STATE OF OREGON

DEPARTMENT OF CONSUMER & BUSINESS SERVICES

DIVISION OF FINANCIAL REGULATION

REPORT OF FINANCIAL EXAMINATION

OF

PROVIDENCE HEALTH PLAN
PORTLAND, OREGON

AS OF

DEC. 31, 2021

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DEPARTMENT OF CONSUMER AND BUSINESS SERVICES

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OF

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PORTLAND, OREGON

NAIC COMPANY CODE 95005

AS OF

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SALUTATION

August 30, 2023

Honorable Andrew R. Stolfi, director
Department of Consumer and Business Services
Division of Financial Regulation
State of Oregon
350 Winter Street NE
Salem, OR 97301-3883

Dear commissioner:

In accordance with your instructions and guidelines in the National Association of Insurance Commissioners (NAIC) *Financial Condition Examiners Handbook*, pursuant to ORS 731.300 and 731.302, respectively, we have examined the business affairs and financial condition of:

PROVIDENCE HEALTH PLAN
4400 NE Halsey, Bldg. 2, Suite 690
Portland, Oregon 97213

NAIC Company Code 95005

The following report is respectfully submitted.

SCOPE OF EXAMINATION

We have performed our regular, full-scope, single-state examination of Providence Health Plan (PHP or plan). The last examination of this health care service contractor was completed as of Dec. 31, 2016. This examination covers the period from Jan. 1, 2017, through Dec. 31, 2021.

We conducted our examination pursuant to ORS 731.300 and in accordance with ORS 731.302(1), which allows the examiners to consider the guidelines and procedures in the NAIC *Financial Condition Examiners Handbook*. The handbook requires that we plan and perform the examination to evaluate the financial condition, assess corporate governance, identify current and prospective risks of the plan, and evaluate system controls and procedures used to mitigate those risks. An examination also includes identifying and evaluating significant risks that could cause the plan's surplus to be materially misstated, both currently and prospectively.

All accounts and activities of the plan were considered in accordance with the risk-focused examination process. This may include assessing significant estimates made by management and evaluating management's compliance with statutory accounting principles. The examination does not attest to the fair presentation of the financial statements included herein. If, during the course of the examination an adjustment is identified, the effects of such an adjustment will be documented separately following the plan's financial statements.

This report includes significant findings of fact, as mentioned in ORS 731.302, and general information about the plan and its financial condition. There may be other items identified during the examination that, due to their nature (e.g., subjective conclusions and proprietary information), are not included within the report but separately communicated to other regulators and/or the plan.

COMPANY HISTORY

In 1984, this nonprofit health maintenance organization was formed by Providence Portland Medical Center and Providence St. Vincent Hospital, and the Division of Financial Regulation issued an original certificate of authority on Sept. 5, 1984, under the name Physician InterHospital Plan (also known as The Good Health Plan). The following year, the plan received approval as a federally qualified health maintenance organization by the U.S. Department of Health and Human Services. In 1997, The Good Health Plan was renamed Providence Health Plan after the merger with The Good Health Plan of Washington and with SelectCare Health Plan of Southern Oregon. The merger was approved by the Division of Financial Regulation on Nov. 24, 1997, to be effective Jan. 1, 1998.

On Jan. 6, 2016, the director issued an order of exemption allowing the combination of the ultimate controlling entity, Providence Health & Services, with St. Joseph's Health System, a California nonprofit public benefit corporation. The two entities formed Providence St. Joseph Health, a Washington nonprofit corporation, to become the new ultimate controlling entity. On May 9, 2016, the director issued an order of exemption allowing a corporate reorganization to facilitate the consolidation of the hospital systems under one holding company, which includes the plan's insurance business. On April 1, 2022, the director issued an order of exemption allowing a corporate reorganization under which the plan's sole corporate membership transferred from Providence Health & Services - Oregon to Providence Health Group LLC, a Washington limited liability company and direct subsidiary of Providence St. Joseph Health. That reorganization took effect on July 1, 2022. Providence St. Joseph Health remains the plan's ultimate controlling entity.

Capitalization

The plan was initially capitalized by the member hospitals of Sisters of Providence in Oregon. The company commenced business with initial funding of $400,000. This funded amount was returned

and currently no gross paid-in or contributed surplus was reported by the plan. During the period under examination, the plan's surplus was comprised entirely of unassigned funds.

Dividends and other distributions

During the period under examination, the plan did not pay any dividend or make any cash distributions to its sole member.

CORPORATE RECORDS

Board minutes

In general, the review of the plan's board meeting minutes indicated support of the plan's transactions and that the board adequately reviews, discusses, and approves significant decisions and transactions. A quorum, as defined by the plan's bylaws, was met at all of the meetings held during the period under review.

The plan's bylaws, in Article IV, authorize an executive committee and all other committees to be formed as are deemed necessary and appropriate. The plan's board has authorized an audit and finance committee and created a formal charter. This committee's main responsibilities are to recommend financial policies, goals, and budgets, and to oversee the plan's audit, accounting, financial reporting processes, and internal control systems. Other committees serving under the board include a compliance and risk committee, which oversees the plan's compliance program, including information privacy, information security, and enterprise risk management; a governance committee, which assists the plan's board in maintaining current best practices in nonprofit corporate governance and also recommends candidates for the board; and a quality and medical management committee, which assists the board with respect to quality of care and medical management activities of the plan. These three committees also have formal charters. The actions of the various committees are summarized and reported to the board of directors during their regular meetings.

