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TESTIMONY OF DC APPLESEED FOR GHMSI SURPLUS HEARING

**DC Department of Insurance, Securities and Banking
September 10, 2009**

Good morning Commissioner Purcell. I am Walter Smith, Executive Director of the DC Appleseed Center. Thank you for holding this hearing and for allowing us to testify. As you know, DC Appleseed has for many years worked with your office to address the appropriate role of GHMSI in the National Capital Area. We have also worked with your counterparts in Maryland and Virginia on the issue.

Our view is that GHMSI has for several years built up excessive surpluses far beyond amounts reasonably needed to maintain its financial soundness, and that in the course of doing so it has both overcharged subscribers and underinvested in community healthcare needs. We issued a report on this in December 2004, which led to a 2005 hearing on the subject by DC Insurance Commissioner Larry Mirel; we testified in support of the legislation that has led to this hearing on the issue; and we submitted a Pre-Hearing Report to your office on August 31 laying out the basis for our view that GHMSI's current surplus is excessive and not in compliance with the legislative requirement that the company commit the "maximum feasible" amount to "community health reinvestment."

Today I would like to comment briefly on three points: (1) how we think the Commissioner should approach the surplus issue, and where we differ with GHMSI about the nature of that issue: (2) why we think it is clear that by any fair measure GHMSI's surplus is excessive; and (3) how we think the Commissioner should approach the issue of attributing a portion of GHMSI's surplus to the District. After these comments, Mr. Corwin Zass, principal of Actuarial Risk Management (ARM), who DC Appleseed engaged for the purpose of reviewing the reports submitted by CareFirst and Milliman, will also testify. Mr. Zass will outline the results of ARM's assessment, which shows that GHMSI's surplus is excessive.

1. The Excess-Surplus Issue Before the Commissioner

Let me begin by stating a point of agreement with GHMSI. GHMSI contends in its Pre-Hearing Report that the Commissioner should examine its surplus on a company-wide basis, and not attempt to first attribute a portion to each jurisdiction and then examine only the portion attributable to the District. As GHMSI says in its August 31 Pre-Hearing Report (p.27), "evaluation of the appropriateness of reserves must be performed at an entity-wide level." We agree with this point completely, and note that both Milliman and our expert examined the reserves on that basis.

But we disagree with GHMSI about how the statute requires those reserves to be evaluated. The statute requires a showing that GHMSI has committed the "maximum feasible" amount to community health reinvestment, "consistent with financial soundness and efficiency." DC Code §

31-3505.01. This requires GHMSI, as it sets surplus levels, to balance the need to maximize community health reinvestments against any further increases in surplus that would bring very marginal increases in risk reduction. This balancing becomes particularly critical as the company's surpluses continue to grow relative to its competitors and other Blues. We do not believe GHMSI has tried to apply this statutory requirement. Instead, it has simply applied the same Milliman analysis as in 2005, and that Milliman developed for a comparable company (Highmark) before the Pennsylvania Insurance Commissioner. In our view, as explained in the Covington & Burling memo, the sensible way for the Commissioner to apply the "maximum feasible" requirement is to develop a range of surplus that is adequate to protect the company's financial soundness. Because any point within the efficient range of surplus would be consistent with GHMSI's financial soundness and efficiency, GHMSI should be directed to set its target surplus toward the lower end of that range.

Our next point of disagreement with GHMSI's description of the issue here today is its contention that it has been required to limit community reinvestment "since doing too much in community giving unduly burdens subscribers as they struggle to afford their coverage." GHMSI August 31 Pre-Hearing Report at 4. It goes on to say that its "concern about subscriber expectations is especially acute in this era of rapidly rising health care costs that has left health care unaffordable for many." Id. In fact, the company contends that if it were required in this proceeding to distribute excess surplus "to the community at large," this would constitute "nothing less than a confiscation or taking of subscribers' funds at a time when subscribers – especially individuals and small groups – are struggling to pay premiums as it is." Id. at 13. For several reasons, this effort to pit "struggling subscribers" against the needs of the "community at large" is both false and ironic.

In the first place, if the Commissioner finds that the company's surplus is excessive, under the statute it is the company that must develop the plan to spend down that surplus; and under the statute the company has the authority to commit *the whole* of that plan to rate reductions for struggling subscribers or, at its discretion, to covering those who have found health insurance unaffordable. Second, as the company elsewhere admits, if it indeed has an excess surplus, this necessarily means that its subscribers "were overcharged and are due a refund." Id. at 12. In other words, the difficulty many subscribers are now facing is the result of *the company's own decisions* to build excessive surplus. And finally, if, as the company now says, any spending on community healthcare needs other than directly for subscribers amounts to "confiscation," the company has been engaging in confiscation for some time; in fact, elsewhere in its paper CareFirst touts what it calls "the disproportionately large share of community reinvestment that occurs in the District." Id. at 10. As GHMSI knows, however, spending on community health care needs that benefit the public at large, and not just subscribers, is authorized not just by the statute, but by its own federal charter. *See* Memo from DC Attorney General Robert Spagnoletti, Aug. 5, 2005 at 1.

Finally, I would like to address GHMSI's contention that "the question for the Commissioner is whether GHMSI *is doing what it can*, consistent with maintenance of an appropriate level of reserves, to safeguard the public health for the benefit of its certificate holders." GHMSI August 31 Pre-Hearing Report at 10 (emphasis added). As earlier noted, the standard in the statute is not "doing what it can"; it is committing the "maximum feasible" amount that is "consistent with financial soundness and efficiency." But having posed the question wrongly, GHMSI then answers it wrongly. It says: "The answer to that question is 'yes.' The Company's health contributions are

very substantial –running into the tens of millions of dollars each year." Id. Leaving aside the fact that GHMSI nowhere details what the "tens of millions" are and where they are spent, the fact is that the statute doesn't say the company should spend "very substantial" amounts on community reinvestments; it requires it to commit the "maximum feasible" amount.

Significantly, GHMSI contends it is spending more than its peers on community reinvestments. *See* GHMSI August 31 Pre-Hearing Report at 29. In fact, that is not so. As Deborah Chollet noted in her statement, Kaiser Permanente reported spending $28.9 million in the mid-Atlantic region on community reinvestments in 2008, equal to more than 1.5 percent of Kaiser Foundation Health Plan's gross revenue. *See* DC Appleseed Pre-Hearing Report, App. C - Chollet statement at 8. In Pennsylvania, the four BlueCross BlueShield plans annually spend 1.6 percent of gross premium revenue on community benefits. Id. If GHMSI were to spend an amount comparable to these fellow non-profits (between 1.5% and 1.6% of gross premium revenue), it would total between $46.9 and $50.0 million in 2008, instead of the $20 million that GHMSI claims to have spent. CareFirst Aug. 31 filing at 28. Furthermore, those other Blues are not subject to the "maximum feasible" standard that GHMSI is.

In the end, the only way to know if GHMSI has met the governing maximum feasible standard is to determine whether its surplus is unreasonable. As next discussed, we believe it is.

2. Determining whether GHMSI's surplus is excessive

To help us determine whether GHMSI's surplus meets the "maximum feasible" standard, we engaged the independent actuarial consulting firm, Actuarial Risk Management (ARM). Because ARM did not have access to the data, ARM proceeded to develop a reasonable range of surplus, based on GHMSI's public filings and information reported in Milliman's analysis.

As Mr. Zass explained in his statement filed with our August 31 Pre-Hearing Report, ARM found serious errors or biases, including unrealistic and unreasonable assumptions, in the Milliman analysis; however, lacking data showing all of Milliman's calculations and assumptions, ARM simply corrected for four of the most dollar-significant assumptions Milliman made: (1)ignoring the Federal Employee Program (FEP) and GHMSI's other major lines of lower-risk insured business – which caused Milliman to overstate the riskiness of GHMSI's revenues and therefore to overstate its need for surplus; (2)assuming that GHMSI needed to have excess surplus sufficient to withstand a prolonged economic downturn that bore no relationship to any of GHMSI's relevant experience – further inflating GHMSI's current need for surplus; (3)assuming also that GHMSI would experience annual premium growth rates of 12-14% even during a prolonged economic downturn, which likewise bore no relationship to the company's historic premium growth and yet further inflated its estimated need for surplus; and (4) assuming a 95% degree of certainty for avoiding the surplus falling to the 375% RBC level, where a 90% probability is more than ample. *See* DC Appleseed Pre-Hearing Report, App. B – ARM Analysis at 13-14.

