STATE OF OREGON

DEPARTMENT OF CONSUMER & BUSINESS SERVICES

DIVISION OF FINANCIAL REGULATION

REPORT OF FINANCIAL EXAMINATION

OF

HEALTH NET HEALTH PLAN OF OREGON, INC.
TIGARD, OREGON

AS OF

DECEMBER 31, 2017

STATE OF OREGON

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NAIC COMPANY CODE 95800

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SALUTATION

May 15, 2019

Honorable Cameron Smith, Director
Department of Consumer and Business Services
Division of Financial Regulation
State of Oregon
350 Winter Street NE
Salem, Oregon 97301-3883

Dear Director:

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

HEALTH NET HEALTH PLAN OF OREGON, INC.
13221 SW 68th Parkway, Suite 200
Tigard, Oregon 97223

NAIC Company Code 95800

Hereinafter referred to as the "Plan." The following report is respectfully submitted.

SCOPE OF EXAMINATION

We have performed our regular, coordinated, single-state examination of Health Net Health Plan of Oregon, Inc., part of the Centene Corporation Group holding company system, with the Texas Department of Insurance designated as the lead state. The last examination of this health care service contractor was completed as of December 31, 2013. This examination covers the period of January 1, 2014 to December 31, 2017.

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 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 Plan'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 Plan.

COMPANY HISTORY

The Company was incorporated as a nonprofit corporation on June 1, 1989, by Foundation Health Corporation. On June 22, 1989, the Company acquired all of the rights Foundation Health Corporation held with respect to Foundation Health Plan, Inc. This acquisition resulted in the legal dissolution of Foundation Health Plan, Inc., and the formation of QualMed Oregon Health Plan, Inc., as a for profit stock corporation. The original Certificate of Authority was issued by the on June 23, 1989, and authorized the Plan to transact the business as a health care service contractor under ORS 750. On April 3, 1991, the Plan became a federally qualified health maintenance organization.

On April 9, 1997, PACC Health Plans and PACC HMO (collectively "PACC"), two Oregon based health care service contractors, entered into an Agreement and Plan of Reorganization for the merger of PACC into the Plan and assignment of PACC's Washington business to other subsidiaries of Foundation Health System, Inc. (FHS), the ultimate parent of the Plan. As a consequence of the merger, the Plan became the surviving entity and PACC no longer existed. Pursuant to the Articles of Merger, the effective date of the merger was October 22, 1997. During 2000, QualMed Oregon Health Plan, Inc., changed its name to Health Net Health Plan of Oregon, Inc.

On March 24, 2016, Health Net, Inc. was acquired by the Centene Corporation (CNC), a publicly traded Delaware corporation. The transaction was valued at approximately $6.8 billion in cash

and stock based on stock prices as of July 1, 2015 and including the assumption of nearly $500 million in debt from Health Net, Inc. The Form A filing was approved by the Director on November 30, 2015.

Capitalization

The Articles of Incorporation authorize the corporation to issue 5,000 shares of common stock with no par value. The Company has 1,000 shares of common stock authorized, issued and outstanding with a stated value of $0.01 per share for a total amount of capital stock of $10. All shares are owned by the direct parent, QualMed, Inc.

The following table displays the capitalization transactions since last examination:

Date	Shares	Common Capital Stock	Paid in and Contributed Surplus
Prior Exam	1,000	$ 10	$ 16,892,197
2014	-	-	39,050,411
2015	-	-	47,006,795
2016	-	-	62,000,000
2017	-	-	-
Totals	1,000	$ 10	$ 164,941,403

Dividends to Stockholders and Other Distributions

During the period under examination, the Company did not declare or pay any dividends to its stockholder.

CORPORATE RECORDS

Board Minutes

In general, the review of the Board meeting minutes of the Plan indicated the minutes supported the transactions of the Plan and clearly described the actions taken by its directors. A quorum, as defined in the Plan's Bylaws, met at all of the meetings held during the period under review.

The Plan's Bylaws, in Article III, section 3.1, authorize the Board to create one or more committees, to include an executive and finance committee. In practice, the Board relies on committees of its upstream parent, Centene, Inc. The actions of the committees are summarized and reported to the Board of Directors during their regular meetings.