Effective July 1, 2016, the plan's re-constituted board of directors assumed oversight with regard to the compensation of its CEO and senior leaders. The plan's board approves an annual budget that includes salaries and compensation of certain senior leaders, which are reimbursed under the management services agreement between the plan and Providence Plan Partners (PPP). This process complies with the provisions of ORS 732.320(3).

However, the plan's appointed actuary did not directly present the actuarial opinion to the board of directors or the audit committee, as required by the NAIC Health Annual Statement Instructions. This violates Oregon Revised Statute (ORS) 731.574, and Oregon Administrative Rules (OAR) 836-011-0000.

I recommend the plan have the appointed actuary report to and directly present the actuarial opinion to the plan's board of directors or the audit committee, in accordance with ORS 731.574 and OAR 836-011-0000.

Articles of Incorporation

The plan last amended its articles of incorporation on July 1, 2016. No changes were made to the articles during the period under examination. The articles of incorporation conformed to the Oregon Insurance Code.

Bylaws

The plan's bylaws were last amended and restated as of July 1, 2016. No changes were made to the bylaws during the period under examination. The bylaws conformed to the Oregon Insurance Code.

MANAGEMENT AND CONTROL

Board of directors

The bylaws state the business and affairs of the corporation shall be managed and controlled by its board of directors. The articles of incorporation, under Article 6, and the bylaws, in Article I, Section 1, state the number of directors shall not be less than five nor more than 15. As of Dec. 31, 2021, the plan was governed by a six-member board of directors as follows:

Name and Address	Principal Affiliation	Member Since	Representative
Isiaah Crawford Seattle, Washington	President University of Puget Sound	2016	Public
Debra A. Canales Timnath, CO	Executive Vice-President, Chief Administrative Officer Providence St. Joseph Health	2016	Company
Donald M. Antonucci West Linn, Oregon	Chief Executive Officer Providence Health Plan	2021	Company
Rhonda M. Medows, MD* Renton, Washington	EVP – Population Health Providence St. Joseph Health	2016	Company
Joseph A. Blankenship Powder Springs, GA	Retired Chief Financial Officer	2018	Public
Heath G. Schiesser Austin, Texas	Founding Partner Pilot Wall Group	2016	Public

* Board chairperson

Under Oregon Law, ORS 750.015, not less than one-third of the group of persons vested with the management of the affairs of a health care service contractor shall be representatives of the public who are not practicing doctors, or employees, or trustees of a participant hospital. The plan was in compliance with ORS 750.015.

Officers

Principal officers serving at Dec. 31, 2021, were as follows:

Officer	Office
Donald M. Antonucci	Chief executive officer
Daniel W. Ryan	Treasurer, chief financial officer
Michael G. White	President
Gregory D. Zamudio	Secretary, chief legal counsel
Robert A. Gluckman	Chief medical officer
Mark Jensen	Chief service operations officer
Nathan Perrizo	Chief strategy and operations officer
Aaron T. Bals	Chief compliance officer risk officer
Bradley J. Garrigues	Chief sales and underwriting officer

Conflict of interest

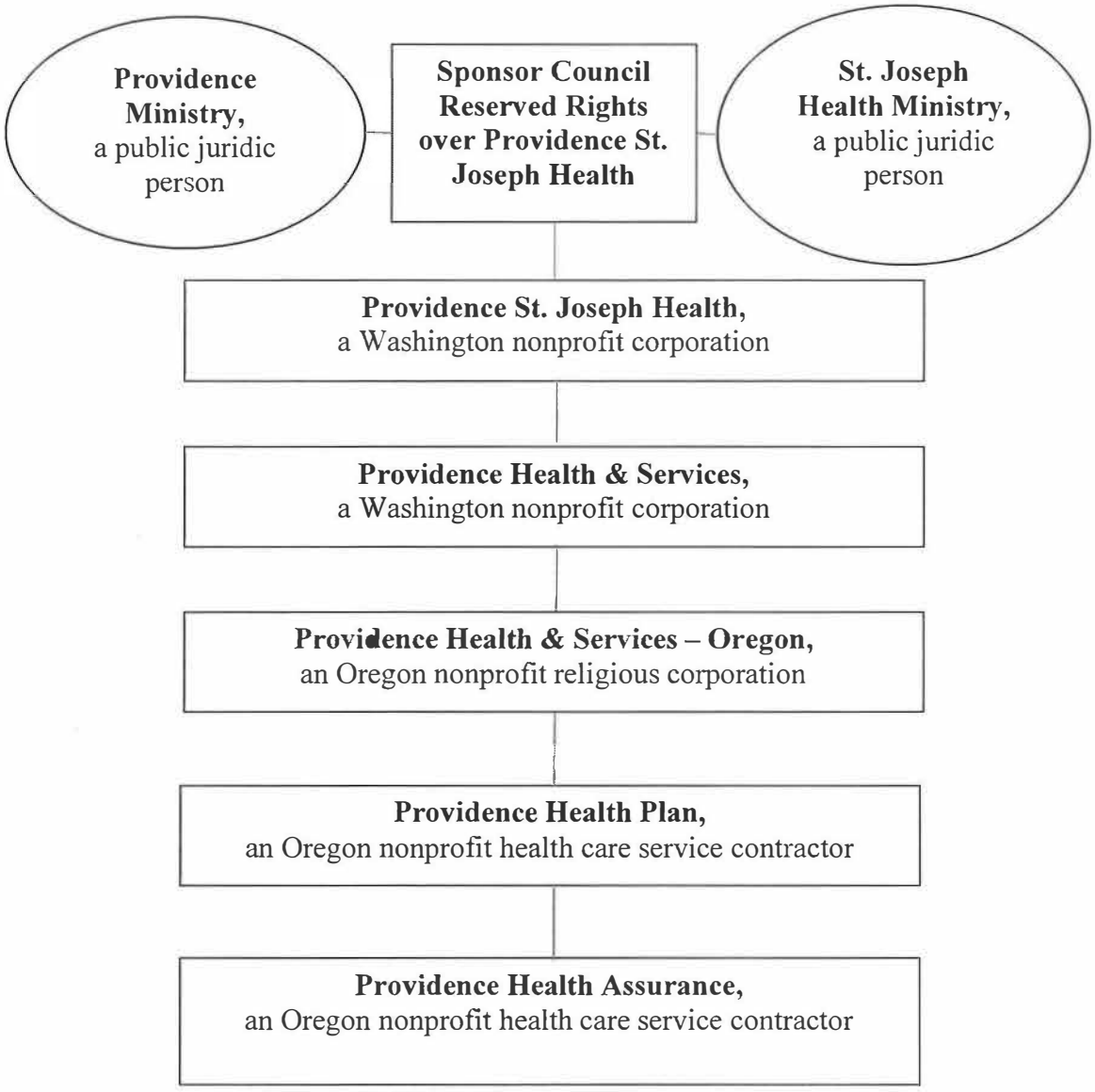
Providence St. Joseph Health (PSJH) has established a code of conduct policy to help ensure it is following its ethical commitments, as well as the laws, rules, and regulations that govern its business conduct and help identify, discourage, and prevent violations. The code is distributed to all employees upon hire and covers integrity and compliance standards, legal and regulatory compliance, patient and workplace standards, reporting concerns, and security for PSJH and all subsidiaries. There is also a procedure established for employees to report any concerns or potential violations anonymously.

