges, the nonprofit health plans themselves should continue to perform and update their own analyses.

Whether their evaluation is based on a detailed analysis such as that performed in 2005 and 2008 by Milliman, or by a more judgmental extrapolation or otherwise in intervening years, we recommend that the MIA obtain management's representations annually asserting their responsibility for the determination of a targeted surplus range, the amount of that range expressed as a percentage of ACL RBC, whether that has changed from the prior year and, if so, why, where the company's surplus is currently relative to the targeted range, and whether notable changes have been made in the manner in which that has been determined, or in the governance over that process by management and applicable committees of the board.

Three-Tiered RBC Range Methodology : The appropriate range of surplus as determined by Invotex and as expressed as a multiple of ACL RBC is as follows for both CFMI and GHMSI:



The three-tiered range methodology would work as follows:

- When reported surplus is below the appropriate range, there is no imminent concern of solvency problems, but the company would be operating at surplus levels that are marginal compared to those dictated by a longer-term view to enable it to withstand risk and to effectively sustain itself in a competitive and changing environment. In such a situation, risk and contingency factors would be included in filed rates so as to foster surplus growth to enable the company to move back within the appropriate surplus range.

- When reported surplus is within the appropriate surplus range, the company has sufficient surplus and is better prepared to withstand risk and sustain itself over a longer term horizon. In this situation, the MIA would work with CFMI and/or GHMSI to approve rates and, if necessary, risk and contingency factors, to maintain the plans within their respective appropriate range of surplus given their unique risk profiles, growth trends, and other factors.

- When reported surplus is above the appropriate surplus range, the possibility of excess surplus is indicated, and the provisions of § 14-117 that provide for a public hearing and an evaluation by the Commissioner of the existence of excess surplus would be triggered.

We recommend that the MIA consider changes to laws, regulations, and/or practices that would adopt a Pennsylvania-like model that would result in the MIA and nonprofit health service plans working proactively together to include or approve, as appropriate, risk and contingency factors in filed rates to enable the nonprofit health service plans to maintain surplus within their respective appropriate range.

TAB 14

14. APPORTIONMENT

The MIA has requested that Invotex consider how, in determining the appropriate amount of surplus, surplus earned in more than one jurisdiction should be apportioned so as to insure that subscribers of a health benefit plan issued or delivered in the State of Maryland are adequately protected. [Emphasis added]

We understand that the question of apportionment was posed to us in a general context. However, a more specific context has arisen through the Medical Insurance Empowerment Amendment Act of 2008 which was adopted last year by the Council of the District of Columbia. Among other matters, the act provides as follows with respect to a hospital and medical service corporation such as GHMSI:

> "Within 120 days of the effective date of the Medical Insurance Empowerment Amendment Act of 2008.....and annually thereafter, the Commissioner shall review the portion of the surplus of the corporation that is attributable to the District and shall issue a determination as to whether the surplus is excessive...." [Emphasis added]

While Maryland does have statutory authority (§ 14-117) for the Commissioner to determine if the surplus of a nonprofit health service plan is excessive, the notion of apportioning surplus by geography or jurisdiction is not specifically mentioned therein.

The language in MIEAA and that of the MIA's charge to Invotex in the RFP is similar with respect to the notion that part of the entity's surplus is at issue. Exactly how one is to measure the amount of that part of surplus is unclear. However, both sources make clear that it relates to their respective jurisdiction, as follows:

- Maryland: "...so as to insure that subscribers of a health benefit plan issued or delivered in the State of Maryland are adequately protected."[40]
- District of Columbia: "...that is attributable to the District..."[41]

[40] RFP Scope of Work, 2.3 (2).
[41] DC ST § 31-3506.

Also seen in these phrases is that the District's act focuses on attribution or causation, whereas the language utilized in Maryland's RFP is more goal-oriented, e.g., to achieve adequate protection.