Articles of Incorporation

The Company's restated Articles of Incorporation were most recently amended on March 22, 2000, and were not amended during the period under examination. The Articles of Incorporation conformed to Oregon Insurance Code.

Bylaws

The Company's Bylaws were last restated on July 10, 2002, and were not amended during the period under examination. The Bylaws conformed to Oregon statutes.

MANAGEMENT AND CONTROL

Board of Directors

The Bylaws state all corporate powers of the corporation shall be exercised by or under the authority of its Board of Directors; the business and affairs of the corporation shall be managed under the direction of its Board of Directors. The Bylaws, in Article II, Section 2.3, state the number of directors shall be not less than one (1) nor more than ten (10) directors. Members of the Board of Directors as of December 31, 2017, were:

Name and Address	Principal Affiliation	Representative	Member Since
Christian D. Ellertson * Beaverton, Oregon	President Health Net Health Plan of Oregon, Inc.	Plan	2002
Kenneth L. Leander Camas, Washington	Retired	Public	2002

*Chairman

The Plan is in compliance with ORS 750.015(1).

Officers

Principal officers serving at December 31, 2017, were as follows:

Officer	Office
Christian D. Ellertson	Chairman of the Board, President & CEO
Jeffrey A. Schwaneke	Vice President
Keith H. Williamson	Secretary
Justin T. Lyman	Vice President, CFO, Treasurer
Steven D. Sickle	Assistant Secretary
Tricia L. Dinkelman	Vice President of Tax

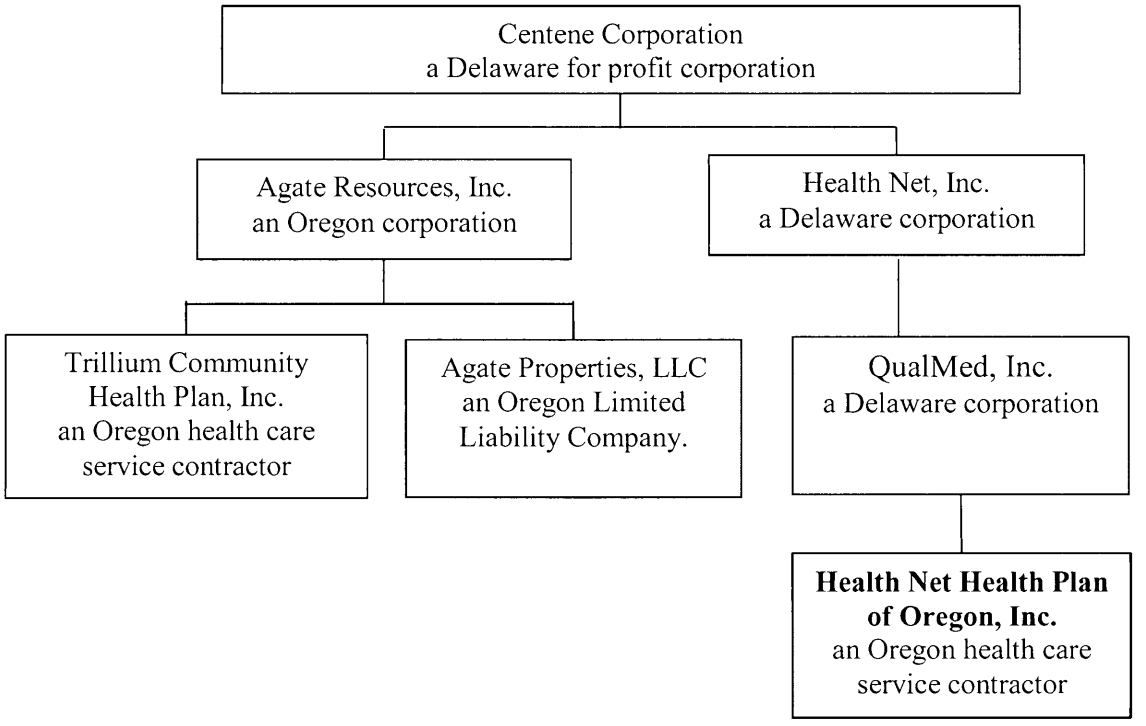
Conflict of Interest

The Plan's Board adopted its ultimate controlling entity's Code of Business Conduct and Ethics, a shared commitment to honesty, integrity, transparency and accountability. The Code requires all employees to notify the Plan if a conflict of interest arises. In addition, the Plan has a process in place requiring all Board members, senior officers and key employees 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).