The code of conduct requires all employees at the director level and above, including board members and senior officers, to complete and sign annual conflict of interest statements. Other employees are required to complete this form based on their roles within the organization. Additionally, any employee who is aware of a personal conflict is required to complete the form voluntarily. From a review of the completed conflict of interest questionnaires, the plan's personnel performed due diligence in completing the conflict of interest statements. No material conflicts of interest were noted.

Insurance company holding system

Provincial Superior and members of the Provincial Council of the Sisters of Providence, Mother Joseph Province (a Roman Catholic order based in Montreal, Canada) received permission from the Vatican in 2010 to form a five-member public juridic person under the name Providence Ministries to be the sponsor of Providence Health & Services. These members, none of whom are employed by any Providence entity, assume some of the responsibilities of the Sisters of Providence, Mother Joseph Province in governing Providence Health & Services. On July 1, 2016, the Oregon Division of Financial Regulation approved the merger of Providence Health & Services with St. Joseph Health System in California, which operates hospitals throughout Southern California. PSJH is the ultimate controlling entity of the organization. The PSJH Sponsors Council is an unincorporated body of individual persons comprised of all members of Providence Ministries and St. Joseph Health Ministry. The sponsors are the formal connection between PSJH and the Catholic Church and are responsible for assuring PSJH's Catholic identity and fidelity to its ministry.

The following abbreviated organizational chart shows the relationships with the plan within the insurance holding company system:



A description of the entities within the holding company is as follows:

Providence St. Joseph Health (PSJH) is a Washington nonprofit corporation that operates hospitals throughout Oregon, Washington, Alaska, Montana, California, Texas, and New Mexico.

Providence Health & Services (PH&S) is a Washington nonprofit organization that operates hospitals, schools, and other facilities throughout Oregon, Washington, Alaska, Montana, and Southern California.

Providence Health & Services – Oregon (PH&S-OR), formerly Providence Health System – Oregon, is an Oregon nonprofit religious organization that operates the hospitals, and other facilities established by the Sisters of Providence in Oregon. PH&S-OR provides all employees to Providence Plan Partners at cost under a management services agreement described below. PH&S-OR is the sole member of the plan and the direct parent.

Providence Plan Partners (PPP) is a Washington nonprofit organization that manages the company's administration and operations through a management services agreement and agency agreement.

Providence Health Assurance (PHA) is an Oregon nonprofit organization that was formed to handle Medicaid business for Oregon members. All Medicaid business for Oregon members was transferred to PHA on Jan. 1, 2004. Effective Jan. 1, 2016, the plan transferred their contract with CMS and related Medicare Advantage business to PHA. All related membership, assets, liabilities, receivables, payables, deferred revenue, other liabilities, and net worth associated with the Medicare Advantage Plan were transferred to PHA during the first quarter of 2016. The plan is the sole member of PHA.

Performance Health Technology Ltd. (PH Tech) is an Oregon for-profit organization that provides the administrative services for Medicaid and Medicare Supplement customers.

INTERCOMPANY AGREEMENTS

The following contracts or agreements with related parties are in place:

Management services and agency agreement – Effective Jan. 1, 2011, the plan entered into an agreement with PPP for overall management and administrative services. These services include employee staff, accounting, financial reporting, utilization review and cost controls, professional

and quality control, patient referral procedures, marketing and sales support, and other administrative services. PPP provides all employees and related business expenses to the plan at cost. PPP shall calculate the cost of all services provided to the plan, which shall be paid prior to the close of each month's fiscal period, or in no case later than within 60 days of receipt of invoice. Cost shall be determined through PPP's cost accounting by product line and shall be updated on an annual basis at a minimum. PPP may if it so chooses, but is not required to, charge a reasonable fee for administering expenses on behalf of the plan.