Correcting only for the four errors listed above, ARM shows that instead of needing surplus in the range of 750 -1050% RBC, the company needs one in the range of 400-525%. This means that instead of its current surplus of $687 million, the company should be targeting a level toward the lower end of a 400-525% range to meet the" maximum feasible" standard–that is, $325 million,

more than $300 million below its current surplus. This lower level, as shown in the statement of Deborah Chollet filed with our August 31 Pre-Hearing Report, will bring the company more into line with its competitors. See DC Appleseed Pre-Hearing Report, App. C – Chollet statement at 5,7.

We note that Milliman used numerous other highly questionable assumptions that further increased GHMSI's apparent need for surplus. Because ARM did not correct further for these assumptions, pending access to detailed data, we believe that their conclusions are conservative with respect to the true amount of excess surplus.

Further confirming the proposition that Milliman's analysis should not be accepted is the fact that in the two most relevant precedents ---the Pennsylvania Insurance Commissioner's surplus determination, and Commissioner Mirel's surplus determination – both Commissioners rejected the Milliman analysis, even though it was virtually identical to that presented here. As we explained in our Pre-Hearing Report (*See* DC Appleseed Pre-Hearing Report, App. A, citing to PA Insurance Commissioner Determination Feb. 9, 2005), the Commissioner in Pennsylvania effectively rejected both Milliman's methodology and its suggested surplus range; and in DC, Commissioner Mirel implicitly rejected Milliman's methodology and range, saying that GHMSI could and should significantly increase its community benefits and spend down its surplus to do so. Yet, since then the company has done the opposite – it has significantly decreased its community benefits and significantly increased its surplus. *See* CareFirst Commitment Community Benefit Statement 2007; GHMSI Annual Statements.

We are aware that GHMSI has presented analysis from the Lewin Group (a wholly-owned subsidiary of United Health Group) with its August 31 Pre-Hearing Report, and contends that this analysis constitutes a "second opinion" that "confirmed" the "reasonableness of [the] range" that Milliman proposed. GHMSI August 31 Pre-Hearing Report at 6. We think a fair reading of the Lewin analysis is that it declined to confirm the specific 750-1050% RBC range calculated by Milliman. What Lewin actually says is that while "we are in agreement with the targets and the rationale," the "actual range would be a function of the assumptions" made, and "our review does not allow us to comment as to whether we would have produced the same range of surplus requirements as shown in the Milliman report." GHMSI August 31 Pre-Hearing Report, Exhibit B - Lewin at 45. In fact, Lewin says "[w]e might...differ as to the precise RBC percentage recommended." Id. at 45, 47. This is not a "second opinion" that Milliman's range is valid. Moreover, it is worth noting that in the Pennsylvania case, Lewin expressly determined that the particularly surplus ranges established by the Insurance Commissioner were "reasonable," even though the Commissioner had rejected the higher range proposed by Milliman. *See* Lewin Group, *Consideration for Regulating Surplus Accumulation and Community Benefit Activities of Pennsylvania's BlueCross and Blue Shield Plan*s, June 13, 2005 at 22.

In summary, we think it is clear that Milliman's analysis should not be accepted as sufficient to demonstrate that the company is in compliance with the statute. While we believe that the Commissioner could reasonably make findings based on ARM's report, we note that the statute contemplates that the Commissioner will engage her own independent actuarial expert to assess the issue. *See* DC Code § 31-3506 (h). We encourage that she do so, and that the public be given opportunity to respond to that assessment.

This would follow the precedent Commissioner Mirel set when CareFirst attempted to convert to for-profit status. There, CareFirst proffered expert analysis showing what it said was the value of the company ($1.3 billion) and both Commissioner Mirel and Maryland Commissioner Larson engaged their own experts to determine the company's value, finding that the company had understated its value by several hundred million dollars. Eventually, it was on that basis that the conversion was denied.

We believe the stakes here are as high as they were in the conversion proceedings, and we therefore urge the Commissioner to engage her own actuarial experts to assess GHMSI's surplus and determine whether it complies with the statutory standard.

3. Determining the "attribution" issue

If the Commissioner determines that GHMSI has excess surplus, the statute contemplates that the company should be required to develop a plan to spend down the portion of the surplus that is attributable to the District. In its August 31 Pre-Hearing Report GHMSI contends that the Commissioner should determine the company's surplus attributable to the District according to the following formula: (1) determine what percentage of GHMSI's subscribers are District residents and (2) multiply GHMSI's surplus by that percentage. Using this approach, and based on GHMSI's assertion that only 11.6% of GHMSI's subscribers are District residents, GHMSI contends that only 11.6% of its surplus is attributable to the District. We completely disagree with GHMSI's approach to this issue.

In the first place, GHMSI candidly acknowledges that its attribution methodology "is a non-standard approach." GHMSI's Pre-Hearing Report at 8. The standard approach -- which is routinely followed within the insurance industry and by GHMSI itself in other circumstances -- is to attribute revenues based *not* on subscribers' residence but on the place where the contract of insurance is issued. We asked our experts to produce a set of attribution rates (as shown in the attached Exhibit A from Actuarial Risk Management) using this standard approach, and in combination with GHMSI's own publicly available data. ARM demonstrates that the portion of GHMSI's surplus attributable to the District is not 11%, but approximately 60%. This percentage substantially coincides with GHMSI's own allocation to DC for purposes of the MD premium tax.

We furthermore note that the Commissioner's own regulations for this proceeding contemplate following this standard approach, i.e., the definition of "attributable to the District" in the regulations refers to the portion of GHMSI's "operations in the District" based on "the number of policies by geographic area" and "the number of health care providers with the company by geographic area." DISB Emergency and Proposed Rulemaking § 4699.2.

In its effort to support its "residence-based" approach and thereby reduce the District's interest in GHMSI's surplus to only 11%, GHMSI appears to be making several arguments: that the company's congressional charter "supports -- indeed requires -- residency as basis for attribution" (Attachment G); that "the relevant case law mandates a residency-based approach;" and that the legislation requiring this hearing itself contemplates that residency be used as the measure for

allocating surplus (Attachment G and in a new report from Milliman labeled Exhibit A). None of these is correct.

The centerpiece of GHMSI's proposed attribution method appears to be based on a misreading of the statute. Milliman argues in its new report that "the intent of the legislation is to have any distribution of surplus ...benefit [only] residents of the District of Columbia. It was our conclusion based on this understanding that the residence method is the appropriate alternative." Milliman's Report dated August 28, 2009 at 40.

But this is not what the statute says. What the statute actually says is: "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." DC Code § 31-3506(g)(1). The statute also says that "the plan" may "consist entirely of expenditures for the benefits of current subscribers of the corporation." Id. at (2). Nothing in the statute supports what seems to be the entire premise of Milliman's residence-based theory, i.e., that only District residents may benefit from any distribution of the District's allocated share of the surplus. Indeed, the statute actually directs that in the implementation of the act "the Commissioner shall consider the interests and needs of the jurisdictions in the corporation service area." DC Code § 31-3506.01 (2).

Furthermore, the contentions in GHMSI's Attachment G that either the federal charter itself or the relevant case law requires a residence-based approach are also unfounded. As explained in the attached memorandum from Covington & Burling (Exhibit B), the charter and relevant case law if anything, confirm that the standard attribution approach -- attributing revenue to the jurisdiction where the insurance contract is issued -- is appropriate here.

Nevertheless, as the DISB considers this issue, we urge that you decline GHMSI's invitation to play the jurisdictions against each other, and instead, as part of your process in formulating your own order, work closely with the Commissioners in the other jurisdictions to encourage a plan of distribution for the excess surplus that will fairly and equitably benefit subscribers and residents throughout the National Capital Area. We believe that such a plan could take into account the numbers of contracts, healthcare providers, and residents within a given jurisdiction, and the amount of employer contributions and health care needs within each jurisdiction. We also urge you to recognize that many healthcare benefits that the company could and should be providing will simultaneously improve the lives of citizens and subscribers in all three jurisdictions. In the end, GHMSI's effort to balkanize this process -- by insisting that the District must benefit only District residents and that Maryland and Virginia must do the same -- is not only contrary to the governing statute; it also ill-serves all three jurisdictions' common interest in ensuring that GHMSI meet its charitable and benevolent obligation throughout the entire region.

