

**Response of Group Hospitalization and Medical Services, Inc.
to Supplemental Information Request 1(d)
in DISB Order No. 14-MIE-08 (October 3, 2014)
Submitted October 31, 2014**

**Summary of 2011 Data
Utilizing the Categories/Format on Page 18 of Rector's July 2010 Report**

Method	DC	MD	VA	Other	Source
Number of Policies by Jurisdiction	18.92%	45.21%	29.94%	5.93%	Table 1
Number of Providers by Jurisdiction	14.88%	65.91%	19.21%		Table 3
Premiums by Jurisdiction	19.03%	49.57%	29.56%	1.84%	Table 4
Number of Certificate holders by Jurisdiction	12.05%	47.24%	20.83%	19.88%	Table 2
Claim Expenses by Jurisdiction of the Policyholder	18.44%	49.70%	29.82%	2.04%	Table 5
Paid Claim Expenses by Jurisdiction	11.97%	67.79%	17.15%	3.10%	Table 6
Milliman Analysis	11.30%				Attached Report from Milliman

Notes:

1. The footnotes to each of the following tables identify the data used to prepare the table. Milliman's analysis is explained in the attached letter from Phyllis Doran.

Table 1: Policies, By Jurisdiction of Policyholder

As of December 31, 2011

Entity	DC	MD	VA	Other	Total
GHMSI (non-FEP)	12,023	24,659	18,423	0	55,105
GHMSI (FEP Only)	39,062	82,026	63,845	16,992	201,925
GHMSI (Total)	51,085	106,685	82,268	16,992	257,030
BlueChoice (non-FEHBP)	5,306	35,496	4,271	0	45,073
BlueChoice (FEHBP Only)	1,491	11,548	3,611	177	16,827
BlueChoice (Total)	6,797	47,044	7,882	177	61,900
GHMSI + 50% BlueChoice	54,484	130,207	86,209	17,081	287,980
GHMSI + 50% BlueChoice (%)	18.92%	45.21%	29.94%	5.93%	100%

Notes:

1. "Policyholder" refers to the individual policyholder in the individual market, the employer/group plan in the group insured and self-insured markets, and the certificate holder for FEP/FEHBP plans.
2. The categories "Non FEP" and "Non FEHBP" include individual insured, group insured, and group self-insured business.
3. The category "Other" includes overseas certificate holders for FEP, and out-of-area certificate holders for FEHBP.

Table 2: Number of Subscribers & Certificate Holders by Jurisdiction

As of December 31, 2011

Entity	DC	MD	VA	Other	Total
GHMSI	68,720	206,376	120,990	119,959	516,045
BlueChoice	22,592	214,406	34,526	23,946	295,470
GHMSI + 50% BlueChoice	80,016	313,579	138,253	131,932	663,780
GHMSI + 50% BlueChoice (%)	12.05%	47.24%	20.83%	19.88%	100.00%

Notes:

1. Subscribers are attributed on the basis of residence. Individual policyholders, group insured and self-insured certificate holders, and FEP/FEHBP certificate holders are included.
2. "Other" represents subscribers living outside of CareFirst's service area, including FEP overseas certificate holders (identified on Table 1) and FEHBP out-of-area certificate holders (identified on Table 1).

Table 3: Network Providers by Jurisdiction

As of December 31, 2011

Entity	DC	MD	VA	Total
GHMSI (RPN Network)	6,319	26,943	7,823	41,085
BlueChoice (HMO Network)	5,073	24,593	7,225	36,891
GHMSI + 50% BlueChoice	8,856	39,240	11,436	59,531
GHMSI + 50% BlueChoice (%)	14.88%	65.91%	19.21%	100.00%

Notes:

1. GHMSI contracts with providers throughout Northern Virginia, DC, and Maryland through its Regional Provider Network for PPO products. BlueChoice contracts with providers throughout the same area through the BlueChoice network for HMO products.
2. Counts are based on individual practitioners. A practitioner is counted one time in each jurisdiction where the practitioner has at least one office location. A practitioner with multiple offices in the same jurisdiction is counted once for that jurisdiction.
3. The above chart includes providers in Maryland, DC, and Virginia. There are a small number of providers contracted with GHMSI or BlueChoice outside of the companies' service territory. In addition, members have nationwide access to a very large number of in-network providers through the Blue Cross and Blue Shield Association's BlueCard program, utilizing networks maintained by other Blue Cross and Blue Shield Plans. Those providers have not been included.

