

STATE OF OREGON

**DEPARTMENT OF
CONSUMER AND BUSINESS
SERVICES**

**DIVISION OF FINANCIAL
REGULATION**



REPORT OF FINANCIAL EXAMINATION

OF

ATRIO HEALTH PLANS, INC.
SALEM, OREGON

AS OF

DEC. 31, 2022

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NAIC COMPANY CODE 10123

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SALUTATION

July 15, 2025

Honorable TK Keen
Administrator, acting insurance commissioner
Department of Consumer and Business Services
Division of Financial Regulation
State of Oregon
350 Winter Street NE
Salem, Oregon 97301-3883

Dear Commissioner Keen:

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

**ATRIO HEALTH PLANS, INC.
2965 Ryan Drive SE
Salem, Oregon 97301**

NAIC Company Code 10123

hereinafter referred to as the “company” or the “plan.” The following report is respectfully submitted.

SCOPE OF EXAMINATION

We have performed our regular, single-state, full-scope examination of ATRIO Health Plans, Inc. The last examination of this health care service contractor was completed as of Dec. 31, 2018. This examination covers the period of Jan. 1, 2019 to Dec. 31, 2022.

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 company and evaluate system controls and procedures used to mitigate those risks. An examination also includes identifying and evaluating significant risks that could cause an insurer's surplus to be materially misstated both currently and prospectively.

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 impact of such adjustment will be documented separately following the company's financial statements.

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

COMPANY HISTORY

The plan was incorporated under the laws of the State of Oregon on Dec. 23, 2004, as a for-profit stock corporation. It was formed by three provider sponsored health plans servicing rural Medicaid enrollees in Southern Oregon; Doctors of the Oregon Coast South (DOCS) in Coos County, Douglas County Individual Practice Association (DCIPA) in Douglas County (now known as Umpqua Health, LLC), and Cascade Comprehensive Care, Inc. (CCC) in Klamath County. Each health partner owned one-third of the issued preferred voting stock of the plan. The plan was granted a certificate of authority in Oregon on March 31, 2005, as a health care service contractor pursuant to ORS Chapter 750. DOCS subsequently sold its shares to the plan. In 2011, Marion Polk Community Health Plan Advantage, Inc. (MPCHPA) acquired a 33.3 percent share of the Series A voting stock of the plan.

On April 29, 2016, CCC purchased an additional 300 shares of Series B preferred stock in the amount of \$1,564,197, which brought its ownership percentage to 33.33 percent. Consequently, both Umpqua Health and MPCHPA's ownership percentage changed to 33.33 percent.

On Nov. 1, 2016, the plan filed an amendment to Article XII of the 2011 restated articles of incorporation, whereby the corporation elected to become a public benefits corporation as defined in ORS 60.750(1), and to be subject to ORS 60.750 – ORS 60.770, as amended. The corporation has the purpose of providing a general public benefit, including making Medicare health insurance coverage available to qualifying member of the communities that it serves.

On June 20, 2019 the holding company structure changed as ATRIO Acquisition Corporation acquired 100 percent of the outstanding common shares of ATRIO Health plan, Inc. At the close of the transaction, CCC and WVP Health Authority (WVP) contributed their ATRIO common

stock holdings in exchange for non-controlling membership interests in ATRIO Holding Company, LLC. ATRIO Acquisition Corporation, a Delaware corporation is wholly owned by ATRIO Holding Company, LLC, a Delaware limited liability company, which is 59.64 percent owned by ATRIO Splitter Fund, LP, 29.82 percent owned by CCC, 9.94 percent owned by Marion Polk Community Health Plan Advantage, Inc. and 0.59 percent owned by Ken Stoll, an individual. ATRIO Splitter Fund, LP is approximately 80 percent owned by Chicago Pacific Founders Fund II, LP. The ultimate controlling entity is a group of limited partners/investors; no limited partner/investor has a 10 percent or greater ownership interest in Chicago Pacific Founders Fund II, LP.

Chicago Pacific Founders Fund II, L.P. consists of Chicago Pacific Founders GP II L.P., Chicago Pacific Founders Fund II-A, L.P., Chicago Pacific Founders Fund II-B, L.P. and Chicago Pacific Founders UGP II LLC (Chicago, IL) which is a limited partnership and private equity fund. Mary Tolan, Chicago, IL, Lawrence Leisure, San Francisco, CA, and Vance Vanier, M.D., San Francisco, CA each have 33.3 percent controlling interest in Chicago Pacific Founders UGP II LLC, the decision-making entity of CPF.

Capitalization

As of Dec. 31, 2018, CCC owned a 33.33 percent interest in ATRIO consisting of 500 shares of Series A stock and 1,579 shares of Series B stock. After close of the stock purchase agreement with Chicago Pacific Founders, the ultimate parent (CPF) on June 20, 2019, CCC held a 30 percent ownership interest and currently holds 29.82 percent in the parent company (ATRIO Holding Company, LLC).

As of Dec. 31, 2018, Marion Polk Community Health Plan Advantage, Inc. owned a 33.33 percent interest in ATRIO consisting of 500 shares of Series A stock and 1,579 shares of Series B stock. After the close of the stock purchase agreement with CPF on June 20, 2019, MPCHPA held a 10 percent ownership interest and currently holds 9.94 percent in the parent company (ATRIO Holding Company, LLC).

As of Dec. 31, 2018, Umpqua Health, LLC. (Umpqua) owned a 33.33 percent interest in ATRIO consisting of 500 shares of Series A stock and 1,579 shares of Series B stock. After the close of the stock purchase agreement with CPF on June 20, 2019, Umpqua no longer has an ownership interest in either the plan or the parent company as it sold its entire ownership stake to Chicago Pacific Founders.

The plan reported total capital stock value of \$20,498,899 in the 2022 annual statement, which is comprised of 6,237 shares of preferred stock.

Dividends to stockholders and other distributions

On Jan. 3, 2022, the company paid an extraordinary dividend of \$300,000 to its parent company, Atrio Holding Company, LLC. The parent company then purchased the preferred shares that were owned by Wendy Edwards, former CEO. The Division of Financial Regulation (DFR) was not notified of this dividend.

On April 4, 2022, the company paid a dividend of \$26,000 to its parent company, Atrio Holding Company, LLC. The parent company then purchased the preferred shares that were owned by Russ Noah, former board of director chair. DFR was not notified of this dividend

On June 28, 2022, the company paid a dividend of \$250,638 to its parent company, Atrio Holding Company, LLC. The parent company then purchased the preferred shares that were owned by Wendy Edwards. DFR was not notified of this dividend.

ORS 732.554 states except as provided in ORS 732.576, each registered insurer shall so report all dividends and other distributions to shareholders within five business days following the declaration thereof and not less than 10 business days prior to payment of the dividends and distributions, commencing from the date of receipt of the report by the director.

ORS 732.576(2)(a) states a domestic insurer subject to registration may not pay or make any extraordinary dividend or distribution to the domestic insurer's shareholders either until 30 days after the director of the Department of Consumer and Business Services has received notice of the declaration of the dividend or distribution, if the director has not disapproved the payment within the 30-day period, or until the date on which the director approves the payment if approval occurs within the 30-day period.