Thank you. I would be happy to answer any questions you have.

EXHIBIT A

Attribution of Surplus – GHMSI, Inc.
Supplemental to Original Report
Actuarial Risk Management

TESTIMONY OF DC APPLESEED FOR GHMSI SURPLUS HEARING

DC Department of Insurance, Securities and Banking
September 10, 2009

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Attribution of Surplus

GHMSI, Inc.

September 10, 2009

Report to DC Appleseed

SUPPLEMENT TO ORIGINAL REPORT

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CHAPTER 1 - Overview

I. *Brief*

The Consultant Team from Actuarial Risk Management ("ARM") was instructed by DC Appleseed to comment on the documents submitted by CareFirst subsequent to the DC Appleseed August 31, 2009 submission to Department of Insurance, Securities and Banking ("DISB"). These documents support CareFirst's position on the relevance for the actual surplus level of Group Hospitalization and Medical Services, Inc. ("GHMSI"), which is a hospital and medical services corporation, controlled by CareFirst.

In a report dated August 28, 2009 Milliman evaluates the proportion of GHMSI surplus attributable to DC and therein they estimate that 11.6% is attributable to the District of Columbia. The purpose of this supplemental report is to briefly review the assumptions and methods underlying the Milliman analysis and to express an alternative opinion as to the appropriate proportion of the 12/31/2008 GHMSI surplus attributable to District of Columbia.

II. *Qualifications, Limitations, and Disclaimers*

The same limitations and disclaimers found in ARM's Assessment Report of GHMSI, Inc. Surplus Position, dated August 31, 2009, continue to be relevant as part of this supplement. Specifically, to this supplemental report, our opinion expressed herein is an estimate based on calculations made from publicly available data. In developing our estimates we use only data from GHMSI's annual Statutory filing with the District of Columbia. If there are an inaccuracies or distortion in that information then the results we calculate may be affected.

CHAPTER 2 – Observations and Commentary

I. *Review of Milliman Report*

Milliman's key assumption is that the allocation of surplus should be based upon the residence of the insured. This is inconsistent with the way insurance is regulated (the District of Columbia regulates insurance contracts entered into in the District as opposed to policies issued to residents of the District) and GHMSI's own annual financial statements filed with insurance regulators, which allocate premiums by jurisdiction based on where the insurance contract is issued.

Milliman goes on to say that they believe the intent of the Medical Insurance Empowerment Amendment Act of 2008 is that "any distribution of surplus that results from the application of the requirements of the law benefit *residents* of the District of Columbia". This interpretation appears to be made simply to support a particular point of view. District of Columbia law specifically states, "Community health reinvestment is defined as "expenditures that promote and safeguard the public health or that benefit current and future subscribers, including premium rate reductions." Enrollment of current was not and enrollment of future subscribers will not be based on location of their residence; rather enrollment is based on where the contract of insurance is issued – which again is consistent with both insurance law and GHMSI's own annual financial statements.

Having made their fallacious residence assumption, Milliman then creates another "black box" process to determine the amount of surplus attributable to DC. They state that their process involves "supplement[ing] the information reported in the Statutory blank with additional data tabulations drawn

from GHMSI's internal reporting and information systems." They go on to state that their methodology then "involves the analysis of the reported change in surplus values by year for the period of 1999 through 2008". Their report provides no data that can be publicly examined or interim calculations that can be repeated, but simply states an amount of surplus that Milliman alone has estimated as fairly attributable to DC.

II. ARM's Methodology and Rationale

We have taken two different approaches to making independent calculations of the amount of surplus attributable to DC. In contrast to Milliman, we have used only publicly available and audited data from GHMSI's annual financial statements from 1999 to 2008.

Approach One

In the first approach we estimated the amount of surplus attributable to insurance contracts issued in the various jurisdictions in which GHMSI does business. We note that, while other miscellaneous items affect surplus in any given year, net underwriting income and net investment income together comprise the overwhelming majority of the change in surplus sources.

Specifically, in our first approach we have taken these steps:

(1) We gathered information as follows:

- From the 5 year Historical Data page: the total surplus, the change in surplus, the net underwriting gain and the net investment income.
- From Schedule T: total premium income, DC non-FEP premium, and DC FEP premium.
- From Analysis of Operations by Line of Business exhibit: net underwriting gain for FEP and net underwriting gain for all other lines of business.

(2) We calculated the DC total profit for a given year as the sum of the net underwriting gain for FEP with a percentage of the net underwriting gain for all other lines of business. The percentage used for all other lines of business was the proportion of total non-FEP premium in DC out of non-FEP premium in all jurisdictions.

(3) We calculated DC net investment income for a given calendar year as GHMSI's total net investment income for that year multiplied by the proportion of all GHMSI premiums in DC for that year to the total of all GHMSI premium in all jurisdictions for that year.

(4) We calculated the DC percentage of the surplus change for a given year as the sum of DC total profit and DC net investment income for a given year divided by the sum of total profit and total net investment income for that year.

Following these steps we calculated that the percentage of surplus attributable to DC for the years 1999-2008 is 56.7%. As reported by GHMSI, DC premium was 70.8% of all premium for GHMSI during this time period and 31.7% of all non-FEP premium during this time period.

Year	Calculated Values		
	DC Share of Profit	DC Share of Net Inv Inc	DC Share of Chg in Surplus
1999	11,787,301	16,558,107	77.9%
2000	16,921,712	19,734,647	63.2%
2001	10,911,349	21,320,080	56.8%
2002	12,596,325	10,581,662	49.1%
2003	17,526,486	18,739,663	45.3%
2004	21,005,765	24,601,883	40.3%
2005	19,749,242	21,291,902	61.7%
2006	21,660,114	22,495,514	53.1%
2007	21,043,058	31,975,414	63.9%
2008	17,474,361	15,296,029	96.9%
	170,675,712	202,594,903	**56.7%**

Note that this calculation attributes only the 77% of GHMSI's current surplus that was accrued since 1999. We understand that GHMSI's business prior to 1999 was geographically distributed more like the 1999 and 2000 business, so that at least 70% of the other 23% of GHMSI's $159 million surplus already existing at 1/1/99 was likely generated largely from DC premiums. Thus, while we believe there may be some anomalies in particular numbers that GHMSI reported in some years, we believe that the estimated proportion of surplus attributable to DC is approximately 60%. The results of the second approach described below support this conclusion.

Approach Two

Under the second approach, we looked at the Exhibit of Premiums, Enrollment and Utilization that has been a part of GHMSI's annual financial statements since 2002. This exhibit reports the number of member months of insurance that are attributable to each jurisdiction in which GHMSI operates. The following table summarizes what we found:

Year	from Exhibit of Premiums, Enrollment & Utilization				
	Total Member Months	MD Member Months	VA Member Months	DC Member Months	DC as % of Total
2002	8,857,516	1,485,321	1,343,770	6,028,425	68.1%
2003	8,643,337	1,536,511	1,198,314	5,908,512	68.4%
2004	8,659,572	1,483,431	1,102,783	6,073,358	70.1%
2005	8,876,199	1,926,710	1,180,415	5,769,074	65.0%
2006	9,399,669	2,361,818	1,247,872	5,789,979	61.6%
2007	9,972,510	2,839,953	1,356,928	5,775,629	57.9%
2008	10,975,857	3,335,381	1,556,732	6,083,744	55.4%
	1999-2008	14,969,125	8,986,814	41,428,721	63.4%

This second approach may be the better approach to determining surplus attributable to DC because it is based not on premiums, but on subscribers. That is, to the extent that any distribution of surplus is to benefit future and current subscribers, this is the best measure publicly available as to the number of GHMSI subscribers by jurisdiction.

CHAPTER 3 - Conclusions

Our rationale and approach is consistent with the methodologies mandated by the NAIC in the completion of the financial statements.

As the results under both approaches are similar, it is fair to conclude that roughly 60% of the 12/31/2008 surplus of GHMSI is attributable to DC.