Table 4: Premiums By Jurisdiction of Policyholder

Calendar Year 2011

Entity	DC	MD	VA	Other	Total
GHMSI (non-FEP)	\$473,305,211	\$710,702,600	\$516,253,778	\$0	\$1,700,261,589
GHMSI (FEP)	\$250,895,648	\$733,798,465	\$664,686,724	\$80,987,221	\$1,730,368,058
Total GHMSI	\$724,200,859	\$1,444,501,065	\$1,180,940,502	\$80,987,221	\$3,430,629,647
BlueChoice (non-FEHBP)	\$231,586,264	\$1,406,340,822	\$233,708,673	\$0	\$1,871,635,759
BlueChoice (FEHBP)	\$15,459,378	\$119,735,009	\$37,440,519	\$1,835,218	\$174,470,124
Total BlueChoice	\$247,045,642	\$1,526,075,831	\$271,149,192	\$1,835,218	\$2,046,105,883
GHMSI + 50% BlueChoice (\$)	\$847,723,680	\$2,207,538,980	\$1,316,515,098	\$81,904,830	\$4,453,682,589
GHMSI + 50% BlueChoice (%)	19.03%	49.57%	29.56%	1.84%	100.00%

Notes:

1. Source: Amended 2011 Exhibit of Premiums, Enrollment and Utilization from GHMSI and BlueChoice Annual Statements, as modified with respect to FEP overseas policyholders (discussed below in note 3). Includes individual and group risk, FEP, FEHBP, and stop loss business.
2. Premiums for individual and group insured business are attributed to the jurisdiction in which the insurance policy was issued.
3. Premiums for FEP certificate holders are attributed to the jurisdiction in which the certificate holder resides. For FEP, the category "Other" includes premiums for FEP overseas certificate holders. Premiums for FEP overseas certificate holders were included with reporting for the District of Columbia on the amended 2011 Annual Statement for GHMSI, but have been broken out separately here.
4. FEHBP premiums are attributed to Maryland in the 2011 Amended Annual Statement for BlueChoice. For purposes of the chart above, FEHBP premiums for each jurisdiction were estimated, by allocating total FEHBP premiums between jurisdictions in proportion to the number of certificate holders, shown on Table 1. For FEHBP, the category "Other" includes out-of-area certificate holders.

Table 5: Paid Claims Expense By Jurisdiction of Policyholder

Calendar Year 2011

Entity	DC	MD	VA	Other	Total
GHMSI (non-FEP)	\$359,357,688	\$573,516,291	\$417,099,553	\$0	\$1,349,973,532
GHMSI (FEP)	\$228,583,803	\$673,496,473	\$581,621,083	\$74,353,023	\$1,558,054,382
Total GHMSI	\$587,941,491	\$1,247,012,764	\$998,720,636	\$74,353,023	\$2,908,027,914
BlueChoice (non-FEHBP)	\$171,214,667	\$1,071,009,385	\$170,694,201	\$0	\$1,412,918,253
BlueChoice (FEHBP)	\$13,045,376	\$101,038,230	\$31,594,133	\$1,548,646	\$147,226,385
Total BlueChoice	\$184,260,043	\$1,172,047,615	\$202,288,334	\$1,548,646	\$1,560,144,638
GHMSI + 50% BlueChoice (\$)	\$680,071,512	\$1,833,036,571	\$1,099,864,803	\$75,127,346	\$3,688,100,233
GHMSI + 50% BlueChoice (%)	18.44%	49.70%	29.82%	2.04%	100.00%

Notes:

1. Source: Amended 2011 Exhibit of Premiums, Enrollment and Utilization from GHMSI and BlueChoice Annual Statements, as modified with respect to FEP overseas policyholders (discussed below in note 3). Includes individual and group risk, FEP, FEHBP, and stop loss business.
2. Claims for individual and group insured business are attributed to the jurisdiction in which the insurance policy was issued.
3. Claims for FEP certificate holders are attributed to the jurisdiction in which the certificate holder resides. For FEP, the category "Other" includes claims for FEP overseas certificate holders. Claims for FEP overseas certificate holders were included with reporting for the District of Columbia on the amended 2011 Annual Statement for GHMSI, but have been broken out separately here.
4. FEHBP claims are attributed to Maryland in the 2011 Amended Annual Statement for BlueChoice. For purposes of the chart above, FEHPB claims for each jurisdiction were estimated, by allocating total FEHBP claims between jurisdictions in proportion to the number of certificate holders, shown on Table 1. For FEHBP, the category "Other" includes out-of-area certificate holders.