ORS 732.576(3)(a) states except as provided in this subsection, a domestic insurer may declare or pay dividends to shareholders only from earned surplus. A domestic insurer may declare a dividend from other than earned surplus only if the director approves the declaration prior to payment of the dividend.

I recommend the company comply with the provisions of ORS 732.554; ORS 732.576(2)(a) and ORS 732.576(3)(a) after declaring and prior to paying extraordinary dividends in the future. I further recommend the company properly report extraordinary dividends in the

notes to the financial statements – Note 13D in compliance with ORS 731.574(1) and OAR 836-011-0000.

As part of the sale of the plan on June 20, 2019, a dividend of \$2,584,036 was paid to CCC and MPCHA. Retroactive approval for the dividend was granted by the Department of Consumer and Business Services, Division of Financial Regulation on Oct. 1, 2019. The amount paid to CCC and MPCHA was \$1,292,018 each.

CORPORATE RECORDS

Board minutes

In general, the review of board meeting minutes of the plan indicated that the minutes support the transactions of the plan and clearly describe the actions taken by its directors. A quorum as defined by the plan's bylaws, met at all of the meetings held during the period under review.

The company's bylaws authorize an audit and compliance committee, and give the board the power to create additional committees as needed. The minutes for the audit and compliance committee were reviewed.

A review of the meeting minutes indicated the board did not directly approve the CEO's compensation in violation of ORS 732.320(3).

I recommend the board of directors directly approve by resolution the CEO's compensation annually, in accordance with ORS 732.320(3).

Articles of incorporation

The plan's articles of incorporation were restated effective Dec. 15, 2017, to reflect the plan's change to a benefit company as defined in ORS 60.750(1) and to be subject to ORS 60.750 to ORS

60.770, as amended. The restated articles require a 100 percent approval of the holders of outstanding shares of Series A voting stock to increase the size of the board of directors above 24 members or decrease the size of the board of directors below three members.

Bylaws

The plan's bylaws were last amended effective June 28, 2019. Per the amended bylaws, board membership shall consist of at least five but no more than 24 directors, which was a change from the prior bylaws, allowing at least three directors. The number of officers shall be a president and secretary as appointed by the board. Other officers may be appointed from time to time. Officers may be removed by the board of directors at any time with or without cause. An audit and compliance committee is authorized, and any other committee consisting of two or more members. The prior bylaws authorized an executive committee and a finance committee. The bylaws conformed to Oregon statutes.

MANAGEMENT AND CONTROL

Board of directors

The bylaws, in Article II, state the business and affairs of the corporation shall be managed and controlled by the board of directors. The board of directors shall consist of not less than five and no more than 24 directors, the specific number within such range to be set by resolution of the board. As of Dec. 31, 2022, the plan was governed by an eight member board of directors as follows:

<u>Name and address</u>	<u>Principal affiliation</u>	<u>Representative</u>	<u>Member since</u>
Tayo Bamidele Akins Klamath Falls, Oregon	President and CEO Cascade Comprehensive Care, Inc.	Ownership	2015

Jeffrey David Fox Phoenix, Arizona	Health care industry advisor Chicago Pacific Founders	Ownership	2022
Jennifer Yeh Portland, Oregon	Senior attorney Standard Insurance Company	Public	2021
Lloyd Brooks Minor, MD Portola Valley, California	Physician and dean Stanford University School of Medicine	Public	2021
Helena Barbey Lankton Portland, Oregon	Retired	Public	2021
Brian Florence McCarthy Atlanta, Georgia	Private equity operating partner Chicago Pacific Founders	Ownership	2021
Etienne Henri Deffarges La Croix sur Lurtry Switzerland	Private equity operating partner Chicago Pacific Founders	Ownership	2019
*Vance Kiernan Vanier Jackson, Wyoming	Private equity managing partner Chicago Pacific Founders	Ownership	2019

* Chairman

The directors as a group has experience in law, insurance, and management, in accordance with the provisions of ORS 731.386. ORS 750.015(1) requires not less than one-third of the group of persons vested with the management of the affairs of a health care service contractor be representatives of the public who are not practicing doctors, employees, or trustees of a participant hospital. The company was in compliance with this statute.

Officers

Principal officers serving at Dec. 31, 2022, were as follows:

Name

Title

Joel G. Kimmer
Mark C. Stewart
Charles J. Wilson

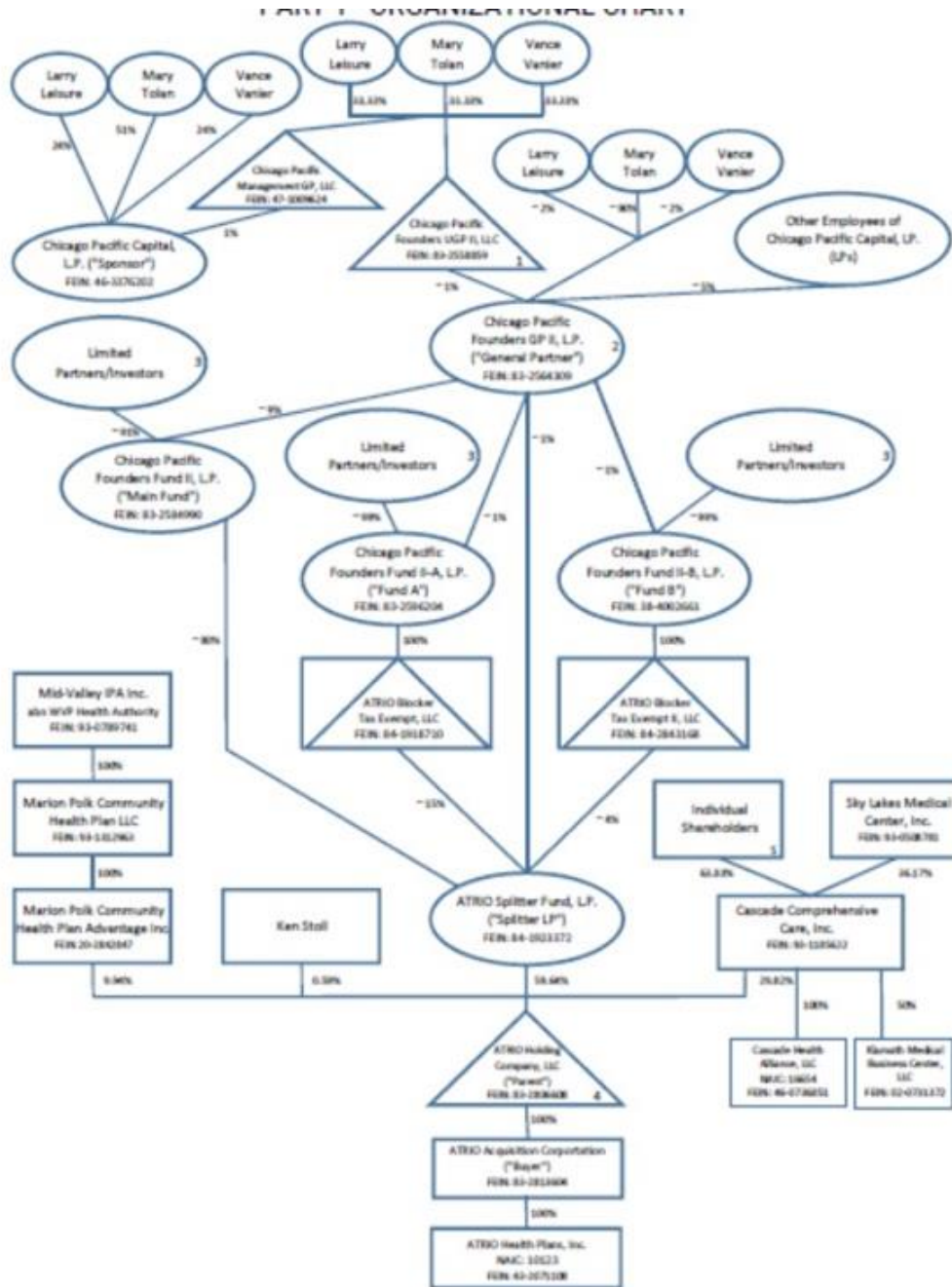
President and CEO
Chief financial officer
Secretary