In financial terms, we understand that a key issue in the District of Columbia pertains to the $686,779,718 of total surplus of GHMSI as of December 31, 2008[42] and how to determine how much of that may be "excessive" or "unreasonably large" as described in the act inasmuch as the act prescribes a review only of "the portion of the surplus of the corporation that is attributable to the District."

It is first necessary to understand, what is "surplus." As a financial term, surplus is unique to the insurance industry and is specifically associated with statutory accounting for insurance companies. Statutory accounting principles currently are established by the NAIC and are adopted by the various states for application by licensed insurance companies in their financial filings with state insurance regulatory agencies using report forms and formats that are also prescribed by the NAIC. One of the most important concepts underlying statutory accounting is conservatism; the NAIC's Statutory Accounting Principles Statement of Concepts provides that "Statutory accounting should be reasonably conservative over the span of economic cycles and in recognition of the primary responsibility to regulate for financial solvency."[43]

Surplus is covered by Statement of Statutory Accounting Principles No. 72 and defined as representing "the undistributed and unappropriated amount of surplus at the balance sheet date."[44] SSAP No. 72 notes that surplus is comprised of the cumulative effect of various items of which the following are pertinent to GHMSI: net income, unrealized capital gains and losses on investments, nonadmitted assets, changes in accounting principles, corrections of errors, changes in deferred tax assets and deferred tax liabilities, and possibly other items as well.

Surplus is a by-product of the double-entry method of accounting. For every transaction, there is a self-balancing entry made so that the assets that are "admitted" – all or a portion

[42] Annual Statement for the Year 2008 of the Group Hospitalization and Medical Services, Inc., p. 28.
[43] Accounting Practices and Procedures Manual as of March 2008, Volume I, Accounting for and Disclosures about Transactions with Affiliates and Other Related Parties, IP 25-7.
[44] Accounting Practices and Procedures Manual as of March 2008, Volume I, Statement of Statutory Accounting Principles, 72-4.

of an asset that is permissible to be reported as an asset under statutory accounting principles – will always remain equal to the sum of liabilities and surplus (capital is ignored in this example inasmuch as the subject is GHMSI, a non-stock corporation). Thus, surplus itself is not a tangible thing that has a physical existence, value or obligation per se; rather, it is a conceptual representation that reflects the cumulative balancing effect of transactions that involve tangible assets and obligations. Simply put, it is the excess of admitted assets over reported liabilities as of a point in time.

The District's act provides that "If the Commissioner determines that the surplus of the corporation is excessive, the Commissioner shall order the corporation to submit a plan for dedication of the excess to community health reinvestment in a fair and equitable manner."[45] Given that surplus is simply an accounting convention, what is really at issue here is not the amount of *surplus* that could be spent or used for such community health reinvestment purposes, but rather the amount of GHMSI's *assets* that could be so dedicated. Assets, such as cash, can be spent; surplus can't. But in using net assets, there will be a corresponding reduction in surplus (net of applicable tax effects) which can impact an assessment of GHMSI's ability to protect its policyholders. This distinction is important because it highlights two different concerns: (1) the impact on surplus and the assessment of financial soundness of the company to protect its policyholders, and (2) the amount of assets that are actually available for the payment of claims and other obligations, i.e., liquidity.

With respect to liquidity, a significant issue exists with respect to the portion of CFMI's and GHMSI's surplus that is comprised of their respective equity in the undistributed earnings of CFBC. CFBC's surplus, and the assets that support it, belong to CFBC. The equity method of accounting provides that GHMSI and CFMI, as equity investors, report on their own books their share (60% and 40%, respectively) of the change in CFBC's surplus. However, should any portion of CFBC's surplus be required by GHMSI or CFMI for current needs, actual cash would have to be dividended upstream from CFBC. Such dividends would not be assured and are subject to:

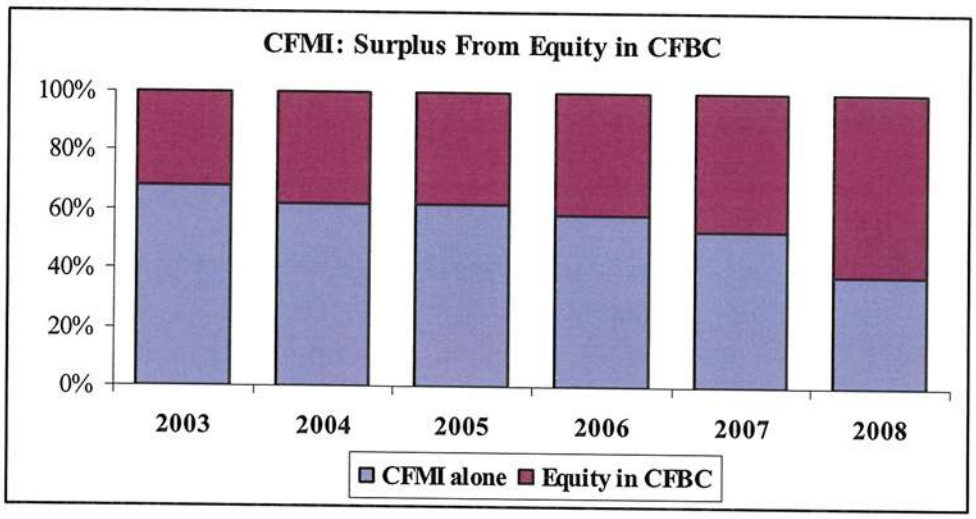
- A determination by CFBC and its board as to an amount to pay that would not reduce its own surplus below an amount deemed prudent to protect its

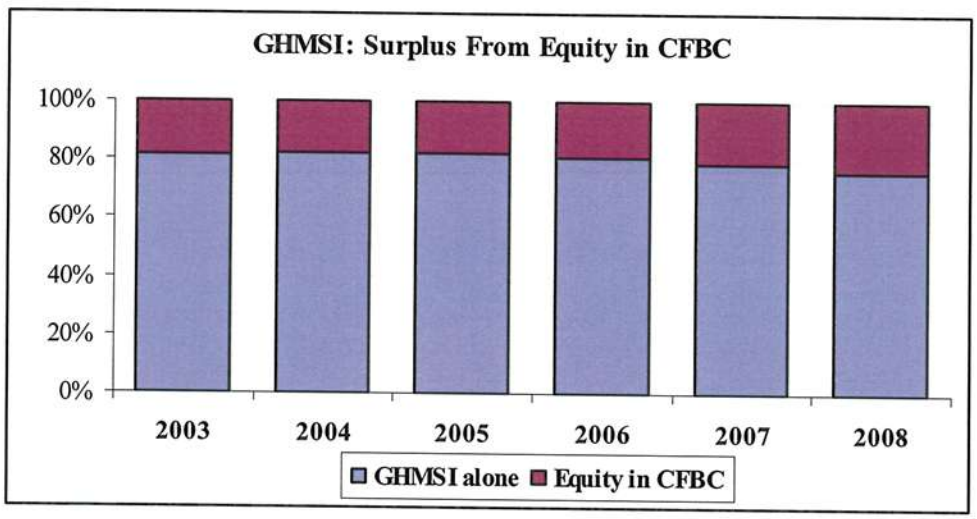
[45] DC ST § 31-3506.

policyholders in light of its own operations and risks; in effect, determining if there is any "excess surplus" at CFBC.

- A decision by CFBC's board to declare a dividend.
- Regulatory approval.

The following charts provide an indication of the amount of CFMI's and GHMSI's surplus that is comprised of their respective 60%/40% equity shares in CFBC's surplus, over time:





As can be seen from the charts above, CFMI's surplus is now more reliant on its equity in CFBC than from all other sources, whereas GHMSI's surplus attributable to its investment in CFBC is much smaller and relatively stable. This is due to CFMI's greater ownership percentage in CFBC as compared to GHMSI, and to CFMI's lower margins on its own business relative to margins experienced by GHMSI.