Administrative services agreement – Effective Jan. 1, 2021, the plan entered into an agreement with Providence St. Joseph Health, plan administrator, on behalf of the group's health plans sponsored by its current and future affiliates and subsidiaries, including Providence Health & Services (PH&S), St. Joseph Health System, Swedish Health Services, Swedish Edmonds, Kadlec Regional Medical Center, and Pacific Medical Center (each a "plan sponsor"). Under the terms of the agreement, the plan administrator has engaged the plan as an independent third party to perform certain administrative services to the self-funded employee welfare benefit plan, established by each of the plan sponsors. The plan will provide the following administrative services: administration forms, a toll-customer services telephone line for participants, enrollment support, standard identification cards for participants, customer service, claims processing, large claim reporting, coordination of benefits, run-out administration, retroactive claim adjustment, claim recovery services, medical management service, care management services, pharmacy benefit administrative and management services, and a nurse advice line. Within 90 days following the close of each agreement period, the plan will, upon request, provide a copy of the reconciliation to the plan administrator. The plan administrator agrees to pay the service fees within 30 days after receiving written notice from the plan of the amounts due. Late payments of amounts that are due and payable by the plan administrator will be assessed the prime interest rate plus 1 percent after 30 days from the due date.

Compensation and risk/incentive structure agreement – Effective and last amended on Jan. 1, 2019, the company entered into an agreement with Providence Health & Services – Oregon (PH&S-OR) to reimburse an enrollee's medical expenses allocated into seven distinct funds: a primary fund to reimburse the primary care practitioner (PCP); a referral fund to reimburse for specific services authorized by the PCP; an institutional fund for the hospital and other facility and ancillary services; a health plan risk fund to reimburse for specific services; an end-stage renal disease (ESRD) fund to reimburse costs for those enrollees with ESRD; a durable medical equipment (DME) fund to reimburse costs for DME; and a PCP quality fund.

100 percent quota share reinsurance agreement – Effective Jan. 1, 2021, the plan entered into a 100 percent quota share arrangement with Providence Health Assurance (PHA) whereby the plan assumed 100 percent of all insurance operating balances and activities associated with Medicaid and Medicare members from PHA, including those outstanding and unsettled at the effective date. PHA retains a ceding commission sufficient to cover administrative expenses.

Sublease agreement – Effective July 30, 2010, the plan entered into a sublease agreement with PH&S-OR. Under the terms of the agreement, the plan subleases a portion of the building to PH&S-OR. The agreement is effective until July 29, 2020, and will automatically renew for a period of one year, until either the plan or PH&S-OR decide to terminate the agreement. PH&S-OR agrees to pay a monthly base rent for the subleased premises at a set rate per rentable square foot. The payment is due on the first day of each month.

Assignment, release, and assumption of sublease agreement – Effective July 30, 2010, the plan entered into an assignment, release, and assumption of sublease agreement with PH&S-OR and PPP. Under the terms of the agreement, the plan has assigned its right, title, and interest as a

sublessee in the sublease agreement to PPP. PPP accepts the assignments and assumes the plan's obligation under the sublease agreement.

Cash management letter of agreement – Effective July 16, 2021, the plan entered into a cash management letter of agreement with PHA. Under the terms of the agreement, the plan will provide specific cash management services to PHA. The amounts are to be settled daily.

Provider agreements – Effective January 2019, the plan entered into provider services contract agreements with PH&S-OR. Under the terms of the agreement, PH&S-OR providers are contracted as part of the plan's provider network.

There were several agreements that were not disclosed in Form B – Insurance Holding Company System Registration Statement to the Division of Financial Regulation, as required by ORS 732.552(1)(c)(E).

I recommend the plan, going forward, disclose all of its affiliated agreements in Form B – Insurance Holding Company System Registration Statement, Item 5 – Transactions and Agreements, in accordance with ORS 732.552(1)(c)(E).

Furthermore, it was noted there were several agreements that were not filed in a timely manner with the Division of Financial Regulation, as required by ORS 732.574 (2) (A).

I recommend the plan, going forward, file Form D – Notice of Proposed Transaction in a timely manner for all of its affiliated agreements to the Oregon Division of Financial Regulation for approval in accordance with ORS 732.574(2)(a)(A).

FIDELITY BOND AND OTHER INSURANCE

The examination of insurance coverages involved a review of adequacy of limits and retentions, and the solvency of the insurers providing the coverages. The plan's insurance coverages are provided through insurance policies covering Providence St. Joseph Health , with the plan and all subsidiaries named as an affiliate. The group as a whole is insured up to $10 million per individual loss, after a $500,000 deductible, against losses from acts of theft, forgery, or alteration, and fraud by its employees and agents. Fidelity bond coverage was found to meet the coverage limits recommended by the NAIC.

Other insurance coverages in force on Dec. 31, 2021, were found to be adequate, and included:

Commercial auto	Officers employment practices
Cyber, security and privacy liability	Crime coverage
Excess medical professional liability	Property coverage
Workers' compensation and employer liability	Fiduciary liability

TERRITORY AND PLAN OF OPERATION

Providence offers medical plans for individuals, families, and commercial groups. Supplemental benefit options and administrative services are also available for group plans. All plans include access to Providence Preferred, a network of hospitals, clinics, urgent care centers, physicians, and other health care providers.

Individual and family plans, including child-only coverage, serve Oregon residents who are under age 65 and not eligible for Medicare. Coverages include a range of medical services at various benefit levels, including preventative and routine health care services for illness and injury. They include prescription drug benefits, wellness benefits, and access to health resources.