Conflict of interest

The plan's board adopted a formal conflict of interest policy for all directors, officers and employees of the plan. All are required to annually sign a conflict of interest declaration. 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

An insurance holding company registration statement was filed by the company in accordance with the provisions of ORS 732.552, ORS 732.554, and Oregon Administrative Rule (OAR) 836-027-0020(1). The following organizational chart depicts the relationship between the related entities of the plan:



Footnotes

A description of the direct entities above is as follows:

Chicago Pacific Founders (CPF) is an investment advisor that manages private funds, focusing exclusively on healthcare services. CPF's leadership team is made up of former health care CEOs and senior executives with a passion and track record of building health care businesses. The fund

will invest up to \$75 million of equity capital per opportunity in buyout and growth transactions for cash flow positive businesses

Larry Leisure, Mary Tolan and Van Vanier, MD are each founders and managing partners of CPF and have a one-third controlling interest in Chicago Pacific Founders UGP II LLC, the decision-making entity of CPF.

Chicago Pacific Management GP, LLC is a shell company that serves as the general partner of the operating company, Chicago Pacific Capital, LP

Chicago Pacific Capital, LP is a Delaware limited partnership offering portfolio management for pooled investment vehicles.

Chicago Pacific Founders UGP II, LLC is Delaware limited liability corporation and a holding company. The above three individuals are each founders, a managing partner and 1/3 owner of CFP and each would be considered the ultimate controlling entity.

Chicago Pacific Founders GP II, LP is a Delaware limited partnership and the general partner of CPF, which makes investments in a variety of businesses. It is 90 percent owned and controlled by Mary Tolan, with the other investors holding less than 5 percent ownership.

Chicago Pacific Founders Fund II, LP (CPF) is a limited partnership acting as an investment advisor to manages private funds, focusing exclusively on health care services. The fund has indicated it will invest up to \$75 million of equity capital per opportunity in buyout and growth transactions for cash flow positive businesses.

Limited partners/investors (3) are made up of the three individuals, Larry Leisure, Mary Tolan, and Vance Vanier. The three have a 99 percent ownership interest (33.33 percent for each limited partner) in two limited partnerships; Chicago Pacific Founders Fund II-A, LP and in Fund II-B, LP. These are two private equity funds established for making investments in healthcare companies across North America.

Chicago Pacific Founders Fund II-A, LP is a Delaware limited partnership (Fund A), managed by the general partner. The private equity fund was established for making investments in health care companies across North America.

Chicago Pacific Founders Fund II-B, LP is a Delaware limited partnership (Fund B), managed by the general partner. The private equity fund was established for making investments in health care companies across North America

Atrio Blocker Tax Exempt, LLC is a Delaware limited liability company.

ATRIO Splitter Fund, LP is a Delaware limited liability company formed as a holding company to hold 60 percent of Atrio Holding Company, LLC.

Atrio Holding Company, LLC is a Delaware limited liability company formed to be the indirect holding company as a result of the stock purchase agreement with Chicago Pacific Founders. It is 60 percent owned by ATRIO Splitter Fund, LP, 30 percent by CCC, and 10 percent by MPCHPA.

Atrio Acquisition Corporation (Buyer) a Delaware corporation created as a mid-level holding company for the purpose of acquiring 100 percent equity interest in the plan as a result of the stock purchase agreement with Chicago Pacific Founders.

Mid Valley IPA, Inc. (MVIPA) is an Oregon corporation incorporated in 1976 as a mutual benefit corporation. MVIPA's membership consists of independent physicians in the Mid-Willamette Valley. With the passage of Coordinated Care Organizations (CCO) legislation, MVIPA and nine other entities developed a new organization, Willamette Valley Community Health LLC (WVCH). WVCH contracted with the State of Oregon to provide capitated health care services to enrollees of the Oregon Health Plan in Marion County and Polk County. Mid Valley IPA, dba WVP Health Authority (WVP) owns all of the issued and outstanding membership interest in Marion Polk Community Health Plan Advantage, Inc., which in turn owns all of the issued and outstanding capital stock of MPCHPA. Shares are not actively traded and management has no ownership interest.

Marion Polk Community Health Plan, LLC. is an Oregon limited liability corporation, organized in Feb. 2001, which is wholly owned by MVIPA. The LLC is a one-hundred percent owner of Marion Polk Community Health Plan Advantage, Inc.

Marion Polk Community Health Plan Advantage, Inc. (MPCHPA) is an Oregon corporation formed to write the Oregon Medicaid business under the OHP, through the DMAP. MPCHPA was organized in April 2005, and is a wholly owned subsidiary of Marion Polk Community Health Plan, LLC (MPCHP). On Nov. 1, 2011, at the same time that MPCHPA purchased a stock ownership interest in the plan, under a novation agreement, it transferred and assigned all of its rights in its Medicare Advantage contracts to the plan.

Individual shareholders are shareholders having a 65.64 percent ownership interest in Cascade Comprehensive Care

Sky Lakes Medical Center, Inc. is a not for profit, community-owned, acute care teaching hospital affiliated with Oregon Health & Science University medical school through the Cascades East Rural Family Medicine Residency Program. The hospital is located in Klamath Falls, Oregon.

Cascade Comprehensive Care Inc. (CCC) is an Oregon domiciled corporation and a managed health care company, started operations January 1996. CCC is owned by individual shareholders comprised of local health care providers, primary care physicians and specialists (65.64 percent) and Sky Lakes Medical Center (34.36 percent). CCC currently manages a Medicaid contract under the Oregon Health Authority. Cascade Health Alliance, LLC was formed in 2012 as a wholly owned subsidiary by CCC as a CCO for most Klamath County Medicaid residents and is certified by the State of Oregon. CCC also provides health care services for the plan's Medicare Advantage members in Klamath county.