As discussed in the Company History section of this report above, on March 24, 2016, the Plan became part of an insurance company holding system in which Centene Corporation, a publicly traded holding company (NYSE – CNC), is the ultimate controlling entity. The following abbreviated organizational chart depicts the relationships within the holding company system:



A description of each of the entities above is as follows:

Agate Resources, Inc. (Agate) is an Oregon corporation formed on December 12, 2003. It provides administrative services and leases employees and buildings for an affiliate, Trillium Health Plan.

Agate Properties, LLC is an Oregon limited liability company formed on March 13, 2009 and is currently inactive.

Health Net, Inc. is a Delaware holding company owning 100% of QualMed, Inc. and a number other Health Net entities that provide services to the Plan.

QualMed, Inc. is a for-profit holding company formed in 1991 and is the direct parent of the Plan.

Intercompany Agreements

Administrative Services Agreements

Effective January 1, 2004, and most recently amended March 30, 2010, the Plan entered into an agreement with Health Net, Inc. Under the agreement, Health Net agrees to provide corporate and administrative services, including executive, strategic and operational consultation, in addition to litigation and legal counsel advice, business insurance, government relations and legislative activities, claims processing, provider contracting, membership accounting, payroll services, financial and accounting services, portfolio management, actuarial and underwriting support, general human resources, product development, facilities management, IT administration, and other services. Fees are calculated monthly based on various drivers depending on which most appropriately correlates with a fair and reasonable allocation of costs, based on discussions with cost center managers.

Effective January 1, 2007, and most recently amended May 1, 2003, the Plan entered into a separate agreement with Health Net of California. Under this agreement, Health Net of California agrees to provide management services, underwriting/actuarial services, broker services, operational support, and fee negotiation services. Fees are calculated monthly based on various

drivers depending on which most appropriately correlates with a fair and reasonable allocation of costs, based on discussions with cost center managers.

Effective January 1, 2003, and last amended May 1, 2003, a separate agreement with Health Net Life Insurance Company. The Plan agrees to provide Health Net Life Insurance Company with underwriting, finance, medical management services, legal services, claims processing and administration services. Compensation shall be based on actual expenses incurred in conformity with customary insurance accounting practices and payable monthly within 10 days of receipt of an invoice.

Effective January 1, 2003, and last amended on February 22, 2010, the Plan entered into aa agreement for managed behavioral health care services with MHN Services. Prepaid fees are calculated on a capitated basis on the number of members enrolled as of the first day of each month. The Plan agrees to pay MHN each month by intercompany transfer process.

Pharmacy Benefits Management Services Agreement

Effective January 1, 2003, and most recently amended March 24, 2010, the Plan entered into an agreement with Health Net Pharmaceutical Services (HNPS). HNPS agrees to adjudicate claims for covered outpatient prescription drug services. The Plan agrees to pay HNPS its proportionate share of the total costs of services provided to all affiliates of HNI, based on the ratio of the number of outpatient prescription drug claims. HNPS shall invoice the Plan periodically during each month and the Plan shall pay within 3 days of receipt of invoice.

Master Service Agreements

Effective March 1, 2017, the Plan entered into an agreement with Envolve PeopleCare, Inc. (EPC), formerly known as NurseWise LP. Under the terms of the agreement, EPC shall provide triage services and chronic pulmonary disease management services to the Plan.

Inter-Company Loan Agreement

Effective August 9, 2010, Health Net, Inc. agrees to lend the Plan up to $20,000,000. Each loan shall be due and payable in full within 45 days of the issue. The Plan has not borrowed any funds under this agreement during the examination period. Interest charges will be at a rate per annum equal to the prime rate as noted by Bank of America, N.A.