EXHIBIT B

Analysis of Surplus Attributable to the District of Columbia
Covington and Burling

TESTIMONY OF DC APPLESEED FOR GHMSI SURPLUS HEARING

DC Department of Insurance, Securities and Banking
September 10, 2009

Method of Attribution

Under the Medical Insurance Empowerment Amendment Act ("MIEAA"), attribution is not a step in the determination of whether GHMSI's surplus is excessive. All agree that the determination of excess is to be made on a corporate-wide basis. Once GHMSI's corporate-wide surplus has been found to be excessive, attribution then determines the amount of the remedy: the portion of the corporate-wide excess that is to be subject to "dedication" to "community health reinvestment in a fair and equitable manner." DC Code § 31-3506 (g) (1).

The community reinvestment plan provides GHMSI with an opportunity to correct its excess in a manner of its choosing, so long as it is fair and equitable. But the MIEAA also directs the Commissioner to impose a mandatory remedy in the event GHMSI fails to submit or implement a plan. That remedy bears directly on the attribution intended in the MIEAA. The Commissioner "shall deny for 12 months all premium rate increases *for subscriber policies written in the District.*" DC Code § 31-3506 (i) (emphasis added). There is no ambiguity in that provision. It contemplates that the denial of rate increases—a remedial proxy for the failure to implement a satisfactory plan for community reinvestment—should accrue to employers and individuals contracting in the District. As with the proxy, so with community reinvestment itself. Attribution for purposes of determining the amount of community reinvestment should be determined according to where GHMSI wrote the insurance contract.

The appropriate measure of GHMSI's surplus reasonably attributable to the District must include the proportion of premiums from all sources related to business that originates in the District—i.e., surplus should be attributed based on the jurisdiction in which the insurance policy was written. For most employer-sponsored group insurance policies, the surplus will therefore be attributed to the jurisdiction where the employer is principally located. For individual policies, the surplus will be attributed to the jurisdiction in which the individual resides. This approach comports with standard practice in the industry, including the practice currently followed by the Maryland Insurance Administration and GHMSI itself. Moreover, in the absence of express guidance from the DC Council that revenue attribution should be measured in a manner other than the existing standard, the appropriate attribution method should remain the standard. Also, it is necessarily easier to attribute premiums based on where the contract is written because that information is readily available and more likely to be current and accurate than other methods.

CareFirst suggests an approach based on residence of subscribers that is inconsistent with GHMSI's current method of revenue attribution. None of the three reasons offered by CareFirst support a departure from GHMSI's current practice: neither the language of GHMSI's federal charter, nor a "plain reading" of the MIEAA, requires attribution based on residence, nor does relevant case law mandate such as result.

A. Attribution Based on Location of Employer Is Consistent with Maryland and GHMSI Practice.

1. Maryland Premium Tax Exemption Reports

Maryland imposes a premium tax on all premium revenues "reasonably attributable" to insurance business in the State. Maryland grants a premium tax exemption, however, equal to any amount spent by a nonprofit health service plan in a manner that serves the public interest, including that the funds must be used, at least in part, to subsidize certain specified programs, including the Senior Prescription Drug Assistance Program, the Maryland Pharmacy Discount Program, and the Community Health Resources Commission.[1]

On October 16, 2008, Maryland Insurance Commissioner Ralph Tyler determined that GHMSI's 2007 Premium Tax Exemption Report complied with Maryland law.[2] In so doing, Commissioner Tyler's determination necessarily endorsed GHMSI's method of attributing premium revenue to Maryland, which GHMSI had reported on Schedule T of its Annual Statement (as has been GHMSI's practice).[3] Accordingly, for 2007, GHMSI attributed 64% of its total premiums, including commercial and FEHBP policies, to the District.[4]

The relevant portions of GHMSI's 2007 Schedule T are summarized in the following table:

GHMSI 2007	Total: FEHBP + Commercial	Commercial		
		Total	Comprehensive (Major medical)	Medicare and other
DC	$ 1,792,818,853	$ 366,790,524	$ 343,659,577	$ 23,130,947
Maryland	$ 631,314,306	$ 631,314,306	$ 577,557,934	$ 53,756,372
Virginia	$ 384,792,858	$ 384,792,858	$ 367,639,580	$ 17,153,278

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[1] Md. Code Ann., Ins. § 6-101(b).

[2] *See* Md. Ins. Admin. Order (Oct. 16, 2008), attached as Exhibit 1.

[3] Apart from the Schedule T, we were unable to locate any reports or other documents indicating how GHMSI attributes revenue for Virginia. We were not able to find any Virginia law or practice requiring GHMSI to use any particular methodology for attributing revenue. Thus, we are unaware of any basis upon which Virginia might oppose an attribution based on the state in which the contract was written, as is set forth in Schedule T, which is in fact how GHMSI attributes revenue as to all three jurisdictions.

[4] GHMSI's attribution for FY2008 appears to be consistent with previous years.

DC	64%	27%	27%	25%
Maryland	22%	46%	45%	57%
Virginia	14%	28%	29%	18%

GHMSI's Schedule T attributes revenue based on the jurisdiction in which the policy is written. Thus, based on Maryland law and consistent with GHMSI's past practices, the proper attribution method for GHMSI surplus should be based on the jurisdiction in which the insurance policy was written.

2. Maryland Act HB1534/SB1070

Recent legislative activity in Maryland reinforces this attribution method. Pursuant to Maryland Act HB1534/SB1070, enacted and effective as of June 1, 2009, the Maryland Insurance Commissioner is authorized to review and evaluate the effects of any surplus evaluation conducted by another state but only with respect to "premiums charged to subscribers under policies issued or delivered" in Maryland. Although the Act does not define "issued or delivered" for purposes of attribution, a review of case law suggests that the phrase should be defined according to place of employment.

By way of analogy, some cases discussing choice of law provisions for group life insurance policies rely on the Restatement (Second) of Conflicts of Laws § 192 in defining "policies issued or delivered." The Restatement explains that the rights of an insured should be determined "not by the local law of the state where the employee was domiciled and received his certificate but rather by the law governing the master policy....This will usually be the state where the employer has his principal place of business."[5]

Finally, attribution based on where the policy is written is sensible when considered in view of the scope of the authority of the Insurance Commissioners of Maryland and Virginia to regulate rates. Specifically, neither insurance commissioner would appear to have the authority to regulate health insurance rates of private employers located in the District and whose policies issue from the District. Similarly, their authority to regulate rates does not extend to FEHB contracts for federal employees, even for those who reside in Maryland or Virginia. It thus seems logical that the attribution method flowing from where a contract is "issued or delivered" should be coterminous with the reach of the rate regulation authority of the insurance commissioners of neighboring jurisdictions—in other words, based on where the insurance contract is written.

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[5] *Cf. Guardian Life Ins. Co. of America v. Insurance Comm'r of State of Md.*, 446 A. 2d 1140 (Md. 1982) (holding that a policy delivered to a Rhode Island trustee was not "issued or delivered" in Rhode Island but was instead issued or delivered in Maryland, the state in which the employer was located).

B. CareFirst Cannot Justify A Departure From GHMSI's Current Practice Of Attributing Revenue Based On Location Of Employer.

1. Ease of Administration Favors Attribution Based on Location of Employer.

In a transparent attempt to forestall this entire process, CareFirst initially contends that it is not "possible" to attribute surplus among jurisdictions. (*See* Pre-Hearing Report, Aug. 31, 2009, at 31.) For the reasons stated above, that argument flies in the face of GHMSI's own practice, not to mention common sense. To the extent that revenue is allocable, so too is any surplus generated by that revenue. Moreover, the MIEAA (as well as Maryland Act HB1534/SB1070) envisions this exact type of analysis. The DC Council has directed that GHMSI's excess surplus will be attributed among jurisdictions, and the only proper question is the manner of that attribution. This is not the correct forum for CareFirst to challenge the Council's legislative wisdom.

Clearly, surplus can be attributed because CareFirst goes on to do so, albeit in a manner that conveniently minimizes the District's interest and which is directly at odds with CareFirst's own practice. (*See* Pre-Hearing Report at 32.) Ease of administration favors attribution based on location of employer. The necessary information is readily available to GHMSI, and it is likely to be accurate and current.