Table 6: Paid Claims Expense by Jurisdiction of Provider/Payee

Calendar Year 2011

Entity	DC	MD	VA	Other	Total
GHMSI	\$146,504,729	\$702,832,983	\$208,807,860	\$39,044,211	\$1,097,189,783
BlueChoice	\$93,896,006	\$786,247,389	\$136,895,957	\$22,069,151	\$1,039,108,503
GHMSI + 50% BlueChoice	\$193,452,732	\$1,095,956,678	\$277,255,839	\$50,078,787	\$1,616,744,035
GHMSI + 50% BlueChoice (%)	11.97%	67.79%	17.15%	3.10%	100.00%

Notes:

1. Payments allocated based on jurisdiction to which payment is made, as provided by treating provider on claim submission. "Other" jurisdiction represents providers with a payment address outside of CareFirst's service area.
2. In accordance with data utilized in Rector's 2010 analysis, individual and group insured business is included.
3. FEP/FEHBP business is not included. Due to the systems utilized for implementation of the nationwide FEP program, FEP PPO claims are received by GHMSI without a provider address or meaningful identification of the provider's jurisdiction.

**Attachment 1: Letter from Phyllis Doran of Milliman
dated October 31, 2014**



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

October 31, 2014

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

Re: Milliman Response to DISB October 3, 2014 Order with Supplemental Information Requests – Item 1.d.

Dear Jeanne:

This material is provided in response to Item 1.d. of the *Order with Supplemental Information Requests (Order No. 14-MIE-008)* issued by Acting Commissioner Chester A. McPherson of the District of Columbia Department of Insurance, Securities and Banking (DISB), dated October 3, 2014. We previously responded to Items 1.a, 1.b, and 1.c of the Order, in my letter to you of October 15, 2014.

Item 1.d. states: “Please provide to DISB data, as of December 31, 2011, for the surplus attribution factors listed on page 18 of Rector’s July 21, 1010 Report, available at <http://disb.dc.gov/node/332152>.” A table on page 18 of that report, titled “Surplus Attribution Factors”, presents factors by jurisdiction for the District of Columbia (D.C), Maryland, and Virginia. You have asked us to respond to the DISB request with respect to the last line of that table, labeled “Milliman Attribution Method”, which contains a value of 11.6% for the District of Columbia jurisdiction.

The 11.6% value was taken from Milliman’s report of August 28, 2009 titled “*Group Hospitalization and Medical Services, Inc.; Evaluation of GHMSI Surplus Attributable to D.C.*” It represents Milliman’s estimate of the portion of Group Hospitalization and Medical Services, Inc (GHMSI) surplus as of December 31, 2008 that is attributable to D.C., based on the methodology, assumptions, and considerations presented in our August 28, 2009 report. I have attached a copy of that report to this document as **Attachment A**.

As described in Attachment A, Milliman undertook this analysis at the request of GHMSI. The request was made in view of 2008 legislation (the MIEAA) providing that, initially and then on an annual basis, “. . . *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.*”

In response to the current DISB request, we have extended the analysis underlying our 2009 report in order to estimate the portion of GHMSI surplus as of December 31, 2011 that is attributable to D.C. This extended analysis produces a value of 11.3% as Milliman’s estimate of the portion of GHMSI’s surplus as of December 31, 2011 that is attributable to D.C., as presented in the table below.

Summary of Estimated Surplus Attributable to D.C. (Values in Millions)			
	GHMSI December 31, 2011 Reported Statutory Surplus	Estimated % Attributable to D.C.	Estimated Surplus Attributable to D.C.
Parent Excluding Value of CFBC	\$625.8	15.0%	\$93.6
CFBC Value¹ Full Value GHMSI Ownership Share²	\$675.6 \$337.8	4.4%	\$30.0 \$15.0
Total GHMSI²	\$963.6	11.3%	\$108.5
¹ Includes CareFirst BlueChoice (CFBC) and affiliate FirstCare, Inc. (FCI)			
² Reflects GHMSI 50% ownership share of CFBC			

Note that, as in our 2009 analysis, we have developed separate estimates for the parent, excluding the value of insuring subsidiaries (CareFirst BlueChoice and affiliate, FirstCare, Inc.) vs. the portion that represents the value of these subsidiaries.