INTERCOMPANY AGREEMENTS

The following agreements are in place between the plan and entities within the insurance company holding system:

Medicare Advantage services agreement

Effective Jan. 1, 2011 the plan entered into a Medicare Advantage agreement with Cascade Comprehensive Care, Inc. (CCC). Under the terms of the agreement, CCC is the service area contractor for the plan in the area in which CCC operates (Klamath County). The agreement directs CCC to arrange for provision of covered services to the plan's enrollees in the network established by CCC in its service area. CCC agrees to provide services in compliance with rules and regulations established by the Center for Medicare Services (CMS) and other regulatory bodies, comply with audits of the governing entities, and provide quarterly reporting to the plan regarding

member activity. In exchange, the plan will pay CCC an amount equivalent to 2.5 percent of revenue generated from serviced enrollees, on a monthly basis, for administrative services rendered.

Medicare Advantage services agreement

Effective Jan. 1, 2020 the plan entered into a Medicare Advantage services agreement with P3 Health Partners-Oregon, LLC.(P3). Under the terms of the Agreement, P3 will arrange for the provision of health care services to enrollees of ATRIO in the P3 service area, operate administrative aspects of the MA plans, and otherwise participate in the operation of the MA plans. The MASA is exclusive within P3's service area, and both parties agree that other service area contractors (SACs) may enter into agreements to provide or arrange for services in the parts of the ATRIO Service Area outside of the P3 service area. Obligations of both the plan and P3 are specified in the agreement. P3 obligations include arranging for covered services to enrollees through P3 providers or participating providers; requiring each P3 provider to enter into a participation agreement with P3 to arrange for health care services for enrollees; assistance with provider contracting; and maintaining medical, financial and encounter data records and providing to the plan with a five-day notice.

Effective Sept. 1, 2021 the agreement was amended to include Jackson and Josephine counties in Oregon. Effective July 1, 2022 the agreement was amended a second time retroactive to Jan. 1, 2022 to remove Jackson and Josephine counties from the P3 service area for the purposes of Part D risk only. Effective Feb. 1, 2023, the agreement was amended a third time to delete and replace the case management statement of work from the original agreement with a revised case management and statement of work. Effective July 1, 2023, the agreement was amended a fourth time to alter the obligations of the plan to include claims processing, to modify the term of the

original agreement to expire no earlier than Dec. 31, 2028, to modify the previous statement of work for the pharmacy program to specify responsibilities of both the plan and P3, to limit enrollees of Jackson and Josephine counties to those that are affiliated with providers that are part of the Health Alliance of Southern Oregon dba Asante Health Network, and to include risk arrangement specifications in those counties for years 2023, 2024, 2025 and 2026. The amendment also expanded the coverage area of P3 to include Clackamas, Lane, Multnomah, Washington, and Yamhill counties, effective Jan. 1, 2024 with a target Medical Loss Ratio equal to 87 percent.

The company failed to comply with the provisions of ORS 731.574 via OAR 836-011-0000 (annual statement blank and instructions) regarding its agreement and disclosure in Notes 10C (detail of material related party transactions) and Note 10D (amounts due from or to related parties) of the year-end (YE) 2022 annual statement. Further, the affiliation of P3 as a related party was not disclosed in Schedule Y – Part 1 of the YE 2022 annual statement. Additionally, the company failed to comply with ORS 732.552 by not disclosing the identity and relationship of P3 in the company's 2022 Form B filing nor the identity and relationship of P3 within the organizational chart of the 2022 Form B filing.

During fieldwork, the company filed an amended YE 2023 annual statement that disclosed P3 Health Partners in Note 10C, Note 10D, and in Schedule Y – Part 1. Further, the identity and relationship of P3 Health Partners was disclosed in the company's 2023 Form B filing, including within the Form B organizational chart.

Finally, the company failed to comply with ORS 732.574 by failing to notify the director of its intention to enter into the transaction in writing not later than the 30th day before the transaction or

within a shorter period, as allowed by the director, and by not obtaining a non-disapproval letter from DFR within the stated time period

I recommend the company comply with ORS 732.574 by properly notifying the director when entering into related party transactions, including all management service agreements, service contracts, tax allocation agreements, guarantees, and cost sharing arrangements.

Business associate agreement

Effective April 20, 2021, the plan entered into a business associate agreement with CPF MIB, LLC (business associate). Under the terms of the agreement, the business associate may use personnel health information (PHI) only as necessary to deliver or prepare delivery services under the agreement. Business associate may disclose PHI only for the purposes authorized by the agreement. The PHI may be disclosed to its affiliates and affiliates employees, subcontractors and agents, as directed by client, or as otherwise permitted by the terms of the agreement, which include:

- For proper management and administration of its business and to fulfill any present or future legal responsibilities of the business associate.
- To a third party for the proper management and administration of its business or to fulfill any present or future legal responsibilities of the business associate, provided that the disclosure are required by law or permitted by the client, and the business associate has an agreement with the third party regarding the use and security of PHI
- The PHI disclosed should be limited to the extent practicable

Administrative services agreement

Effective June 7, 2021, the plan entered into an administrative services agreement with Allymar Health Solutions (Allymar). Under the terms of the agreement, the company retains the services of Allymar to provision, configure and deploy its licensed version of Allymar's proprietary and patented risk and quality AI and operations services to support the performance of risk and quality operational services. Allymar's services include the following:

- Host, maintain and support Allymar's solutions on cloud-based platform
- Perform risk and quality operational services
- Use of AI for risk adjustment, AI for HEDIS, risk adjustment operational services, quality operational services, and application support

In exchange for services rendered, the company pays Allymar on a monthly basis according to the types of services utilized for each enrollee, up to \$14.04 per member per month (according to fee schedule included in the associated statement of work No. 2). Additional charges may be incurred for chart review services, depending on the nature and quantity of review.

Effective May 10, 2022, the company amended the agreement to include in-home health assessments to the services provided by Allymar, as well as additional optional screening services, for various amounts according to a fee schedule. The amendment stipulates a minimum number of enrollees serviced of 7,500.

The company failed to comply with the provisions of ORS 731.574 via OAR 836-011-0000 (annual statement blank and instructions) regarding its agreement and disclosure in Note 10C (detail of material related party transactions). Further, the affiliation of Allymar as a related party was not disclosed in Schedule Y – Part 1 nor in Schedule Y – Part 2 of the YE 2022 annual statement. Additionally, the company failed to comply with ORS 732.552 by not disclosing the

identity and relationship of Allymar in the company's 2022 Form B filing nor the identity and relationship of Allymar within the organizational chart of the 2022 Form B filing.

During fieldwork, the company filed an amended YE 2023 annual statement that disclosed Allymar in Note 10C, Note 10D, and in Schedule Y – Part 1. Further, the identity and relationship of Allymar was disclosed in the company's 2023 Form B filing, including within the Form B organizational chart.

Finally, the company failed to comply with ORS 732.574 by failing to notify the director of its intention to enter into the transaction in writing not later than the 30th day before the transaction or within a shorter period, as allowed by the director, and by not obtaining a non-disapproval letter from DFR within the stated time period.

I recommend the company comply with ORS 732.574 by properly notifying the director when entering into related party transactions, including all management service agreements, service contracts, tax allocation agreements, guarantees, and cost sharing arrangements.