Group plans provide employers in Oregon and southwest Washington with medical plans tailored to their benefits budget. Benefit riders such as prescription drug, vision and dental are also available. The plan offers more than 30 different plans based on deductible amounts, coinsurance maximums, and other options. Group plans can be integrated with health savings accounts (HSA), health reimbursement arrangements (HRA), and flexible spending accounts (FSA).

Administrative services include third-party, self-funded, or administrative services only contracts.

The plan reported total enrolled members over the past five years as follows:

Line of Business	2021	2020	2019	2018	2017
Individual hospital and medical	52,266	56,684	62,107	80,128	91,461
Group hospital and medical	117,210	122,335	144,201	160,660	178,622
Total enrollment	169,476	179,019	206,308	240,788	270,083

GROWTH OF THE COMPANY

The growth of the plan over the past five years is reflected in the following table. Amounts were obtained from the plan's filed annual statements, except in those years where a report of examination was published by the Division of Financial Regulation.

Year	Assets	Liabilities	Capital and Surplus	Net Income (Loss)
2017	$ 812,394,325	$ 313,156,463	$ 499,237,862	$ 16,502,894
2018	863,933,481	308,470,578	555,462,903	39,076,913
2019	844,429,747	240,564,572	603,865,172	81,658,082
2020	1,191,181,456	423,955,897	767,225,559	87,739,700
2021*	1,754,556,959	930,428,774	824,128,185	44,180,595

*Per examination

LOSS EXPERIENCE

The following exhibit reflects the annual underwriting results of the plan over the last five years. The amounts were compiled from copies of the plan's filed annual statements and, where indicated, from examination reports.

Year	(1) Total revenues	(2) Total hospital and medical	(2)/(1) Medical loss ratio	(3) Claim adjustment and general expenses	(2)+(3)/(1) Combined loss ratio
2017	$ 1,294,627,843	$1,183,416,953	91.4%	$ 103,353,040	99.4%
2018	1,377,586,926	1,230,213,684	89.3%	146,197,746	99.9%
2019	1,278,812,743	1,121,911,296	87.7%	139,482,604	98.6%
2020	1,189,801,265	913,561,078	76.8%	148,756,804	89.3%
2021*	2,003,870,378	995,312,997	49.7%	227,378,505	61.0%

*Per examination

A combined loss incurred and expense-to-premium ratio of more than 100 percent would indicate an underwriting loss. The plan reported underwriting gains in all years under examination.

REINSURANCE

Assumed

An intercompany 100 percent quota share reinsurance agreement between the plan and PHA was described under intercompany agreements above.

Ceded

During the period under examination, the plan entered into an annual HMO excess of loss reinsurance agreement for each year, which was covered by annual policies with RGA Reinsurance Company (NAIC No. 93572), a Missouri domiciled life and health insurer, authorized in Oregon on May 25, 1982. Under the 2021 policy, the reinsurer agrees to reimburse the plan's commercial HMO members for loss up to an unlimited maximum for each covered member after a retention of $800,000. The plan pays a fixed per member per month premium for each commercial HMO members, due 30 days after the beginning of the month. The reinsurer shall reimburse amounts in excess of retention limits for inpatient hospital services, inpatient rehabilitation services, skilled nursing facility services, outpatient health services, drug-related services, durable medical equipment, medical transportation, and regenerative or advanced therapies.

The reinsurance agreements contained a proper insolvency clause that specified payments would be made to a statutory successor without diminution in the event of insolvency, as required by the provisions of ORS 731.508. Neither agreement contained a settlement clause, as required by OAR 836-012-0310, which required the reinsurer to pay all reinsured claims at least quarterly.

I recommend the plan amend its reinsurance agreements with RGA Reinsurance Company and Providence Health Assurance to include a settlement clause pursuant to the provisions of OAR 836-012-0310.

It was determined that the two reinsurance agreements did not provide for risk transfer in accordance with the requirements of the *Accounting Practices and Procedures Manual*, SSAP No. 61R, as there is no requirement for the reinsurer to pay the reinsured claims timely. ORS 731.302 states that in conducting the examination, each examiner shall consider the guidelines and procedures in the examiner handbook, or its successor publication, adopted by the National Association of Insurance Commissioners. The director may prescribe the examiner handbook or its successor publication and employ other guidelines and procedures that the director determines to be appropriate.

I recommend the plan amend the reinsurance agreements to provide for risk transfer, pursuant to the provisions of SSAP No.61R and ORS 731.302.

In view of the plan's adjusted capital and surplus of $824,128,185 on Dec. 31, 2021, it does not maintain risk on any one subject in excess of 10 percent of its surplus to policyholders, in compliance with ORS 731.504.

ACCOUNTS AND RECORDS

In general, the plan's records and source documentation supported the amounts presented in its Dec. 31, 2021, annual statement and were maintained in a manner by which the financial condition was readily verifiable pursuant to the provisions of ORS 733.170. The plan has a system in place to account for unclaimed funds and the company has filed the reports on abandoned property pursuant to the provisions of ORS 98.352.

However, it was noted that the plan did not completely disclose several of the Notes to the Financial Statement in its 2021 annual statement. The incomplete disclosures are in violation of ORS 731.574 and OAR 836-011-0000.

I recommend the plan ensure all of the Notes to the Financial Statement are disclosed in its annual financial statements in accordance with the requirements of ORS 731.574(1) and OAR 836-011-0000.

STATUTORY DEPOSITS

To satisfy the statutory deposit requirements in Oregon for a health care service contractor, the plan has a surety bond in the amount of $250,000 placed with the Department of Consumer and Business Services, Division of Financial Regulation. This surety bond was confirmed with the Division of Financial Regulation.