Another important feature to understand about surplus is that it exists as a measure to protect all of an insurer's insureds, regardless of their location. In that sense, surplus is not divisible. While each insured has an interest in knowing that the company is financially sound to honor its promises to them in the event they may have a claim, the only obligation the insurer has to the insured is to pay valid claims, which amounts are then reported in the unpaid claim liability in the balance sheet and which, to that extent, reduces surplus. No insured has a claim against the *surplus* of the insurer (although current subscribers would have certain rights under § 14-117 to the extent of surplus found to be excessive by the Commissioner after a public hearing). To the extent there is a valid claim (e.g., claim for coverage, premium refund, policyholder dividends where applicable) those are reflected in the *liability* section of the insurer's balance sheet.

The notion of apportionment presents an enigma in that it implies that once surplus has been divided, that a portion of a portion (e.g., some, not all, of the surplus that is attributable to the District) will then be used for some other purpose (community reinvestment in the District) or to otherwise benefit some policyholders greater than others, depending on jurisdiction. The concept suggests that there is a wall that could enable regulators in two or more different jurisdictions to separately evaluate the financial soundness of the company that exists to protect the specific contract holders in their jurisdiction.

The problem is, no such wall exists regarding GHMSI, nor is there any precedent for such a wall that we are aware of within the insurance industry or its regulation by the states. The concept of such a wall is flawed in that it is antithetical to the fundamental purpose of surplus which is to protect all of the insurer's policyholders. The concept of apportionment thus is analogous to trying to lower the water level in the right half of a swimming pool while leaving the water level in the left half at its original height. Just as the water will instantly seek a uniform lower level across the entire pool, so will the

surplus of an insurer seek a uniform lower level and thus impact the financial soundness of the company from the standpoint of all contract holders, regardless of their location.

Therefore, any effort by one jurisdiction (e.g., DC pursuant to MIEAA) to apportion surplus and use the company's assets for purposes unrelated to the claims of existing contract holders will, by definition, lower the surplus of the entity as a whole and, to that extent, leave the contract holders in both jurisdictions (MD, VA and DC) less protected than they were before.

Thus, the net effect of the District's act with respect to attribution on the financial condition of GHMSI is to spread the negative impact on surplus to all; it does not impact just DC's insureds or residents with no adverse impact on others. As a simple example, if the District determined that 50% of the surplus of GHMSI is attributable to the District and that 20% of that is excessive, based on December 31, 2008 reported amounts that would equate to $68,677,972.[46] If GHMSI was required to expend that amount, it would reduce surplus by 10%. Each existing contract holder – regardless of jurisdiction – would therefore be supported by an insurer that has that much less surplus than it did before. To that extent, they are all less protected.

In short, we find the notion of apportionment of surplus attributable to a particular jurisdiction – as is embodied in MIEAA – to be a concept that has no financial meaning, applicability, or relevance. It is a concept that should be reconsidered.

The Challenges of Attribution: The fact that all contract holders may be less protected does not mean that a jurisdiction still won't proceed with a determination of excess surplus and effectively cause the company to disgorge assets for purposes unrelated to existing obligations to subscribers. In that event, there still remains the difficulty in measuring how much surplus is attributable to each jurisdiction. That presents a myriad of potential difficulties, including the following:

- As described above, surplus is the cumulative, inception-to-date impact of every transaction involving the company: earned premiums, incurred claims, investment

[46] $686,779,718 of total capital and surplus (Annual Statement for the Year 2008 of the Group Hospitalization and Medical Services, Inc., p. 28) times 50% times 20%.

earnings and gains and losses (both realized and unrealized), administrative expenses, taxes, and much more.