Administrative services agreement – claims services

Effective June 7, 2021, the plan entered into an administrative services agreement for claims services with CPF MIB, LLC (provider). Under the terms of the agreement, the plan retains the services of an affiliated entity to provide certain claims processing services. Services provided include:

- Claim receipt, scanning and data entry, inventory management tracking reporting
- Claim processing, adjustments, and dispute resolution
- Claim audits including high dollar claims

- Payment processing and report generation

The plan retains some of the claims processing functions, including:

- Environment provisioning, maintenance and security (operating platforms)
- Maintenance of policies, procedures, and compliance requirements
- Claim dispute exceptions and final determination
- Generation of explanation of benefits
- Inbound and return mail processing

The services provided by CPF MIB are performed in India and may utilize employees working on a remote basis. In exchange for services rendered, The plan pays the Provider a monthly fee of \$1.75 per member per month, based on projected membership through the end of 2024 (at an annual assumed increase of 15 percent). The plan has agreed to pay a termination fee, based on a descending amount scale through 2024, if it wishes to end the contract before Dec. 31, 2024.

Surplus notes from parents

Effective Dec. 22, 2022, the company received an \$18.2 million capital infusion in the form of three surplus notes from its ultimate parents as follows:

- Chicago Pacific Founders Fund II, L.P. – \$14,617,473.68
- Chicago Pacific Founders Fund II-A, L.P. – \$2,816,210.53
- Chicago Founders Fund II-B, L.P. – \$766,315.79

Under the terms of the notes, the company is required to pay interest semi-annually on June 30 and Dec. 31 of each year at an 8 percent rate of interest. The surplus notes have no specific maturity dates. The surplus notes were issued to increase the company's RBC levels to above 300 percent.

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 insurance coverages are provided through insurance policies issued by unaffiliated carriers. The plan is insured up to \$3 million per occurrence, after a \$25,000 deductible per single loss, against losses from acts of dishonesty and fraud by its employees and agents. Fidelity bond coverage was found to meet the coverage recommended by the NAIC.

Other insurance coverages in force at Dec. 31, 2022, were found to be adequate, and are as follows:

Business owner liability	Business personal property
Employment related practices	Cyber coverage
Workers' Compensation	Business auto coverage
Employee benefits liability	Directors and officers coverage
	Crime coverage

TERRITORY AND PLAN OF OPERATION

The plan is licensed in the states of Oregon, Louisiana, Tennessee, and Nevada. The plan serves as a plan sponsor offering four Medicare Advantage plans (each an “MA plan” or collectively the “MA plans”) under a contract with CMS. As an Oregon health care service contractor, the plan provides MA plan benefits to enrollees in Douglas, Josephine, Jackson, Klamath, Marion, and Polk counties. The plan also offers Medicare Part D prescription drug insurance coverage. Coverage is provided in the following counties through partnerships with these entities:

- Asante Physician Partners: Josephine
- P3 Health Partners (Medicare): Douglas, Marion and Polk
- Cascade Comprehensive Care (CCC) (MA): Klamath
- PacificSource (Medicaid/SNP): Marion and Polk

Direct premium written in 2022 was \$272,209,307

During the last five years, the plan reported total enrolled members as follows:

<u>Line of Business</u>	<u>2018</u>	<u>2019</u>	<u>2020</u>	<u>2021</u>	<u>2022</u>
Individual hospital and medical	-	-	-	-	-
Group hospital and medical	-	-	-	-	-
Medicare	<u>19,937</u>	<u>18,009</u>	<u>18,931</u>	<u>19,825</u>	<u>22,842</u>
Total enrollment	<u>19,937</u>	<u>18,009</u>	<u>18,931</u>	<u>19,825</u>	<u>22,842</u>

GROWTH OF THE PLAN

Growth of the plan over the past five years is reflected in the following schedule. Amounts were derived from company's annual statements, except in those years where a report of examination was published by DFR.

<u>Year</u>	<u>Assets</u>	<u>Liabilities</u>	<u>Capital and surplus</u>	<u>Net income (loss)</u>
2018*	\$ 62,854,744	\$ 44,216,528	\$ 18,638,215	\$ 2,669,507
2019	69,869,887	49,073,009	20,796,878	4,499,969
2020	71,622,736	46,122,400	25,500,336	4,194,208
2021	69,868,318	46,527,376	23,340,942	(3,872,043)
2022 *	66,140,320	52,395,643	13,744,677	(13,488,884)

*Per examination

LOSS EXPERIENCE

The following exhibit reflects the annual underwriting results of the plan over the last five years.

The amounts were obtained from copies of the plan's filed annual statements and, where indicated, from the previous examination reports.

	(1)	(2)	(2)/(1)	(3)	(2)+(3)/(1)
<u>Year</u>	<u>Total revenues</u>	<u>Total hospital and medical</u>	<u>Medical loss ratio</u>	<u>Claim adjustment and general expenses</u>	<u>Combined ratio</u>
2018 *	\$ 203,870,780	\$ 162,919,930	79.9%	\$ 35,843,704	97.5%
2019	210,052,919	179,038,773	85.2%	27,255,371	98.2%
2020	235,722,063	195,514,706	82.9%	31,176,653	96.2%
2021	243,821,157	209,438,448	85.9%	39,038,476	101.9%
2022 *	271,661,484	236,246,358	86.9%	49,331,678	105.1%

*Per examination

A combined ratio of more than 100 percent would indicate an underwriting loss. The company reported net underwriting losses in 2021 and 2022

REINSURANCE

Assumed

None.

Ceded

Effective Jan. 1, 2022 through Dec. 31, 2022, the plan ceded business under a medical excess of loss reinsurance agreement with Hannover Life Reassurance Company of America. The agreement covered all Medicare (all Part A and Part B services defined by CMS) dual and non-dual policies. Loss was limited to the lesser of the paid or contracted amount. The agreement did not cover Part D services as defined by CMS. Under the terms of the agreement, each member was covered up

to 90 percent of the reinsurance limits. Reinsurance limits were as follows for each member annually:

- Jackson, Josephine & Klamath counties – \$4.7 million excess of \$300,000
- Douglas, Marion & Polk counties – \$250,000 excess of \$750,000
- TN & LA Non-Dual – \$250,000 excess of \$750,000
- Nevada Non-Dual – \$4,750,000 excess of \$250,000.

The plan retained the following amounts of loss incurred by the plan during the agreement period:

- Jackson, Josephine, and Klamath counties – dual and non-dual – first \$300,000
- Douglas, Marion, and Polk counties – dual and non-dual – first \$750,000
- Tennessee and Louisiana non-dual – first \$750,000
- Nevada non-dual – First \$250,000

Risk retention

The plan did not retain risk on any one subject in excess of 10 percent of its surplus in compliance with ORS 731.504.

Insolvency clause

The reinsurance agreement contained an insolvency clause that specified payments would be made to a statutory successor without diminution in the event of insolvency in compliance with ORS 731.508(3).

Settlement clause

The reinsurance agreement contained a settlement clause to verify risk transfer in compliance with OAR 836-012-0310.

Entire agreement clause

The reinsurance agreement contained an entire agreement clause in compliance with OAR 836-012-0320.