COMPLIANCE WITH PRIOR EXAMINATION RECOMMENDATIONS

There was one recommendation made in the 2016 report of examination; however, no adjustments were made to the surplus as a result of the examination finding.

1) As a repeat from the 2013 examination, I again recommend the plan develop a procedure to have the board of directors, or a responsible committee of the board, approve all

investment transactions on a regular basis, and that a formal resolution be voted on by the board at the meetings, pursuant to ORS 733.730.

2) I recommend the board formally approve all distributions by resolution, and that any future distributions be submitted to the Division of Financial Regulation within five business days after declaration by the board, pursuant to ORS 732.554 and 732.576.

The current examination revealed that the company has been approving all investment transactions on a regular basis. No dividends or distributions were declared by the plan during the period under examination.

SUBSEQUENT EVENTS

Effective May 2022, Nathan Perrizo, chief information officer, chief strategy and operations officer, resigned from the position. Effective August 2022, the plan hired Michael Mathias to fill the position of chief information officer. Further, the plan hired Cheryl Morrison as the chief operations officer, effective June 2022.

Effective June 2022, Michael White, president, resigned from the position.

Effective April 2023, Mark Jensen, chief service operations officer, resigned from the position.

Effective June 2023, Daniel Ryan, chief financial officer, resigned from the position. The plan hired Lina Saadzoi to fill the position.

FINANCIAL STATEMENTS

The following financial statements are based on the statutory financial statements filed by the plan with the Oregon Division of Financial Regulation and present the financial condition of the plan for the period ending Dec. 31, 2021. The accompanying comments on financial statements reflect

any examination adjustments to the amounts reported in the annual statement and should be considered an integral part of the financial statements.

Statement of assets
Statement of liabilities, capital, and surplus
Statement of revenue and expenses
Reconciliation of surplus since the last examination

PROVIDENCE HEALTH PLAN
ASSETS
As of Dec. 31, 2021

Assets	Balance per Company	Examination Adjustments	Balance per Examination	Notes
Bonds	$ 814,879,927	$ -	$ 814,879,927	1
Common stocks	185,719,627	-	185,719,627	1
Properties occupied by the company	42,624,500	-	42,624,500	
Cash, cash equivalents, and short-term investments	304,456,948	-	304,456,948	1
Receivables for securities	179,866,417	-	179,866,417	
Subtotals: cash and invested assets	1,527,547,419	-	1,527,547,419	
Investment income due and accrued	1,560,494	-	1,560,494	
Premiums and considerations				
Uncollected premiums and agents' balances in the course of collection	76,043,471	-	76,043,471	
Accrued retrospective premiums and contracts subject to redetermination	38,292,595	-	38,292,595	
Amounts recoverable from reinsurers	35,019,658	-	35,019,658	
Amounts receivable relating to uninsured plans	7,110,614	-	7,110,614	
Electronic data processing equipment and software	2,274,770	-	2,274,770	
Receivables from parent: subsidiaries and affiliates	20,329,976	-	20,329,976	
Health care and other amounts receivable	46,377,962	-	46,377,962	
Aggregate write-ins for other-than-invested assets	-	-	-	
Total assets	$1,754,556,959	$ -	$ 1,754,556,959	

PROVIDENCE HEALTH PLAN
LIABILITIES, CAPITAL AND SURPLUS
As of Dec. 31, 2021

Liabilities, Surplus and other Funds	Balance per Company	Examination Adjustments	Balance per Examination	Notes
Claims unpaid	$ 211,426,417	$ -	$ 211,426,417	2
Accrued medical incentive pool and bonus	63,784,867	-	63,784,867	
Unpaid claims adjustment expenses	10,960,581	-	10,960,581	2
Aggregate health policy reserves	63,777,742	-	63,777,742	2
Premiums received in advance	23,036,103	-	23,036,103	
General expenses due or accrued	7,827,491	-	7,827,491	
Amounts due to parent: subsidiaries and affiliates	15,840,788	-	15,840,788	
Payable for securities	369,081,384	-	369,081,384	
Liability for amounts held under uninsured plans	59,158,601	-	59,158,601	
Aggregate write-ins for other liabilities	105,534,800	-	105,534,800	
Total liabilities	$ 930,428,774	$ -	$ 930,428,774	
Common capital stock	$ -	$ -	$ -	
Gross paid in and contributed surplus	-	-	-	
Unassigned funds (surplus)	824,128,185	-	824,128,185	
Surplus as regards policyholders	824,128,185	-	824,128,185	
Total liabilities, surplus, and other funds	$ 1,754,556,959	$ -	$ 1,754,556,959	

PROVIDENCE HEALTH PLAN
STATEMENT OF REVENUE AND EXPENSES
For the Year Ended December 31, 2021