2. Neither the MIEAA Nor GHMSI's Federal Charter Compels a Residency-Based Attribution Approach.

The "plain meaning" of the term "attributable" in the MIEAA does not dictate a method based on residence of subscribers. Although CareFirst quotes the dictionary definition of the word "attribute" as including both "belonging to" and "being caused by," none of the cases cited by CareFirst suggest a method for evaluating the factors that "cause" a surplus. (*See* Pre-Hearing Report at 32-33.) Obviously, GHMSI subscribers pay premiums that contribute to the surplus. It is the employer who holds the master contract with GHMSI, however, and the employer pays a significant share of the premiums.

CareFirst's argument based on the language of GHMSI's charter fails for the same reason. The "master contract" is the "legal document certifying the relationship between the insurer and the group policyholder and insuring a number of people under one contract." The employees hold "certificates of insurance" that explain their rights to coverage under the master contract.[6] The group policyholder is the employer who makes insurance coverage available to individual subscribers by virtue of their status as employees.

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[6] *See* Life Office Management Association, Glossary of Insurance & Risk Management Terms, available at http://www.irmi.com/online/insurance-glossary/terms/l/life-office-management-association-loma.aspx.

3. <u>Cases Cited by CareFirst Do Not Discuss Attribution of Surplus by Jurisdiction.</u>

CareFirst attempts to avoid this obvious fact by suggesting, in a footnote without explanation, that a Kansas Supreme Court case is somehow dispositive. (*See* Pre-Hearing Report at 35, n.64 (*citing NEA-Coffeyville v. United School District No. 445*, 996 P.2d 821 (Kan. 2000).) The *NEA-Coffeyville* case, although involving another insurer with excess surplus, did not purport to resolve issues related to attribution by jurisdiction, or even a geographic attribution, let alone mandate an attribution method designed to fulfill the purpose of the MIEAA. Indeed, in resolving the *contract* issue—namely, whether employers or employees should be beneficiaries of any excess surplus—the Kansas Supreme Court never mentioned the residence of policyholders as a factor for consideration. Here, the issue is what CareFirst must do in order to meet its *statutory obligation* under the MIEAA: to "engage in community health reinvestment to the maximum feasible extent consistent with financial soundness and efficiency." MIEAA, § 2(c); D.C. Code § 31-3505.01. In analyzing whether CareFirst has done so, the Commissioner will evaluate whether "the surplus of the corporation that is attributable to the District is excessive." MIEAA, § 2(d); D.C. Code § 3506(e). The present evaluation of CareFirst surplus simply bears no relation to the contract issue decided by the *Coffeyville* Court.

Other cases cited by CareFirst are likewise inapposite. For example, CareFirst attempts to rely on two cases (each nearly a half century old) involving taxation of newspaper carriers. (*See* Pre-Hearing Report at 34 (*citing District of Columbia v. Evening Star Newspaper Co.*, 273 F.2d 95 (D.C. Cir. 1959); *Broadcasting Publications, Inc. v. District of Columbia*, 313 F.2d 554 (D.C. Cir. 1962).) Unlike newspaper companies, which deliver a product directly to a customer's home, GHMSI contracts with employers to provide insurance coverage, regardless of an individual employee's residence. And, as discussed in Part A above, GHMSI currently reports revenue for purposes of Maryland's premium tax exemption based on where the policy is written, *i.e.*, jurisdiction where the employer is located.

CareFirst's arguments are simply devoid of merit. There is no legitimate reason to depart from the current practice of attributing revenue, and any surplus generated by that revenue, according to the place where the contract is written. CareFirst's pre-hearing report strains to avoid the framework for accountability created by the Act, first by arguing (without support) that no attribution is possible, and then arguing that any such attribution must result in the vast majority of its surplus falling outside of the Act's purview. CareFirst's shell game should be seen for what it is, and the Commissioner should attribute surplus in accordance with the convention set forth in GHMSI's Schedule T and in a manner consistent with the Maryland Insurance Commissioner's attribution of revenue.

EXHIBIT 1

Maryland Insurance Administration
Administrative Order No. 2008-10-026

TESTIMONY OF DC APPLESEED FOR GHMSI SURPLUS HEARING

DC Department of Insurance, Securities and Banking
September 10, 2009

STATE OF MARYLAND
MARYLAND INSURANCE ADMINISTRATION

IN THE MATTER OF
THE 2007 PREMIUM TAX
EXEMPTION REPORTS OF

CAREFIRST OF MARYLAND, INC.
10455 Mill Run Circle
Owings Mills, MD 21117

And

GROUP HOSPITALIZATION AND
MEDICAL SERVICES, INC.
550 Twelfth Street, S.W.
Washington, DC 20065

MIA NO. MIA-2008-10-026

* * * * * * * * * * *

ORDER

This Order is issued pursuant to §§ 2-204, 14-106 and 14-107 of the Insurance Article, Annotated Code of Maryland. Section 14-106 establishes as public policy in this State that the value of the premium tax exemption granted to a nonprofit health service plan under Section 6-101(b)(1) be used by the nonprofit for a public purpose in a "like manner and amount" to the public purpose for which the funds would be used if collected by the state. Specifically the nonprofit must demonstrate that the plan has "used funds equal to the value of the premium tax exemption…in a manner the serves the public interest." 14-106(b)(2). As part of the requirement that the nonprofit expend funds in the public interest in amounts at least equal to their premium tax exemption amounts, Section 14-106 requires them to subsidize certain specified programs. These include the Senior Prescription Drug Assistance Program, the Maryland Pharmacy Discount Program and the Community Health Resources Commission.

This Order addresses the premium tax exemption reports filed by Carefirst of Maryland, Inc. ("CFMI") and Group Hospitalization and Medical Services, Inc. ("GHMSI") A copy of the final, revised reports are included as exhibit A.

1. Both Carefirst of Maryland, Inc. ("CFMI") and Group Hospitalization and Medical Services, Inc. ("GHMSI") hold Certificates of Authority from the State of Maryland to act as nonprofit health service plans ("NPHSP").

2. CFMI and GHSMI timely filed their initial 2007 premium tax exemption reports ("2007 Reports") on February 29, 2008.

3. The 2007 Reports indicate that both CFMI and GHMSI expended funds in the public interest in amounts at least equal to their calendar year 2007 premium tax exemption amounts.

4. For 2007, the value of CFMI's premium tax exemption amount was $12,074,073. CFMI's premium tax exemption report indicated that CFMI spent $15,245,595 in 2007 to serve the public interest.

5. For 2007, the value of GHMSI's premium tax exemption amount was $12,626,286. GHMSI's premium tax exemption report indicated that GHMSI spent $13,071,847 in 2007 to serve the public interest. This amount included a reimbursement to CFMI totaling $1,300,000 for expenditures initially made by CFMI.

6. Under the formula in Section 14-106, the nonprofits should have provided subsidies totaling $11,231,136 to the Senior Prescription Drug Assistance Program, the Maryland Pharmacy Discount Program and the Community Health Resources Commission during calendar year 2007. The MIA's review disclosed that due to a miscalculation, the total amount the nonprofits paid to those programs was $81,136 less than required.

7. CFMI's report reflected this shortfall by $51,927 and GHMSI's report reflected the shortfall by $29,209. The shortfall related to the allocation to the Community Health Resources Commission for operating grants to community health resources, the documented direct costs of fulfilling the statutory and regulatory duties of the Commission, and the administrative costs of the Commission.

8. CareFirst acknowledged the error in a letter, dated May 28, 2008, revised the 2007 Reports, and issued a check to the Department of Health and Mental Hygiene on behalf of the Community Health Resources Commission for the amount of $81,136.

9. The 2007 Reports for CFMI and GHMSI are now final and complete. The MIA is satisfied that the items listed in all of the 2007 Reports are properly included as activities or expenditures that serve the public interest. The MIA also is satisfied that the values listed in the 2007 Reports are accurate.

ACCORDINGLY, it is therefore ORDERED effective this 16th day of October, 2008, that the Commissioner has determined that CFMI and GHMSI's 2007 Premium Tax Exemption Reports are in compliance with the requirements of §14-106, of the Insurance Article, Annotated Code of Maryland.