Methodology

The methodology that we followed is the same as that employed in our 2009 analysis, described in our 2009 report as follows:

The estimation methodology that we have employed in developing surplus attributable to D.C. involves the analysis of historical annual changes in surplus values as reported in GHMSI's Statutory blank. Each year's change in surplus, due to operating results and other factors, was evaluated in order to attribute an appropriate portion to each jurisdiction. In order to carry out this evaluation it was necessary to supplement the information reported in the Statutory blank with additional data tabulations drawn from GHMSI's internal reporting and information systems. The approach we have selected is designed to be relatively straightforward, allowing future replication and updating with a reasonable level of effort.¹

Our 2009 study involved the analysis of the reported change in surplus values by year for the period of 1999 through 2008, in order to evaluate which portion of each year's amount is attributable to D.C. The Statutory surplus value as of December 31, 1998 was then assumed to be attributed by jurisdiction in the same proportions as the surplus accumulated from 1999 through 2008.

For purposes of extending our analysis to December 31, 2011, we considered the additional reported change in surplus values for the period of 2009 through 2011. We also reflected the change in GHMSI's ownership percentage of CFBC from 40% to 50% effective as of December 31, 2010, as well as the cash transactions and surplus transfers that accompanied that ownership change.

We considered two alternative approaches to the determination of how membership, premium, and other financial measures would be attributed by jurisdiction. These were: (a) attribution of values to the jurisdiction in which a given subscriber resides (the "residence" approach), or (b) attribution to the jurisdiction of the situs of the associated contract, meaning the residence of an individual subscriber or the situs of the employer of

¹ Milliman, *Group Hospitalization and Medical Services, Inc.; Evaluation of GHMSI Surplus Attributable to D.C.*, dated August 28, 2009 (hereinafter, "Milliman"), Page 7.

a group subscriber (the “situs” approach). We used the residence approach, and explained our selection of this approach in our 2009 report as follows:

While we are not attorneys and cannot offer legal interpretations, it appears to us that the intent of the legislation is to have any distribution of surplus that results from the application of the requirements of the law benefit residents of the District of Columbia. It was our conclusion, based on this understanding, that the residence method is the appropriate alternative. If the funds are to be used to benefit only D.C. residents, then it would seem that they should be comprised of amounts that are attributable to only D.C. residents. The situs approach, if used instead, could have the effect of causing surplus that was attributable in part to residents of Maryland and Virginia to be expended on behalf of residents of D.C. only. This would not be equitable, and we concluded that the situs approach would therefore not be appropriate.²

As indicated in the table above, our estimate of the portion of GHMSI surplus as of December 31, 2011 that is attributable to D.C., based on our extended analysis using the methodology outlined here and described in our August 28, 2009 report, is 11.3%.

Limitations and Caveats

This letter refers to, and relates to, Milliman’s August 28, 2009 report titled “*Group Hospitalization and Medical Services, Inc.; Evaluation of GHMSI Surplus Attributable to D.C.*”, which is included as Attachment A to this document. It should be considered only in connection with that report; applicable terms, concepts, and methodological descriptions are not repeated here. The limitations and caveats presented in that report also apply to this letter.

In developing these estimates, Milliman has relied on various descriptions, data, and sources of information provided by GHMSI. We have not audited or verified this data or information. If there should be any inaccuracies in this information, then the results shown may be affected accordingly.

² Milliman, Page 6.

The results presented in this report represent estimates, and are based on the methodology described. Other methods could be expected to produce different results. Further, application of this methodology in future years may produce different results.

This material was developed for the exclusive use of GHMSI management, for its internal consideration in connection with surplus targets. We understand that GHMSI may wish to share this material with regulators and their professional advisors in the District of Columbia, Maryland and Virginia, or other appropriate regulators. We hereby grant permission, so long as the document is provided in its entirety. We recommend that any party receiving this material have its own actuary or other qualified professional review this material to ensure that the party understands the assumptions and uncertainties inherent in our estimates. Milliman does not intend to benefit any third party either through this analysis or by granting permission for this material to be shared with other parties.

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

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

Sincerely,

A handwritten signature in cursive script that reads "Phyllis Doran".

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

PAD/jpj/go



CareFirst, Inc.
Group Hospitalization and Medical Services, Inc.