- While some transactions might be "tagged" in one way or another to a jurisdiction (e.g., the addresses of contract holders), many others are not (e.g., all investments are made out of a common pool in which the funds are fungible).
- Notwithstanding that the District's act requires a determination of "the portion of the surplus of the corporation that is attributable to the District," there is no prescribed way to do that, nor is there any practical way to do so after the fact looking back on many years short of a calculation that would, by necessity, have to involve very broad assumptions.

For example, consider investment earnings. For GHMSI, its total surplus as of December 31, 2008 was $687 million.[47] Because of the company's difficulties in the early 1990s, we can generally make the case that surplus accumulated from 1993 forward. Over that time frame, a cumulative view of the sources and uses of surplus is as follows ($ in thousands):

GHMSI Surplus

Underwriting gains	$	359,170
Investment gains		397,843
Other income		55,883
Income taxes		(118,091)
Net income		694,805
Unrealized gains		151,834
Nonadmitted assets		(127,097)
Payments on surplus notes		(55,000)
Pension change		(22,773)
Other		(8,033)
		633,735
Surplus, Dec.31, 1993		53,044
Surplus, Dec.31, 2008	**$**	**686,780**

As the chart shows, a significant portion of GHMSI's surplus is comprised of investment earnings and realized gains and losses. These transactions are made from a common pool of investable asset funds that is not designated by source. While it is true that investable

[47] Annual Statement for the Year 2008 of the Group Hospitalization and Medical Services, Inc., p. 28.

funds emanate from subscriber premiums, once pooled they are fungible and there has been neither need nor means to attribute them to a source jurisdiction.

Key among those assumptions is whether apportionment should be made on the basis of residency of individual subscribers and certificate holders, on the basis of situs of the contract, or perhaps split in some way recognizing that in the case of group coverage that a portion of the premium may be paid by the employer and a portion paid by employees who may reside in various jurisdictions. The ability of GHMSI to accurately determine amounts relating to increasingly more complex theories as to how to determine attribution of surplus is inherently difficult if not impossible given that the need to make such calculations was never anticipated years ago and therefore the mechanics and data requirements to do so were not put in place.

Therefore, and with respect to the notion of attribution, any basis for calculation will be inherently subject to significant overarching assumptions of questionable validity.

Structural Means of Apportioning Surplus: There are ways in which insurers can effectively wall off surplus for the benefit of specific groups of subscribers or policyholders, but they involve structural mechanics that are not currently in place at CareFirst. Moreover, and while they might accomplish one goal of apportioning surplus, they may nonetheless abdicate other beneficial goals that exist at CareFirst. For example, segmenting the company into smaller risk pools results in less diversification of risk and a higher surplus requirement, all other factors held equal. And, doing so may make for a much less efficient operation and thus negate the benefits of affiliation. Nonetheless, we share some of these structural means of apportioning surplus for the MIA's consideration:

- Separate legal entities: Use of multiple legal entities in a group is common, and is often the result of (1) the desire to maintain separate pricing tracks as in the case of preferred and standard auto insurance risks, (2) legal requirements in some states that require separate state-by-state legal entities for HMOs, or (3) the desire to limit other risks, such as certain extraterritorial provisions of state laws in New York that have resulted over the years in many insurers setting up New York-only affiliates. Where separate legal entities are involved, their surplus is available to protect only the policyholders of each respective entity. In the case of CFMI and GHMSI, they are separate legal entities, but the underwriting experience in each

reflects their traditional marketing territories — a geographic footprint that does not match state boundaries. Therefore, and should the MIA desire to have more control over the degree of protection provided to all Maryland subscribers, one possibility is that it could work with CareFirst to align underwriting along state boundaries, e.g., all policies sold or delivered in the state of Maryland by CareFirst would be underwritten by, and only by, CFMI.