Ralph S. Tyler
INSURANCE COMMISSIONER

RIGHT TO REQUEST A HEARING

Pursuant to § 2-210 of the Insurance Article and COMAR 31.02.02.03, you may request a hearing on this Order. This request must be in writing and be received by the Commissioner within thirty (30) days of the date of the letter accompanying this Order.

Pursuant to §2-212 of the Insurance Article, the Order shall be stayed pending a hearing only if a demand for hearing is received by the Commissioner within ten (10) days after the Order is issued.

The request for hearing must be made in writing. This request must be addressed to the Maryland Insurance Administration, 525 St. Paul Place, Baltimore, MD 21202, ATTN: Sharon Kraus, Appeals Clerk. Failure to request a hearing timely or to appear at a scheduled hearing will result in a waiver of your rights to contest this Order and the Order shall be made final on its effective date.

EXHIBIT A

CareFirst BlueCross BlueShield
10455 Mill Run Circle
Owings Mills, MD 21117-5559

CareFirst BlueCross BlueShield

RECEIVED
MAR 0 4 2008
MARYLAND INSURANCE ADMINISTRATION

February 29, 2008

Mr. Lester C. Schott
Associate Commissioner
Maryland Insurance Administration
525 St. Paul Place
Baltimore, Maryland 21202-2272

Re: 2007 Premium Tax Exemption Reports

Dear Mr. Schott:

The attached 2007 Premium Tax information for CareFirst of Maryland, Inc. (CFMI) and Group Hospitalization and Medical Services, Inc. (GHMSI) is provided for your review.

For CFMI, the first page of the report reflects data on the following basis:

- The data represents Risk (including stop loss), Non Risk and FEP. It excludes mandated coverages--Individual over 65, Individual under 65 Open Enrollment, Group Conversion and HIPAA, and SEGO. (Attachment A)

For GHMSI the first page of the report reflects data on the following basis:

- The data represents Risk (including stop loss) and Non Risk. It excludes mandated coverages—Individual under 65 Open Enrollment, Group Conversion and HIPAA, Individual over 65, SEGO, and FEP (reported as DC business on the GHMSI blank).(Attachment B)

If you have any questions or need additional information please contact Paula Holt at (410) 998-4715.

Sincerely,

Edward W. O'Neil/PRH

Edward W. O'Neil, FSA, MAAA

cc: J. Picciotto
W. Showman
P. Holt
J. Groves
L. Broccolino

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Livio Broccolino
Vice President and
Deputy General Counsel

CareFirst BlueCross BlueShield
10455 Mill Run Circle
Owings Mills, MD 21117-4208
Tel. 410-998-5737
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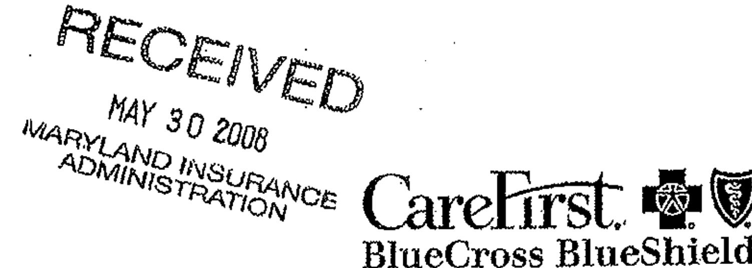

May 28, 2008

Lester C. Schott, Associate Commissioner
Maryland Insurance Administration
525 St. Paul Place
Baltimore, Maryland 21202-2272

Re: *2007 Premium Tax Exemption Report*

Dear Mr. Schott:

Please accept the following response to your May 7, 2008, letter regarding additional questions related to the CareFirst Calendar Year 2007 Premium Tax Exemption reports.

1. You requested additional detail as to which programs both CFMI and GHMSI funded based on the Attachment A "Actual Legislative Spending During Calendar Year 2007". We have updated Attachment A to include each program that was funded and the total amount funded by program. In summary, the annual funding was as follows:

   a. Sr. Rx Assistance Program - $14,000,000

   b. Maryland Pharmacy Discount Program - $300,000

   c. Community Health Resource Unified Data System - $1,700,000

   d. Community Health Resource Commission Operating Budget - $6,705,990

2. You requested an explanation of why CareFirst capped the State FY 2007 funding amount at $22,300,000–instead of funding the entire calculated Premium Tax Exemption amount of $22,381,136. This was an error on CareFirst's part based on preliminary schedules that were internally prepared, but not updated. We have updated all of the supporting schedules to our filing to reflect the additional $81,136 of required funding and included a copy of the check we issued to the Community Health Resource Commission this past week.

3. You requested additional detail related to the contributions, sponsorships and Community Health spending amounts that were included on the CFMI and GHMSI Exemption Computation Worksheets. We have attached a schedule that should address your questions on these expenditures.

Please let me know if you have additional questions or concerns. Thank you.

Sincerely,

Livio Broccolino

LRB\ms!

Attachment

CareFirst BlueCross BlueShield is an independent licensee of the Blue Cross and Blue Shield Association.
® Registered trademark of the Blue Cross and Blue Shield Association. ®' Registered trademark of CareFirst of Maryland, Inc.

This information is for CareFirst of Maryland, Inc. for 2007 representing the revenue and care. The data on this page represents Risk (including stop loss), Non Risk, and FEP. It excludes Individual <65, Individual > 65, and SEGO.

Funds used by the plan to serve the public interest:

Description and name of each activity, insurance product or coverage, or project and explanation how each meets the requirements of section 14-106 (D) of the insurance article. (Attached additional sheets as needed)

Community served, recipients or beneficiaries of each item listed:

Number of members or individuals served (as of 12/31/07):

Non-Mandated Risk	133,289
FEP	184,851
Non Risk	997,853
Total Enrollees	1,315,993

Project Financial Information

Revenues

- ☐ Premiums Earned
- ☐ Other Income

Non-Mandated Risk	317,105,837
FEP	801,262,045
Non Risk	2,158,108,000
Total Revenues	$ 3,276,475,882

Medical Expenses

- ☐ Comprehensive (Hospital & Medical)
- ☐ Medical Only
- ☐ Dental
- ☐ Other (please list)

Non-Mandated Risk	250,803,750
FEP	763,479,326
Non Risk	2,011,382,000
Total Medical Expenses	$ 3,025,665,076

Non Medical Expenses
(Refer to the Underwriting and Investment Exhibit Part 3- Analysis of Expenses in the Annual Report Statement for appropriate expense classifications)

Non-Mandated Risk	59,594,360
FEP	32,878,665
Non Risk	181,221,081
Total Non Medical	$ 273,694,106
Total Expenses	$ 3,299,359,182

*This Report incorporates by this reference, its cover-letter of even date herewith, from Edward W. O'Neil, CareFirst Sr. Vice President & Chief Actuary

This information is for CareFirst of Maryland, Inc. for 2007 representing the revenue and care. The data on this page represents Risk (including stop loss), Non Risk, and FEP. It excludes Individual <65, Individual > 65, and SEGO.

Project Net Profit (LOSS)		
Non-Mandated Risk		6,707,727
FEP		4,904,054
Non Risk		(34,495,081)
Total Project Net Profit (LOSS)	$	(22,883,300)

Value of Premium Tax Exemption

Premiums Written, Calendar Year 2007 (should agree to Schedule T, Maryland Business form Annual Statement)		1,348,718,809
Adjustments:		
ASO/ASC business included in premiums written		
Federal Employee Health Program Premiums		745,015,156
Minimum Premium contracts		
Other		
Total Adjustments	$	745,015,156
Premiums subject to taxation		603,703,652
Premium tax rate		2%
Value of Premium Tax Exemption	$	12,074,073

This information is for GHMSI, Inc. for 2007 representing the revenue and care. The data on this page represents Risk (including agg & spec stop loss), Non Risk, and FEP. It excludes Individual <65, Individual > 65, and SEGO.