Evaluation of GHMSI Surplus Attributable to D.C.

August 28, 2009

Prepared by:

Robert H. Dobson, F.S.A.
Phyllis A. Doran, F.S.A.
James A. Dunlap, F.S.A.

Evaluation of GHMSI Surplus Attributable to D.C.

I. Introduction

At the request of CareFirst, Inc., Milliman has carried out an analysis of the surplus accumulation of Group Hospitalization and Medical Services, Inc. (GHMSI). This analysis addresses the estimated portion of the accumulated Statutory surplus that is attributable to the District of Columbia (D.C.).

In December 2008 the D.C. Council enacted an amendment to the Hospital and Medical Services Corporation Regulatory Act of 1996, known as the “Medical Insurance Empowerment Amendment Act of 2008”. This Amendment Act included a provision that requires the Commissioner of Insurance to determine whether the portion of the surplus of GHMSI that is attributable to D.C. is excessive. We were asked by CareFirst to evaluate what portion of the GHMSI surplus could be considered attributable to D.C.

We have estimated that 11.6% of GHMSI’s surplus as of December 31, 2008 is attributable to D.C. This report describes our approach to this evaluation. We believe that the assumptions and methods underlying our analysis are reasonable and appropriate based on the data and other information available and the purpose for which it has been developed.

Limitations

In developing these estimates, Milliman has relied on various descriptions, data, and sources of information provided by CareFirst. We did not audit any of the information we received, although we did review it for general reasonableness. If there should be any inaccuracies in this information, then the results shown may be affected accordingly.

The results presented in this report represent estimates, and are based on the methodology described. Other methods could be expected to produce different results. Further, application of this methodology in future years may produce different results.

Use of Work Product

This material has been prepared for the use of and is only to be relied upon by the management of CareFirst. We understand that CareFirst may wish to share this report with regulators in the District of Columbia and other jurisdictions in which they are licensed. We hereby grant permission, so long as the document is provided in its entirety. Milliman does not intend to benefit any third party either through this analysis or by granting permission for this report to be shared with other parties.

This report represents the opinions of the authors and does not necessarily reflect the opinions of other Milliman consultants. The authors are Members of the American Academy of Actuaries and meet its qualification standards for performing this type of analysis.

Judgments as to the conclusions contained in our report should be made only after studying the report in its entirety. Furthermore, conclusions reached by review of a section or sections on an isolated basis may be incorrect. The results in this report are technical in nature and are dependent upon specific assumptions and methods. No party should rely upon these results without a thorough understanding of those assumptions and methods. Such an understanding may require consultation with qualified professionals.

II. Background and Role of Surplus

The Medical Insurance Empowerment Amendment Act of 2008 provides that, initially and then on an annual basis, “. . . *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.*” In view of this legislation, CareFirst management asked for Milliman’s assistance in evaluating the portion of GHMSI surplus that could be considered attributable to the District.

Adequate surplus is central to the viability and sound operation of any insuring organization. It is needed to enable a company like GHMSI to ensure that the promises and commitments to its customers, as well as to hospitals, physicians, and other providers, can be met. In addition to providing for the many and varied risks assumed by an insuring organization, surplus is needed to develop new products, maintain service capabilities, respond to regulatory requirements, build infrastructure, and generally operate effectively as a viable ongoing business entity over time.

The surplus is available for the protection of all policyholders and for the sound business operations of the entity as a whole. GHMSI management must continually evaluate and monitor surplus requirements, and make decisions regarding the products and services offered by the company in order to ensure its ability to provide sufficient protection from risks (known and unknown) and contingencies. These decisions are made based on the conditions and operations of the entire company. All members are protected by the same surplus, without regard to their line of business, type of product, age, gender, geographic location, or other classification.

The concept of attributing accumulated surplus to geographic jurisdictions within the same company is not one that we have seen employed in the health insurance industry and we are aware of no precedent for this process. While the attribution of existing surplus arises in the demutualization of an insurance company, in that situation a portion of the surplus is allocated to policyholders as consideration for relinquishing membership rights. Geographic jurisdiction is

generally not a direct factor in this allocation process. In any case, the demutualization process represents a unique circumstance where surplus is being allocated over the policyholders / owners of the company for the purpose of reorganizing the company. This is decidedly different from attempting to allocate the surplus of a not-for-profit corporation where surplus is maintained for the ongoing protection of the policyholders.