- In certain troubled company situations, states have often caused insurers to place additional funds in a separate deposit held by the state. In such situations, and if the company were to advance into receivership, those funds would form the basis of an ancillary receivership and would be used first to pay the claims of subscribers or policyholders in that state. Conceptually, this could be another technique that the MIA could use to assure that Maryland subscribers are protected. In effect, it involves the apportionment and control over assets, rather than the apportionment of surplus per se. Nonetheless, in our experience such measures by states to look after their own come at the expense of the greater good which is to work with all interested states in assuring that the company is in sound financial condition for the benefit of all and, if not, that appropriate remedial actions are taken on a timely basis.

- In the case of mutual insurance companies that seek to become stock companies, they undergo what is referred to as a demutualization process, a process that is established by statute and overseen by the domestic state insurance department. In those situations, the surplus of the company as of a point in time is sourced to individual policies that had been in force over time. This involves an intensive effort to gather and analyze data and to perform allocations so as to determine an amount of surplus on a policy-by-policy basis. The most notable of demutualizations to date have involved many of the larger life companies that converted over the past 10-15 years, including Prudential and MetLife. While there is no thought here that CareFirst would convert in a similar manner, the notion of allocating surplus is nonetheless akin to what these life insurers have gone through.

In the case of CareFirst and with respect to the DISB's consideration of the surplus of GHMSI in the context of the MIEAA, the most practical scenario may be one in which

both the MIA and the DISB agree as to whether there is an excess surplus and, if so, to what extent, and GHMSI then submits a plan calling for that excess surplus to benefit existing subscribers over a reasonable time frame, presumably through temporary premium rate deferrals or similar means. In this manner, the benefits would then be allocated back by jurisdiction and by group or subscriber in close proportion to the source of recent contributions to surplus.

TAB 15

15. CONCLUSIONS

Through our study, we gained an adequate understanding of CareFirst and its unique and in some respects inefficient corporate stucture; of CFMI and GHMSI specifically; of the work performed by Milliman in support of their evaluation of targeted surplus ranges for CFMI and GHMSI; and of surplus requirements of other states. We applied our knowledge of the industry and of surplus evaluation techniques, performed a risk analysis of the companies, performed peer review analysis, and assessed Milliman's work.

As a result of those efforts, we derived a unique range of surplus that we believe to be appropriate for each of CFMI and of GHMSI. Notwithstanding that both of these entities are nonprofit health service plans within an affiliated group, they have somewhat differing risk profiles which resulted in a different range of surplus for each company. For both companies, our range was somewhat lower and tighter than Milliman's range, expressed as a percentage of ACL RBC.

With our range established, we addressed certain specific questions posed to us by the MIA:

- Does the existing Maryland statute pertaining to surplus requirements of nonprofit health surplus plans adequately protect Maryland subscribers? *We believe it does not, and have posed recommendations for the MIA's consideration.*
- What should be the appropriate risk based capital requirements for nonprofit health service plans? *We believe that the appropriate amounts are as determined based on our analysis: 825-1075% ACL RBC for CFMI, and 700-950% ACL RBC for GHMSI.*
- What methodology should the MIA use going forward? *We believe an effective model to use is a three-tiered range concept that focuses on different actions for the company and the MIA to take when reported surplus amounts are below, within, or above an appropriate range of surplus as determined in our study.*
- Should the surplus evaluations be made on a combined basis or on a stand-alone basis for each of CFMI and GHMSI? *Because the unique organizational structure of the CareFirst group creates an inefficient means to manage risk and surplus*

across the enterprise, surplus evaluations should be performed separately for each company.

- How frequently should surplus evaluations be made? *Every 3-5 years should be adequate, but more frequent evaluations may be appropriate from time to time depending on events impacting the company. For example, an updated or supplemental analysis may be appropriate once the outcome of health care reforms at the national level is known.*

- Would the apportionment of surplus enhance the protection of Maryland subscribers to nonprofit health service plans operating in more than one state? *No; it is a concept that has no financial meaning, applicability, or relevance and should be reconsidered.*

The section in the front of our report entitled *Summary of Findings and Recommendations* contains more information on these and other points resulting from our study. The summary also references page numbers in the report text where additional supporting information for each recommendation can be found.