Revenue	Balance per Company	Examination Adjustments	Balance per Examination	Notes
Net premium income	$ 2,003,870,378	$ -	$ 2,003,870,378	
Change in unearned premium reserves and reserve for rate credits	-	-	-	
Fee for service	-	-	-	
Risk revenue	-	-	-	
Aggregate write-ins for other health care related revenues	-	-	-	
Total revenues	2,003,870,378	-	2,003,870,378	
Hospital and Medical:				
Hospital/medical benefits	553,419,703	-	553,419,703	
Other professional services	199,186,305	-	199,186,305	
Outside referrals	66,311,501	-	66,311,501	
Emergency room and out-of-area	35,939,036	-	35,939,036	
Prescription drugs	137,381,479	-	137,381,479	
Aggregate write-ins for other hospital and medical	3,653,445	-	3,653,445	
Incentive pool: withhold adjustments and bonus amounts	(578,472)	-	(578,472)	
Subtotal	995,312,997	-	995,312,997	
Less:				
Net reinsurance recoveries	(789,773,432)	-	(789,773,432)	
Total hospital and medical	1,785,086,429	-	1,785,086,429	
Non-health claims (net)	-	-	-	
Claims adjustment expenses	73,402,526	-	73,402,526	
General administrative expenses	153,975,979	-	153,975,979	
Increase in reserves for life and accident and health contracts	(43,000,000)	-	(43,000,000)	
Total underwriting deductions	1,969,464,934	-	1,969,464,934	
Net underwriting gain or (loss)	34,405,444	-	34,405,444	
Net investment income earned	10,720,349	-	10,720,349	
Net realized capital gains or (losses)	(543,371)	-	(543,371)	
Net investment gains or (losses)	10,176,978	-	10,176,978	
Net gain or (loss) from agents' or premium balances charged off	(401,827)	-	(401,827)	
Aggregate write-ins for other income or expenses	-	-	-	
Federal income taxes incurred	-	-	-	
Net income (loss)	$ 44,180,595	$ -	$ 44,180,595	

PROVIDENCE HEALTH PLAN
RECONCILIATION OF SURPLUS SINCE THE LAST EXAMINATION
For the Year Ending Dec. 31

	2021	2020	2019	2018	2017
Surplus as regards policyholders, Dec. 31, previous year	$ 767,225,559	$ 603,865,172	$ 555,462,903	$ 499,237,863	$ 466,192,374
Net income or (loss)	44,180,595	87,739,700	81,658,082	39,076,913	16,502,894
Change in net unrealized capital gains (losses)	19,123,866	71,485,028	20,887,388	24,279,914	37,574,148
Change in net unrealized foreign exchange capital gain or (loss)	-	-	-	-	-
Change in net deferred income tax	-	-	-	-	-
Change in nonadmitted assets	(6,401,836)	4,135,659	(4,143,201)	(7,131,787)	(6,031,553)
Change in unauthorized and certified reinsurance	-	-	-	-	-
Change in treasury stock	-	-	-	-	-
Change in surplus notes	-	-	-	-	-
Cumulative effect of changes in accounting principles	-	-	-	-	-
Capital changes					
Paid in	-	-	-	-	-
Transferred from surplus (stock dividend)	-	-	-	-	-
Transferred to surplus	-	-	-	-	-
Surplus adjustments:					
Paid in	-	-	-	-	-
Transferred to capital (stock dividend)	-	-	-	-	-
Transferred from capital	-	-	-	-	-
Dividends to stockholders	-	-	(50,000,000)	-	(15,000,000)
Aggregate write-ins for gains or (losses) in surplus	-	-	-	-	-
Change in surplus as regards policyholders for the year	56,902,625	163,360,387	48,402,269	56,225,040	33,045,489
Surplus as regards policyholders, Dec. 31, current year	$ 824,128,184	$ 767,225,559	$ 603,865,172	$ 555,462,903	$ 499,237,863

NOTES TO FINANCIAL STATEMENTS

Note 1 – Invested Assets

At year-end 2021, the plan's long-term bond investments were in a diversified portfolio of U.S. obligations, U.S. federal agency bonds, municipal obligations, and corporate issues. The plan reported direct exposure in mortgaged-backed or asset-backed securities in the amount of $102,890,117, equal to 12.6 percent of total bonds and 9.9 percent of total invested assets.

The plan reported common stocks consisted of equity in a wholly-owned subsidiary, Providence Health Assurance, and four mutual funds.

The plan reported $129,951,509 in short-term investments, consisting of 16 corporate bonds maturing in less than one year. Cash on deposit was held in 28 accounts at U.S. Bank and one account at the Northern Trust Company.

Short-term deposits consisted of two money market mutual funds one held at U.S. Bank, and one held in the custodial account at Northern Trust Company.

A comparison of the major investments over the past five years shows the following:

Year	A Bonds	B Common stocks	C Cash and short-term	Ratio A/ Total assets	Ratio B/ Total assets	Ratio C/ Total assets
2017	337,377,661	254,669,665	114,690,416	41.5%	31.3%	14.1%
2018	335,100,666	349,022,380	44,911,227	38.8%	40.4%	5.2%
2019	307,830,426	368,038,553	51,623,498	36.5%	43.6%	6.1%
2020	429,886,748	308,326,525	290,118,859	36.1%	25.9%	24.4%
2021*	814,879,927	185,719,627	304,456,948	46.4%	10.6%	17.4%

* Balance per examination.

As of Dec. 31, 2021, sufficient assets were invested in amply secured obligations of the United States, the State of Oregon, or in FDIC insured cash deposits in accordance with ORS 733.580.

The board of directors approved the investment transactions in each of the years under review, pursuant to ORS 733.740. The plan uses a discretionary adviser, Metropolitan West Asset Management LLC, as its investment consultant, and TCW Investment Management Company LLC, to actively manage its portfolio. Transactions are monitored by an investment officer with PHS, who reports the transactions to the CFOs of PHS and the plan.

Effective Jan. 1, 2014, and amended on Aug. 31, 2017, the plan entered into a custodial agreement with The Northern Trust Company located in Chicago, Illinois. The agreement contained all of the relevant protections described in OAR 836-027-0200(4)(a) through (n).