Given these considerations, we believe that any attribution of GHMSI surplus by jurisdiction is artificial. The surplus is intended to benefit all policyholders. If the portion determined to be attributable to D.C. were found to be excessive and therefore used for other purposes, the protection afforded to all policyholders, including those in Maryland and Virginia, would be diminished. Likewise, if the regulators in Maryland or Virginia were to determine that the surplus attributable to their respective jurisdictions was to be expended for a designated purpose, the protection of all policyholders, including those in the District, would be affected.

Note that our analysis is limited to the surplus of GHMSI and does not include any consideration of the relationship of GHMSI to the holding company CareFirst, because the law applies only to hospital and medical service corporations.

III. Development of Estimated Surplus Attributable to D.C.

We have developed an estimate of the portion of GHMSI surplus as of December 31, 2008 that is attributable to D.C., as summarized in the following table.

Summary of Estimated Surplus Attributable to D.C. (Values in Millions)			
	GHMSI December 31, 2008 Reported Statutory Surplus	Estimated % Attributable to D.C.	Estimated Surplus Attributable to D.C.
Parent Excluding Value of CFBC	\$524.1	13.9%	\$72.8
CFBC Value	162.7*	4.2%**	6.8
Total GHMSI	\$686.8	11.6%	\$79.5
* Full value ** Reflects GHMSI 40% ownership share			

Note that we have developed separate estimates for the portion of GHMSI surplus that excludes the value of CareFirst BlueChoice (CFBC), a partially-owned affiliate, vs. the portion that represents the value of CFBC. This and other facets of our development are discussed below.

Considerations in Development of Methodology

As mentioned previously, we are unaware of any precedent for the development of surplus attributable to geographic jurisdictions within the same company. In defining the approach that we have utilized, we considered the purpose for which this development is to be used, the characteristics of GHMSI's business, and the limitations of the available historical data. Our objective was to develop a methodology within these parameters that is equitable, and at the same time relatively straightforward and replicable. We believe that the assumptions and methodology we have employed meet this objective, and that they are reasonable and appropriate from both an actuarial and a general financial perspective.

Following is a brief discussion of some of the major considerations in the development of our approach, and the manner in which they have been addressed in our evaluation.

Purpose – The development of estimated surplus attributable to the District has been prepared in response to recent legislation that requires the Commissioner of Insurance to determine whether the portion of the surplus of GHMSI that is attributable to D.C. is excessive. This legislation also states 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.”*

Determination of Jurisdiction – We considered two alternative approaches to the determination of how membership, premium, and other financial measures would be attributed by jurisdiction. These were: (a) attribution of values to the jurisdiction in which a given subscriber resides (the “residence” approach), or (b) attribution to the jurisdiction of the situs of the associated contract, meaning the residence of an individual subscriber or the situs of the employer of a group subscriber (the “situs” approach).

While we are not attorneys and cannot offer legal interpretations, it appears to us that the intent of the legislation is to have any distribution of surplus that results from the application of the

requirements of the law benefit residents of the District of Columbia. It was our conclusion based on this understanding, that the residence method is the appropriate alternative. If the funds are to be used to benefit only D.C. residents, then it would seem that they should be comprised of amounts that are attributable to only D.C. residents. The situs approach, if used instead, could have the effect of causing surplus that was attributable in part to residents of Maryland and Virginia to be expended on behalf of residents of D.C. only. This would not be equitable, and we concluded that the situs approach would therefore not be appropriate.

Time Period of Evaluation – The estimation methodology that we have employed in developing surplus attributable to D.C. involves the analysis of historical annual changes in surplus values as reported in GHMSI’s Statutory blank. Each year’s change in surplus, due to operating results and other factors, was evaluated in order to attribute an appropriate portion to each jurisdiction. In order to carry out this evaluation it was necessary to supplement the information reported in the Statutory blank with additional data tabulations drawn from GHMSI’s internal reporting and information systems. The approach we have selected is designed to be relatively straightforward, allowing future replication and updating with a reasonable level of effort.

We worked with GHMSI staff to identify the types of information that were required, and the availability of such information by year. While the data available for the most recent five years was fairly comprehensive, for earlier periods the level of detail that could be obtained was more limited. In general, we found that the degree of detail of the information and its level of quality both tended to decline with each additional year, working backward in time.