ACCOUNTS AND RECORDS

In general, the plan's records and source documentation supported most amounts presented in the company's Dec. 31, 2022, annual statement and were maintained in a manner by which the financial condition was readily verifiable pursuant to the provisions of ORS 733.170. However, some records and source documentation did not support amounts presented in the company's Dec. 31, 2022 annual statement as described in Note 2 under receivables from parent, subsidiaries, and affiliates.

The company 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.

STATUTORY DEPOSIT

As of the date of the examination, the plan maintained a deposit with DFR, totaling \$285,000 in accordance with ORS 750.045. The deposit was verified from the records of DFR and was properly listed in the 2018 annual statement, Schedule E – Part 3.

COMPLIANCE WITH PRIOR EXAMINATION RECOMMENDATIONS

There were three recommendations made from the prior examination performed by DFR as follows. The company subsequently showed compliance with all three of the recommendations.

SUBSEQUENT EVENTS

Effective Jan. 1, 2023, the company entered into a coinsurance agreement with Canada Life Assurance Company, a Canadian insurance company using its branch in the State of Michigan as its U.S. domestic port of entry. Under the terms of the agreement, claims are reinsured on a funds withheld coinsurance basis. The company retains its liability on the policies net of the benefits provided by the inuring agreements in effect as of the effective date and net of the reinsurance provided under the Agreement. Further reinsurance of the company's retained liability is subject to the reinsurer's prior written consent.

Related inuring agreement is as follows:

The reinsurer is American National Insurance Company. The agreement period is from Jan. 1, 2023 to Jan. 1, 2024. Covered membership is for Nevada Medicare members, and for Medicare dual and non-dual eligible membership located in Jackson, Josephine, Klamath, Douglas, Marion, and Polk counties in Oregon. Eligible expenses include claims incurred from Jan. 1, 2023 to Jan. 1, 2024, with claims reporting and submitting deadlines of Jan. 1, 2025. Eligible claims are 90 percent coinsured for each covered member up to \$5 million per agreement period for members of Nevada; \$5 million per agreement period for covered members of Jackson, Josephine, and Klamath counties in Oregon, and \$1 million per agreement period for covered members of Douglas, Marion, and Polk counties in Oregon. The agreement covers Medicare Parts A and B. Medicare Part D is excluded.

The inuring agreement contained a settlement clause to verify risk transfer and an entire agreement clause in accordance with SSAP No.61R, OAR 836-012-0310 and OAR 836-012-0320.

Effective Jan. 1, 2023, the company entered into an HMO reinsurance agreement with American National Insurance Company. The agreement is effective from Jan. 1, 2023 to Jan. 1, 2024. Covered membership includes Medicare membership in Nevada county, and Medicare dual and non-dual membership in Jackson, Josephine, Klamath, Douglas, Marion, and Polk counties in Oregon. The agreement covers claims incurred from Jan. 1, 2023 to Jan. 1, 2024 and related claims paid to Jan. 1, 2025, which is also the claims reporting and claims submitting deadline. The agreement is based on 90 percent coinsurance, with claims covered up to \$1 million per covered member excess of \$1 million retention for members in Douglas, Marion, and Polk counties, and up to \$5 million per covered member excess of \$250,000 retention for members in Nevada county, excess of \$300,000 retention for members in Jackson, Josephine and Klamath counties, and excess of \$750,000 for member Arthur Alfinito.

The agreement contained an entire agreement clause but did not contain a settlement clause to verify risk transfer in violation of SSAP No.61R and OAR 836-012-0310. During fieldwork, the company amended the agreement to include a settlement clause.

On Feb. 27, 2023 the plan partnered with Health at Scale, a leading provider of machine intelligence for value-based care delivery and management to leverage Health at Scale's AI and machine learning technologies to prevent low-value care corresponding to fraud, waste and abuse errors in real-time.

In 2023, the plan had a complete turnover of its C-suite managerial team, focusing on adding seasoned industry leaders. This included the hiring of the plan's current CFO, Mark Stewart.

On Feb. 22, 2024, the company received an additional surplus note of \$14.6 million from Atrio Holding Company, LLC. to increase the company's capital and surplus levels and to also increase falling RBC levels. The note stipulates quarterly interest payments of eight percent, with the first interest payment due on March 31, 2024. Additional quarterly payments are due on June 30, September 30, and Dec. 31. The surplus note has no specific maturity date.

Effective Jan. 1, 2023, the company changed its contracted actuarial firm from Milliman to Lewis & Ellis.

Effective June 17, 2024, the company filed an amended YE 2023 annual statement to properly disclose both Allymar Health Solutions and P3 Health Partners in Schedule Y – Part 1A and Part 2 (organizational chart), and in the notes to the financial statements (Notes 10B and 10C) in accordance with ORS 731.574(1) annual financial statement and OARS 836-011-0000 annual statement blank and instructions. The company also filed a YE 2023 holding company registration statement that disclosed the identity and relationship of P3 Health Partners and Allymar (CPF MIB, LLC, dba as Allymar Health Solutions) in compliance with of ORS 732.552 (registration statement; form; contents).

Effective June 26, 2024, the company received an additional surplus note of \$11 million from Atrio Holding Company, LLC. to increase the company's capital and surplus levels and to also increase falling RBC levels. The note stipulates quarterly interest payments of 8 percent, with the first interest payment due on Sept. 30, 2024. Additional quarterly payments are due on Dec. 31st, March 31, June 30, and Sept. 30. The surplus note has no specific maturity date.

Effective Aug. 31, 2024, Mark Stewart, CFO left the company. Effective Sept. 1, 2024 James Kirkpatrick assumed the role of vice president of finance. Also, during August 2024, Jennifer Callahan became the company's president. Gregg Kimmer remains as the company's CEO.

On Sept.30, 2024, DFR called a limited-scope examination of ATRIO Health Plans, Inc. covering the areas noted below, and is documented in a separate report. The limited-scope examination was called due to the findings within this full-scope examination of ATRIO Health Plans, Inc. and the subsequent financial position of the company.

The limited-scope examination included a more detailed review of the following:

1. Escrow agreement – Risk adjustment processing system liability
2. Affiliated receivable – P3 Health Partners
3. Excess policy reserves – P3 Health Partners
4. Evaluation of the unpaid claims liability
5. Investigation of provider complaints
6. Viability of the 2025 business plan

FINANCIAL STATEMENTS

The following financial statements are based on the statutory financial statements filed by the company with DFR and present the financial condition of the plan for the period ending Dec. 31, 2022. 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. These statements include:

- Statement of assets
- Statement of liabilities, surplus, and other funds
- Statement of income
- Reconciliation of capital and surplus since the last examination

ATRIO HEALTH PLANS, INC.
ASSETS
As of Dec. 31, 2022

Assets	Net admitted assets	Notes
Bonds	\$ 2,834,820	1
Cash, cash equivalents and short-term investments	<u>9,937,453</u>	1
Subtotal, cash and invested assets	<u>12,772,273</u>	
Investment income due and accrued	7,839	
Premiums and considerations		
Uncollected premiums, agents' balances in course of collection	172,850	
Accrued Retrospective Premiums (\$1,155,514) and contracts subject to redetermination (\$16,940,447)	18,095,961	
Reinsurance		
Amounts recoverable from reinsurers	26,900	
Amounts receivable relating to uninsured plans	2,048,362	
Current federal and foreign income tax recoverable	1,086,682	
Net deferred tax asset	4,775,235	
EDP equipment and software	212,349	
Receivables from parent, subsidiaries and affiliates	16,945,615	2
Health care and other amounts receivable	25,628,254	
Aggregate write-ins for other than invested assets	<u>1,309,519</u>	
Total assets	<u>\$ 83,081,840</u>	