Note 2 – Actuarial reserves

A review of the unpaid claims and claim adjustment expense reserves for the plan was performed by Andrew D. Bux, FSA, MAAA, life and health actuary for the Oregon Division of Financial Regulation. As part of his review, he examined the actuarial report supporting statements as of Dec. 31, 2021, prepared by Lynn F. Dong, FSA, MAAA, from Milliman Inc.

Mr. Bux reviewed the reconciliation of the data used in the plan's actuarial report to the data in the actuarial work papers and found them to be consistent. He relied on work performed by the examiners who reviewed the underlying data used to create the annual statement filing, as well as prepared his own independent calculations. He determined the following:

	My estimate	Annual statement
Claims unpaid	$ 211,426,417	$ 211,426,417
Accrued medical incentive pool and bonus payments	63,784,867	63,784,867
Unpaid claims adjustment expenses (CAE)	10,960,581	10,960,581
Aggregate health policy reserves	63,777,742	63,777,742
Aggregate health claim reserves	-	-
Rate stabilization reserve for groups	2,315,280	2,315,280
Medicare advantage RADV	15,000,000	15,000,000
Pharmacy rebates	(30,517,289)	(30,517,289)
Provider incentive receivables	(10,430,000)	(10,430,000)
ACA risk adjustment receivables	(12,862,000)	(12,862,000)
Medicare Advantage risk adjustment revenue	(17,900,000)	(17,900,000)
Total Actuarial Reserves	$ 295,555,598	$295,555,598

The appointed actuary opined that the reserves for unpaid claims and CAE carried by the plan as of Dec. 31, 2021, were reasonable. Mr. Bux concurred that the reserves of the plan were reasonably stated as of Dec. 31, 2021.

SUMMARY OF COMMENTS AND RECOMMENDATIONS

The following is a summary of the recommendations made in this report of examination:

Page

7 I recommended the plan have the appointed actuary report to and directly present the actuarial opinion and the actuarial memorandum the company's board of directors or audit committee, in accordance ORS 731.574 and OAR 836-011-0000.

15 I recommend the plan, going forward, disclose all of its affiliated agreements in Form B - Insurance Holding Company System Registration Statement, Item 5 – Transactions and Agreements in accordance with ORS 732.552(1)(c)(E).

15 I recommend the plan, going forward, file Form D – Notice of Proposed Transaction in a timely manner for all of its affiliated agreements to the Oregon Division of Financial Regulation for approval in accordance with ORS 732.574(2)(a)(A).

19 I recommend the plan amend its reinsurance agreements with RGA Reinsurance Company and PHP, to include a settlement clause pursuant to the provisions of OAR 836-012-0310.

19 I recommend the plan amend the reinsurance agreements to include provisions for risk transfer, pursuant to the provisions of SSAP No.61R and ORS 731.302.

20 I recommend the plan ensure all of the Notes to the Financial Statement are disclosed in its annual financial statements in accordance with the requirements of ORS 731.574(1) and OAR 836-011-0000.

CONCLUSION

During the five-year period covered by this examination, the surplus of the plan has increased from $466,192,374, as presented in the Dec. 31, 2016, report of examination, to $824,128,185, as shown in this report. The comparative assets and liabilities are:

	2021	Dec. 31, 2016	Change
Assets	$ 1,754,556,959	$ 750,735,770	$ 1,003,821,189
Liabilities	930,428,774	284,543,396	645,885,378
Surplus	$ 824,128,185	$ 466,192,374	$ 357,935,811

ACKNOWLEDGMENT

The cooperation and assistance extended by the officers and employees of the plan during the examination process are gratefully acknowledged.

In addition to the undersigned, Chivonne Scott, insurance examiner, and Andrew D. Bux, ASA, MAAA, life and health actuary for the State of Oregon, Department of Consumer and Business Services, Division of Financial Regulation, participated on this examination. Additionally, Robin Brown, CFE, supervising examiner; Sara Schumacher, CPA, CFE, CPCU, CIE, MCM, ARe, manager; Andy Jennings, CFE, ARM, manager; Stephen Skenyon, CISA, CPA, IT Senior manager; and Jolene Nansel, CIRD, manager from Risk and Regulatory Consulting LLC participated on this examination.

Respectfully submitted,

/s/ Tho Le

Tho Le, CFE, PIR
Senior Financial Examiner
Division of Financial Regulation
Department of Consumer and Business Services
State of Oregon

AFFIDAVIT

STATE OF OREGON)
) ss
County of Marion)

Tho Le, CFE, PIR, being duly sworn, states as follows:

1. I have authority to represent the State of Oregon in the examination of Providence Health Plan, Portland, Oregon.

2. The Division of Financial Regulation of the Department of Consumer and Business Services of the State of Oregon is accredited under the National Association of Insurance Commissioners Financial Regulation Standards and Accreditation.

3. I have reviewed the examination work papers and examination report. The examination of Providence Health Plan was performed in a manner consistent with the standards and procedures required by the Oregon Insurance Code.

The affiant says nothing further.

/s/ Tho Le
Tho Le, CFE, P
Senior Financial Examiner
Division of Financial Regulation
Department of Consumer and Business Services
State of Oregon

Subscribed and sworn to me this 27 day of September , 2023.

/s/ Lori Ann Kirschmann
Notary Public for the State of Oregon
My Commission Expires: January 9, 2027

OFFICIAL STAMP
LORI ANN KIRSCHMANN
NOTARY PUBLIC - OREGON
COMMISSION NO. 1032313
MY COMMISSION EXPIRES JANUARY 09, 2027