Funds used by the plan to serve the public interest:

Description and name of each activity, insurance product or coverage, or project and explanation how each meets the requirements of section 14-106 (D) of the insurance article. (Attached additional sheets as needed)

Community served, recipients or beneficiaries of each item listed:

Number of members or individuals served (as of 12/31/06):

Non Mandated Risk (excluding FEP)	97,740
Non Risk	144,026
Total Enrollees	241,766

Project Financial Information

Revenues

- ☐ Premiums Earned
- ☐ Other Income

Non Mandated Risk (excluding FEP)	$	323,510,377
Non Risk	$	465,030,000
Total Revenues	$	788,540,377

Medical Expenses

- ☐ Comprehensive (Hospital & Medical)
- ☐ Medical Only
- ☐ Dental
- ☐ Other (please list)

Non Mandated Risk (excluding FEP)	$	265,518,316
Non Risk	$	431,727,000
Total Medical Expenses	$	697,245,316

Non Medical Expenses
(Refer to the Underwriting and Investment Exhibit Part 3- Analysis of Expenses in the Annual Report Statement for appropriate expense classifications)

Non Mandated Risk (excluding FEP)	$	42,611,118
Non Risk	$	40,618,000
Total Non Medical	$	83,229,118
Total Expenses	$	780,474,435

*This Report incorporates by this reference, its cover-letter of even date herewith, from Edward W. O'Neil, CareFirst Sr. Vice President & Chief Actuary

This information is for GHMSI, Inc. for 2007 representing the revenue and care. The data on this page represents Risk (including agg & spec stop loss), Non Risk, and FEP. It excludes Individual <65, Individual > 65, and SEGO.

Project Net Profit (LOSS)		
Non Mandated Risk (excluding FEP)	$	15,380,942
Non Risk	$	(7,315,000)
Total Project Net Profit (LOSS)	$	8,065,942

Value of Premium Tax Exemption

Premiums Written, Calendar Year 2007 (should agree to Schedule T, Maryland Business form Annual Statement)	$	631,314,306
Adjustments:		
ASO/ASC business included in premiums written		
Federal Employee Health Program Premiums		
Minimum Premium contracts		
Other		
Total Adjustments		
Premiums subject to taxation	$	631,314,306
Premium tax rate		2%
Value of Premium Tax Exemption	$	12,626,286

CFMI EXEMPTION COMPUTATION

	2007
Premiums Written (Should agree to Schedule T, Maryland business from the Annual Statement)	1,348,718,808
Adjustments:	
ASO/ASC included in premiums written	
Federal Employee Health Benefits Program Premiums	745,015,156
Other	-
Premiums Subject to Taxation	603,703,652
Premium Tax Rate	2%
Value of Premium Tax Exemption	12,074,073

CFMI USES

	2007
Value of Premium Tax Exemption	12,074,073
Funds Used by the Plan to Serve the Public Interest:	
Legislative Funding Request *	12,888,520
Contributions, Sponsorships, Comm Hlth. Spending	3,657,075
GHMSI Purchase of Excess Credits from CFMI	(1,300,000)
Total Funds Used by the Plan to Serve the Public Interest:	15,245,595
Net Excess/(Deficit) in Public Interest Spending	3,171,522

* see Attachment A

GHMSI EXEMPTION COMPUTATION

	2007
Premiums Written (Should agree to Schedule T, Maryland business from the Annual Statement)	631,314,306
Adjustments:	
ASO/ASC included in premiums written	
Federal Employee Health Benefits Program Premiums	
Other	
Premiums Subject to Taxation	631,314,306
Premium Tax Rate	2%
Value of Premium Tax Exemption	12,626,286

GHMSI USES

	2007
Value of Premium Tax Exemption	12,626,286
Funds Used by the Plan to Serve the Public Interest:	
Legislative Funding Request *	9,817,469
Contributions, Sponsorships, Comm Hlth. Spending	1,954,378
CFMI Sale of Excess Credits to GHMSI	1,300,000
Total Funds Used by the Plan to Serve the Public Interest:	13,071,847
Net Excess/(Deficit) in Public Interest Spending	445,561

* see Attachment A

Attachment A

Actual Legislative Spending During Calendar Year 2007

State Program FY	Total FY Obligation	Basis of Obligation	Ck Date	CFMI	GHMSI	Total
FY 2007	$ 22,381,136	2005 Schedule T Filed 3/06 for State Programs 7/06 - 6/07	Jan-07	3,163,070.50	2,411,929.50	5,575,000.00
			Apr-07	3,163,070.50	2,411,929.50	5,575,000.00
			May - 08*	51,927.00	29,209.00	81,136.00
FY 2008	$ 22,949,707	2006 Schedule T Filed 3/07 for State Programs 7/07 - 6/08	Jul-07	3,255,226.17	2,482,200.58	5,737,426.75
			Sep-07	3,255,226.17	2,482,200.58	5,737,426.75
Total				12,888,520.34	9,817,469.16	22,705,989.50

*Original Payment schedule for FY 2007 payments erroneously understated by $81,136. Late payment to settle shortfall issued 5/08

Program Funding Based on Above Payments

Payee	Program	Total Due	01/01/07	04/01/07	07/01/07	10/01/07
MHIP	Sr Rx Assistance Program	$ 14,000,000	3,500,000.00	3,500,000.00	3,500,000.00	3,500,000.00
DHMH	Comm Hlth Res Comm - Data System	$ 1,700,000	425,000.00	425,000.00	425,000.00	425,000.00
	Comm Hlth Res Comm - Operating Budget	$ 6,624,854	1,575,000.00	1,575,000.00	1,737,426.75	1,737,426.75
	Comm Hlth Res Comm - Operating Budget	$ 81,136				
	Md Pharmacy Discount Program	$ 300,000	75,000.00	75,000.00	75,000.00	75,000.00
		$ 22,705,990	5,575,000.00	5,575,000.00	5,737,426.75	5,737,426.75
	Late Payment To Comm Hlth - Operating Budget (5/2008)			81,136.00		
			2nd Half of FY 2007 Funding based on 2005 Premium Exemption amount $22,381,136		1st Half of FY 2008 Funding based on 2006 Premium Exemption amount $22,949,707	

Contributions, Sponsorships and Community Health Related Spending

		Actual 2007 Expense		GHMSI Expenses Used for Justification						
Special Community Based Initiatives	Total	CFMI	GHMSI Total	Direct or 100% MC/PG	Allocated @ 54.354%*	No Charge Allocated @ 45.646%	No Charge, DC/Va Only	CFMI Justification Total	GHMSI Justification Total	
1 BTE Pilot Program	997,240	460,900	536,340	476,340			60,000	460,900	476,340	
2 100,000 Lives Campaign	150,500	75,250	75,250		40,901	34,349		75,250	40,901	
3 Hapi-CC Health Awareness	209,951	-	209,951		114,117	95,834			114,117	
4 UMMS Cardiovascular	150,000	148,879	1,121	1,121				148,879	1,121	
5 Outreach in Spanish	198,313	198,313	-		-	-		198,313		
6 HIT	150,000	75,000	75,000		40,766	34,235		75,000	40,766	
7 MPSC/MRSA	195,000	97,500	97,500		52,995	44,505		97,500	52,995	
8 DC Open Enrollment	5,989	-	5,989	-	-	-	5,989		-	
9 YMCA	400,000	200,000	200,000	-			200,000	200,000	-	
10 HIE-CHIPS	728,500	364,250	364,250	364,250				364,250	364,250	
11 HIE-Lifebridge	406,230	406,230	-	-	-	-		406,230	-	
12 Spanish Catholic Dental Center	50,752	50,752	-	-	-	-		50,752	-	
13 La Clinica Del Pueblo (Diabetes Prog.)	117,824	-	117,824	-	64,042	53,782		-	64,042	
14 Cardiovascular/Obesity Disparity Prog. (BMS)	271,260	135,630	135,630	135,630				135,630	135,630	
Total Special Community Based Initiatives	4,031,559	2,212,704	1,818,855	977,341	312,821	262,704	265,989	2,212,704	1,290,162	see 2 of 3 (a)
								-	-	
2007 Community Spending**	2,839,927	1,444,371	1,395,556	37,500	528,101	443,495	386,460	1,444,371	565,601	see 3 of 3 (b)
Total Details Received From Corp Comm Relations	6,871,486	3,657,075	3,214,411	1,014,841	840,922	706,199	652,449	3,657,075	1,855,763	
Dr First - Software license renewal fee. Hand-held Rx prescription devices. Issued to 500 providers of which 371 are in MD (74.2%)	132,904		132,904	26,514	72,100		34,289	-	98,615	
Total	7,004,390	3,657,075	3,347,315	1,041,355	913,022	706,199	686,738	3,657,075	1,954,378	