ATRIO HEALTH PLANS, INC.
LIABILITIES, SURPLUS AND OTHER FUNDS
As of Dec. 31, 2022

	Current year total	Notes
Claims unpaid	\$ 19,772,065	3
Accrued medical incentive pool	-	3
Unpaid claims adjustment expenses	186,469	3
Aggregate health policy reserves	18,918,716	3
Premiums received in advance	65,692	
General expenses due or accrued	8,504,777	
Ceded reinsurance premiums payable	184,016	
Amounts due to parent, subsidiaries and affiliates	292,438	
Liability for amounts held under uninsured plans	<u>4,451,436</u>	
Aggregate write-ins for other liabilities	<u>20,035</u>	
Total Liabilities	<u>\$ 52,395,643</u>	
Common capital stock	-	
Preferred capital stock	20,498,899	
Gross paid-in and contributed capital	-	
Surplus notes	18,200,000	
Unassigned funds (surplus)	<u>(8,012,702)</u>	
Surplus as regards policyholders	<u>30,686,197</u>	
Total liabilities, surplus, and other funds	<u>\$ 83,081,840</u>	

ATRIO HEALTH PLANS, INC.
STATEMENT OF INCOME
For the Year Ended Dec. 31, 2022

REVENUE	Current year total	Notes
Net premium income	\$ 271,641,281	
Aggregate write-ins	<u>20,203</u>	
Total Revenues	271,661,484	
 HOSPITAL AND MEDICAL		
Hospital/medical benefits	137,529,099	
Other professional services	77,980,411	
Emergency room and out-of-area	7,160,796	
Prescription drugs	17,601,749	
Incentive pool, withhold adjustments and bonus amounts	<u>(3,720,930)</u>	
Subtotal	236,551,126	
 Less		
Net reinsurance recoveries	<u>304,768</u>	
Total Hospital and Medical	236,246,358	
Non-health claims	-	
Claim adjustment expenses	6,550,520	
General administrative expenses	42,781,158	
Increase in reserves for life and accident and health contracts	<u>(733,960)</u>	
Total Underwriting Deductions	<u>284,844,077</u>	
Net underwriting gain or (loss)	(13,182,593)	
Net investment income earned	235,295	
Net realized capital gains (losses)	<u>(356,411)</u>	
Net investment gains (losses)	(121,117)	
Net gain or (loss) from agents' or premium balances charged off	(184,652)	
Aggregate write-ins for other income or expenses	<u>(523)</u>	
Net income or (loss) after capital gains tax and before all other federal income taxes	(13,488,884)	
Federal and foreign income taxes incurred	-	
Net income(loss)	<u>\$ (13,488,884)</u>	

ATRIO HEALTH PLANS, INC.
RECONCILIATION OF SURPLUS SINCE THE LAST EXAMINATION
For the Year Ended Dec. 31,

	2022	2021	2020	2019
Surplus as regards policyholders, Dec. 31, previous year	<u>\$ 23,340,942</u>	<u>\$ 25,500,336</u>	<u>\$ 20,796,878</u>	<u>\$ 18,638,216</u>
Net income (loss)	(13,488,884)	(3,872,043)	4,194,208	4,999,969
Change in net unrealized capital gains or (losses)	-	-	(3,790)	56,695
Change in net deferred income tax	2,752,385	322,985	730,171	(189,272)
Change in non-admitted assets	458,391	1,415,663	(217,131)	375,306
Change in provision for reinsurance	-	-	-	-
Change in surplus notes	18,200,000	-	-	-
Cumulative effects 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	-	-	-	-
Distributions to parent (cash)	(576,638)	(26,000)	-	(2,584,036)
Change in treasury stock	-	-	-	-
Examination adjustment	-	-	-	-
Aggregate write-ins for gains and losses in surplus	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>
Change in surplus as regards policyholders for the year	<u>7,345,254</u>	<u>(2,159,394)</u>	<u>4,703,458</u>	<u>2,158,663</u>
Surplus as regards policyholders, Dec. 31, current year	<u>\$ 30,686,196</u>	<u>\$ 23,340,942</u>	<u>\$ 25,500,336</u>	<u>\$ 20,796,878</u>

ANALYSIS OF CHANGES TO SURPLUS

(Note 2)

Surplus at Dec. 31, 2022, per Annual Financial Statement			\$30,686,197
	Increase	Decrease	
Receivables from parent, subsidiaries, and affiliates		\$16,941,520	
Net increase (decrease)			\$16,941,520
Surplus at Dec. 31, 2022 after adjustment			\$13,744,677

NOTES TO FINANCIAL STATEMENTS

Note 1 – Invested assets

At year-end 2022, the plan's long-term bond investments were in U.S. government issuer obligations, U.S. special revenue bonds, and industrial and miscellaneous issuer obligations. Cash equivalents consisted of two money market mutual funds. The plan did not hold any short-term investments.

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

	A	B	C	Ratio	Ratio	Ratio
		Cash, short-term and cash	Other			
<u>Year</u>	<u>Bonds</u>	<u>equivalents</u>	<u>invested assets</u>	<u>A/</u>	<u>B/</u>	<u>C/</u>
				<u>Total assets</u>	<u>Total assets</u>	<u>Total assets</u>
2018*	\$ 10,947,574	\$ 10,100,561	\$1,862,777	17.4%	16.1%	3.0%
2019	8,990,918	14,962,554	1,871,356	12.9%	21.4%	2.7%
2020	9,480,683	23,340,499	780,852	13.2%	32.6%	1.1%
2021	8,655,234	9,230,083	393,017	12.4%	13.2%	0.6%
2022*	2,834,820	9,937,453	-	3.4%	11.9%	-

* Balance per examination

As of Dec. 31, 2022, sufficient invested assets were invested in amply secured obligations of the U.S., the State of Oregon, or in FDIC insured cash deposits, and the company was in compliance with ORS 733.580.

A review of board of directors and committee minutes indicated the board formally approved all investment transactions for the years under review as required by ORS 733.730. The plan uses

Piper Sandler to provide investment advisory services, including actively managing the bond portfolio in accordance with the plan's investment policy.

Note 2 – Receivables from parent, subsidiaries, and affiliates

The majority of the receivable balance are RAPS (Risk Adjustment Processing System or patient risk adjustment factor scores) amounts due from service area contractors (SACs) that are fully escrowed. These balances relate to deleted HCC codes that the company self-reported to CMS, whereby CMS paid the company a premium, but the company did not have the medical record support to validate the HCC codes submitted. The balance in this account relates to years 2010-2014 and are the percentage to be recouped from the plan's risk partners (SACs) that the plan will eventually owe back to CMS. These are an estimated balance the company would owe, and would require an audit from CMS to identify the actual payable amount. They are being held in an escrow account currently. Per NAIC guidance, the amount is not an admitted asset per SSAP No.4 (Assets and Non-Admitted Assets) and per SSAP No.25 (affiliates and other related parties). The company is not a party to the escrow agreement, and therefore does not control the receivable amounts. Additionally, there is no documented related party agreement between the company and its Service Area Contractors with a specified due date. SSAP No.25 requires intercompany balances (other than government insured plan receivables) to be settled within 90 days to be considered an admitted assets.