After analysis and discussions with GHMSI management, we determined that a ten-year period of historical information would be studied, and that this would produce equitable results by offering a reasonable compromise between the desire to incorporate a sufficient historical period of time and the importance of utilizing reliable information.

Therefore our methodology involves the analysis of the reported change in surplus values by year for the period of 1999 through 2008, in order to evaluate which portion of each year's amount is attributable to D.C. The Statutory surplus value as of December 31, 1998 was then assumed to be attributed by jurisdiction in the same proportions as the surplus accumulated from 1999 through 2008.

Treatment of Affiliates and Subsidiaries – GHMSI owns a 40% share of CareFirst BlueChoice (CFBC), and holds a 100% share in a number of materially smaller subsidiaries, none of which are insuring entities. Given the significant size of CFBC and the materiality of its contribution to GHMSI's surplus, we carried out a parallel evaluation of the reported annual change in surplus of CFBC and its predecessor (Capital Care, Inc.) for the period of 1999 through 2008. Based on this analysis, we estimated the portion of GHMSI surplus contributed by CFBC and its predecessor that can be considered attributable to D.C. residents.

The annual changes in value associated with other GHMSI subsidiaries were treated as investment returns in our evaluation, and were therefore attributed to jurisdiction based in part on premium income and in part on the attribution of the prior year's ending surplus value. The subsidiaries of CFBC were treated in a parallel manner in our evaluation of CFBC and its predecessor.

Surplus Target - We have not done an evaluation of optimal surplus levels for GHMSI at the jurisdictional level (and there would be many technical problems with trying to do so). However, we can state that any range that is appropriate for the District of Columbia portion of GHMSI would be higher, when expressed as a percentage of the applicable benchmark, than the optimal surplus target range that we recommended for GHMSI as a whole.

Brief Description of Methodology

The general approach that we employed in our evaluation was to first attribute each year's Statutory underwriting gain/loss (UGL) by jurisdiction in proportion to estimated premium or fee

income by jurisdiction of residence. This attribution was made separately for the UGL of each of the three major risk categories – i.e., Risk (excluding FEP¹), FEP, and Non-Risk. Each of these was considered separately in view of their unique underwriting and risk characteristics, which have resulted in materially differing financial objectives and underwriting results.

The evaluation of premium or fee income by residence necessarily involved an estimation process, because this information is not directly tabulated. Therefore, premium was first attributed to jurisdiction of situs, based on information in the Statutory blank for the Risk segment², and using the distribution of membership by residence for FEP. For the Non-Risk segment the fee income by situs from internal jurisdictional tabulations was utilized. The premium or fee income for each situs jurisdiction was then attributed to jurisdiction of residence based on available membership data, which was cross-tabulated by situs and residence for periods in 2005 through 2008.

After attributing each year's underwriting gain/loss by jurisdiction of residence, the other components of the change in surplus were attributed in proportion to premium and fee income, with the exception of investment returns. Attribution of the annual investment return was based in part on premium income (in recognition of the float generated by the time lag between premium collection and claims payment) and in part on the attribution of the prior year's ending surplus value.

It must be emphasized that while the process described above involved the direct use of detailed data where possible, it also required a significant degree of judgment and estimation due to the limitations on availability of such data. The earlier years, in particular, required some reliance

¹ By FEP, we mean GHMSI's participation in the BCBSA Federal Employee Program offerings within the Federal Employees Health Benefits Program (FEHBP). This does not include the CFBC offering within FEHBP, which is not part of the BCBSA program.

² For 2008 this allocation was based on internal jurisdictional tabulations, because the premium information by jurisdiction in the Statutory blank did not reflect the impact of reinsurance agreements that became effective in 2008 between GHMSI and CareFirst of Maryland, Inc. (CFMI).

on incomplete data tabulations, and where no applicable data was available, on patterns observed in subsequent years.

IV. Conclusion

In our opinion, the assumptions and methods employed in our analysis are reasonable and appropriate given the limitations of the data and other information that was available, and in view of the purpose for which it has been developed. Further, we believe that the methodology satisfies the objectives of providing an equitable approach to the attribution of surplus, while being straightforward, replicable and easily updated in future years.

We appreciate the opportunity to present the results of our analysis of GHMSI surplus attributable to the District of Columbia. The authors are available to explain and / or amplify any matter presented herein, and it is assumed that the reader of this report will seek such explanation and / or amplification as to any matter in question.