*Md Counties (MC & PG) as a percentage of GHMSI service area per 2000 US Census
**Includes UW

Control Totals	
Total Justification amounts	5,611,453
Plus - No Chg Allocated process	706,199
Plus - No Chg DC/VA Only	686,738
	7,004,390
Variance from total expenses	-

GHMSI Splits of Community Based Initiatives

	Program	GHMSI Total Expense from 1 of 3	Expense Allocation Justification	Census Splits 54.3540% Used for Premium Tax Exemption	Census Splits 45.6460% Non Allowed for Premium Tax Exemption
1	BTE Pilot Program	536,340	Only one office in DC Proper. Amount Paid in 2007 was $60,000	476,340	60,000
2	100,000 Lives Campaign	75,250	Funds made to area hospitals in MD and DC service areas. Split by Census	40,901	34,349
3	Hapi-CC Health Awareness	209,951	Vietnam Cervical Cancer. Starting in 06 services N Va and MC facilities. Split by Census	114,117	95,834
4	UMMS Cardiovascular	1,121	100% Md Region	1,121	
5	Outreach in Spanish	-	na		
6	HIT	75,000	Health Systems imitative servicing total region, split by census	40,766	34,235
7	MPSC/MRSA	97,500	Hospital Initiative benefiting all 18 facilities within total service area, split by census	52,995	44,505
8	DC Open Enrollment	5,989	not allowed		5,989
9	YMCA	200,000	GHMSI payments made to DC after school programs		200,000
10	HIE-CHIPS	364,250	Health Info Exchange at 8 Health centers all in MD	364,250	
11	HIE-Lifebridge	-	na		
12	Spanish Catholic Dental Center	-	na		
13	La Clinica Del Pueblo (Diabetes Prog.)	117,824	Payments made to DC physician centers servicing patients in surrounding service area, split by census	64,042	53,782
14	Cardiovascular/Obesity Disparity Prog. (BMS)	135,630	100% Md Region	135,630	
	Total GHMIS Community Based Initiatives	1,818,855	**Total GHMSI Comm Based Initiatives used for Prem Tax Exemption Justification**	**1,290,162**	528,693

(a)

Community Giving (Premium Tax Reporting)
Jan-Dec 2007

CY 2007

Location of Spending	Jan	Feb	Mar	Apr	May	Jun	Jan-Jun Total	Jul	Aug	Sep	Oct	Nov	Dec	YTD Total
1 - PG/Mont.	2,500	-	-	5,000	25,000	-	32,500	-	-	5,000	-	-	-	37,500
2 - DC Only	-	-	-	1,000	20,600	18,000	39,600	1,750	180,000	5,210	48,500	25,400	86,000	386,460
3 - Entire GHMSI	13,000	144,250	86,850	122,340	303,712	61,375	731,527	45,000	81,250	4,125	1,500	102,194	5,000	970,596
4 - GHMSI/CFMI	-	2,000	-	-	-	-	2,000	-	-	-	-	-	-	2,000
5 - CFMI	62,500	147,635	182,600	94,922	78,850	80,300	646,807	40,390	192,766	59,850	150,650	301,408	51,500	1,443,371
Total	78,000	293,885	269,450	223,262	428,162	159,675	1,452,434	87,140	454,016	74,185	200,650	429,002	142,500	2,839,927

	CFMI	GHMSI				
	100%	100% to PTJE	Allocated 54.354% to PTJE	Not Allowed for PTJE	Total GHMSI	Total
1		37,500			37,500	37,500
2			-	386,460	386,460	386,460
3			527,558	443,038	970,596	970,596
4	1,000		544	456	1,000	2,000
5	1,443,371				-	1,443,371
	1,444,371	37,500	528,101	829,954	1,395,556	2,839,927

Total GHMSI contri/sponsorships/comm giving used for PTJE 565,601

(b)

Corporate Giving
Community Based Initiatives

Bridges to Excellence Program (BTE)
A three-year program that will recognize and reward 20 physician offices throughout the region who deliver safe, timely, effective, efficient, equitable and patient-centered care. Quality measures are according to uniformly nationally accepted standards, collected by independent third party – NCQA. All patients, not just CareFirst members, of these physician offices benefits from the quality enhancements put in place.

100K Lives Campaign
Campaign broadens the content area and geographic availability of the work from the Maryland Patient Safety Center to all hospitals with the CareFirst region. The goals are to prevent central line infections, prevent ventilator-assisted pneumonia, deploy rapid response teams, prevent adverse drug events, prevent surgical site infections and deliver reliable, evidence-based care for Acute Myocardial Infarction. The collaborative model brings the life saving proven practices to the front lines of 31 hospitals to aid teams to make rapid changes and implement effective strategies for sustained improvement. This model encourages spread and sharing of knowledge – within hospital units, between hospitals, and throughout the country.

Hapi-CC Health Awareness
Vietnamese women are reluctant to be screened for cervical cancer, which puts them at a higher risk for developing the disease. CareFirst is partnering with Boat People S.O.S. –a leading Vietnamese service and advocacy group on a three-year program designed to raise awareness of the disease and increase screening rates by 10%. The program has three components: 1) targets Northern Virginia, 2) Expand to MD and outpost centers in DC, 3) expand to include services for Vietnamese men and women for colon and liver cancer screening in all geographical areas.

UMMS Cardiovascular
University of Maryland and CareFirst are partners in providing a community health awareness program focused on cardiovascular disease in African Americans in Barber Shops and Beauty Salons in Baltimore City. The goals are to promote awareness and health education of cardiovascular risk factors specifically high blood pressure, high blood cholesterol, obesity, diabetes, and sedentary lifestyles.

Outreach in Spanish
Because many Latinos prefer to receive health information in their native language, CareFirst launched a new online site www.carefirst.com/salud and produced new educational materials, brochures and mailings in Spanish. Access to the health information web site and the publications are available to the public.

MD/DC Collaborative for Health Information Technology (HIT)
This collaboration is to connect disparate health care systems in the MD/DC area to improve patient safety, quality of care and efficiency. The group will design, implement and measure a common data exchange infrastructure that is replicable, scalable and economically sustainable.

La Clinica del Pueblo (DC Based Clinic)
CareFirst is partnering with this clinic on a three year project focused on improving the care for diabetes in the Latino population. The program has the following components:

- Implementation of the "Chronic Care Model, or CCM"
- Intensive education will be provided by a culturally competent health educator
- An innovative intervention in the use of a home education visit program, in which peer health educators visit patients with diabetes in their homes to counsel them on self-management. The program launched in 2005.

MPSP/MRSA
CareFirst, the Maryland Patient Safety Center (MPSC) and the Delmarva Foundation are partners introducing a new program developed to focus on combating the transmission of Methicillin-resistant staphylococcus aureus (MRSA) – a type of bacterium found on the skin that can lead to serious infections. MRSA has been pegged as a primary source of infections transmitted in health care settings. CareFirst funded an effort by the Delmarva Foundation to introduce specific interventions in hospitals, nursing homes and beyond to prevent transmission and associated infections.

CHIPS
CareFirst supported the Community Health Integrated Partnership (CHIP) in conducting a readiness assessment to implement an electronic patient record system, including development of functional specifications and documentation requirements. The development of the electronic patient record system will provide a solid platform for community health centers to work collaboratively and achieve practice efficiencies.

LifeBridge
(Electronic Health Information Interchange utilizing a consumer controlled record bank)
The development of an electronic medical record and clinical support tools to improve care to patients in their two acute hospitals, Sinai and Northwest Hospital Center. Office based information will be integrated with hospital based data in the electronic medical record already in place. The final step will be to link the consumer with their providers.

Spanish Catholic Dental Center
A dental program developed to increase access to appropriate oral health care for over 300 low-income, uninsured members of the immigrant and Hispanic communities of Washington, DC metropolitan area by the Spanish Catholic Center.

Cardiovascular/Obesity Disparity Program (BMS)
Program focused on health disparities in the Latino and African American populations at two Baltimore Medical Centers; Highlandtown and Belair Edison-Baltimore City.