I recommend the company non-admit the majority of the receivables from parent, subsidiaries, and affiliates, RAPs due from SACs that are fully escrowed per the requirements of SSAP No. 4 and SSAP No. 25.

Note 3 – Actuarial reserves

A review of the claims unpaid and unpaid claim adjustment expense reserves for the plan was performed by Andrew D. Bux, FSA, MAAA, life and health actuary for DFR. As part of the review, he examined the supporting statements prepared by the plan's opining actuary, Scott Jones, FSA, MAAA, principle and consulting actuary for Milliman, Inc.

Mr. Bux's review was based on the data, actuarial methodologies and calculations used in the Actuarial Memorandum supporting the Actuarial Opinion as of Dec. 31, 2022; the data, methods, and calculations used by the plan to establish its claims unpaid and unpaid claim adjustment expense liabilities; the plan's reserve position as measured by the appointed actuary's range; and independent analysis of the reserve calculations. It also included a review of the reconciliation of the data used in the plan's financial statement to the data in the actuarial work papers, which he found to be consistent. He also relied on work performed by the examiners who reviewed the underlying data used to create the annual statement filing. Based on his review, he determined the following:

	<u>Andrew Bux estimate</u>	<u>Annual statement</u>
Claims unpaid	\$ 17,542,747	\$19,772,065
Accrued medical incentive pool	-	-
Unpaid claim adjustment expenses	186,469	186,469
Aggregate health policy reserves	<u>18,918,716</u>	<u>18,918,716</u>

Total actuarial liabilities	<u>\$ 36,647,932</u>	<u>\$ 38,877,250</u>
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The appointed actuary opined that the reserves for claims unpaid and unpaid CAE carried by the plan as of Dec. 31, 2022 were reasonable. Bux concluded that reserves held as of Dec. 31, 2022 were developed according to actuarial standards of practice and were within a reasonable range to be sufficient to cover expected liabilities.

Appointed actuary reporting to board of directors or audit and compliance committee

Official NAIC annual statement instructions, health, for the 2022 reporting year (actuarial opinion, page 9) states the following requirement: “The appointed actuary must report to the board of directors or the audit committee each year on the items within the scope of the actuarial opinion. The actuarial opinion and the actuarial memorandum must be made available to the board of directors.” The appointed actuary from Milliman did not formally report to either the board of directors nor the audit and compliance committee on the items within the scope of their actuarial opinion for the years under review, in violation of ORS 731.574(1) and OAR 836-011-0000.

I recommend the appointed actuary formally report annually to either the board of directors or the audit and compliance committee on the items within scope of their actuarial opinion in accordance with ORS 731.574(1) and OAR 836-011-0000.

SUMMARY OF COMMENTS AND RECOMMENDATIONS

There was a \$16,941,520 reduction to surplus as a result of this examination. The following is a summary of the recommendations made in this report of examination:

Page:

- 9 I recommend the company comply with the provisions of ORS 732.554; ORS 732.576(2)(a) and ORS 732.576(3)(a) after declaring and prior to paying extraordinary dividends in the future. I further recommend the company properly report extraordinary dividends in the notes to the financial statements – Note 13D in compliance with ORS 731.574(1) and OAR 836-011-0000.

- 10 I recommend the board of directors directly approve by resolution the CEO's compensation annually, in accordance with ORS 732.320(3).
- 21 Medicare Advantage services agreement with P3 Health Partners-Oregon, LLC.(P3):
I recommend the company comply with ORS 732.574 by properly notifying the director when entering into related party transactions, including all management service agreements, service contracts, tax allocation agreements, guarantees, and cost sharing arrangements.
- 23 Administrative services agreement with Allymar Health Solutions (Allymar):
I recommend the company comply with ORS 732.574 by properly notifying the director when entering into related party transactions, including all management service agreements, service contracts, tax allocation agreements, guarantees, and cost sharing arrangements.
- 38 I recommend the company non-admit the majority of the receivables from parent, subsidiaries and affiliates, RAPs due from SACs that are fully escrowed per the requirements of SSAP No.4 and SSAP No.25.
- a. *Subsequent Event: It was agreed during the limited-scope exam, that ATRIO will, by Sept. 30, 2025, enter into a new agreement (in a form acceptable to and approved by DFR) with all parties to the escrow agreement dated as of June 20, 2019, sufficient to establish and secure ATRIO's right to immediate reimbursement from escrow funds of any amounts paid to satisfy any CMS RAPs overpayment liabilities.*
1. *Atrio submitted a new agreement to DFR on Sept. 30, 2025, which was reviewed and determined that it met the requirements in order for the company to admit the asset and report the liability on their financial statements. It also contained the signatures of all parties of the original agreement.*
- 40 I recommend the appointed actuary formally report annually to either the board of directors or the audit and compliance committee on the items within scope of their actuarial opinion in accordance with ORS 731.574(1) and OAR 836-011-0000.

CONCLUSION

During the three-year period covered by this examination, the surplus of the plan has decreased from \$18,638,216, as presented in the Dec. 31, 2018, report of examination, to \$13,744,677, as shown in this report. The comparative assets and liabilities are:

	<u>Dec. 31,</u> <u>2022</u>	<u>2018</u>	<u>Change</u>
Assets	\$ 66,140,320	\$ 62,854,744	\$ 3,285,576
Liabilities	<u>52,395,643</u>	<u>44,216,528</u>	<u>8,179,115</u>
Surplus	<u>\$ 13,744,677</u>	<u>\$ 18,638,216</u>	<u>\$ (4,893,539)</u>

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, Jordan Mills, AFE, Tho Le, CFE, PIR, and David Lorenz, APIR, insurance examiners, and Andrew D. Bux, FSA, MAAA, life and health actuary for the State of Oregon, Department of Consumer and Business Services, Division of Financial Regulation, all participated in this examination.

Respectfully submitted,

/s/ Mark Giffin
 Mark A. Giffin, CFE
 Senior insurance examiner
 Division of Financial Regulation
 Department of Consumer and Business Services
 State of Oregon

AFFIDAVIT

STATE OF OREGON)

County of Marion)

Mark A. Giffin, CFE, being duly sworn, states as follows:

1. I have authority to represent the State of Oregon in the examination of ATRIO Health Plans, Inc., Salem, 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 ATRIO Health Plans, Inc. was performed in a manner consistent with the standards and procedures required by the Oregon Insurance Code.

The affiant says nothing further.

/s/ Mark Giffin

Mark A. Giffin, CFE
Senior insurance examiner
Division of Financial Regulation
Department of Consumer and Business Services
State of Oregon

Subscribed and sworn to before me this 4th day of November, 2025.

/s/ Cindy Engle

Notary Public in and for the State of Oregon

My commission expires: 7/9/2027