Tax Allocation Agreement

Effective September 1, 2015, the Plan entered into an agreement with Centene Corporation. Under the terms of the agreement, the Plan, along with the other affiliates within the Centene Group will file consolidated federal and state tax returns. Each party shall compute its separate tax liability or benefit, as applicable, for federal and state income taxes on an individual company basis using the separate return method. Centene Corporation will pay all consolidated taxes. Once it is determined, the Plan agrees to pay its share of the consolidated taxes based on its portion of the consolidated tax liability. Any subsequent adjustments shall be due within 15 days.

Parental Guarantee

Effective with the completion of the acquisition by Centene Corporation, the parent provided a guarantee to ensure certain financial benchmarks of the Plan are within regulatory thresholds, as defined under the Insurance Code, Oregon Administrative Rules and guidance and processes as defined by the National Association of Insurance Commissioners (NAIC). The guarantee is solely

limited to the regulatory authority of the Division of Financial Regulation of the Oregon Department of Consumer and Business Services.

FIDELITY BOND AND OTHER INSURANCE

The Plan is covered by a $10,000,000 crime wrap policy which has a $150,000 deductible. The policy is issued to Centene Corporation, with the Plan named as an insured. Fidelity coverage met the suggested coverage recommended by the National Association of Insurance Commissioners for companies of comparable size. Other coverages include managed care errors and omissions liability, directors and officer's management liability, umbrella liability, workers' compensation, commercial property and general liability.

TERRITORY AND PLAN OF OPERATION

The Plan writes health insurance coverage in the states of Oregon and Washington on a group and individual basis, including Medicare coverage in the state of Oregon. It also offers dental only plans, as well as a Medicare supplement plan.

Individual and family plans include a Preferred Provider Organization (PPO) product, a Health Maintenance Organization (HMO) product, a short term health insurance product, and a health savings account (HSA) health insurance option. The large- and small-group plans include HMO, PPO, tailored networks, and an HSA option.

The Plan distributed its products through independent producers. The marketing plan is directed from the parent, Health Net, Inc., with input from executive staff at the local level. The Plan contracts with independent professional associations, hospitals and other providers to provide medical services to its members in Oregon and Washington. The Company also provides

healthcare services to individuals through government subsidized programs, including Medicare through its contract with Center for Medicare and Medicaid Services (CMS). The Plan bears the risk that the actual cost of health care services may exceed the per-member, per-month amount paid by CMS.

The Plan's commercial products include exclusive provider organizations (EPN), point of service (POS), preferred provider organizations (PPO), indemnity, Medicare supplement and dental products.

The Plan has experienced changes in the number of enrollees during the past five years, as follows:

Line of Business	2017	2016	2015	2014	2013
Health maintenance organizations	33,816	-	-	-	-
Preferred provider organizations	29,871	39,585	35,888	42,134	58,645
Point of service	9,817	10,063	8,542	7,954	3,972
Indemnity only	8	7,678	7,154	7,028	2,970
Exclusive provider organization	3,485	36,725	28,709	15,886	4,206
Total enrollment	76,997	94,051	80,293	73,002	69,793

GROWTH OF THE COMPANY

Growth of the Plan over the past five years is reflected in the following schedule. Amounts were derived from Plan's annual statements, except in those years where a report of examination was published by the Oregon Division of Financial Regulation.

Year	Assets	Liabilities	Capital and Surplus	Net Income (Loss)
2013*	$ 94,617,882	$ 41,322,678	$ 53,295,204	$ 4,590,737
2014	131,596,286	75,848,998	55,747,288	(43,820,219)
2015	152,052,291	83,968,789	68,083,502	(25,390,633)
2016	181,638,258	81,977,012	99,661,246	(31,842,735)
2017*	182,947,422	109,888,039	73,059,383	(23,493,133)

*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.

Year	(1) Total Premium Revenues	(2) Total Hospital and Medical	(2) / (1) Medical Ratio	(3) CAE and General Expenses	(2)+(3)/(1) Combined Loss Ratio
2013*	$ 294,056,815	$ 245,401,586	83.4%	$ 48,599,990	100.0%
2014	327,884,445	293,709,002	89.6%	57,727,425	107.2%
2015	418,841,165	396,743,095	94.7%	68,106,365	111.0%
2016	506,176,430	481,524,281	95.1%	80,790,303	111.1%
2017*	526,473,594	494,651,986	94.0%	70,756,158	107.4%

*Per examination

A combined claims and expense to premium ratio in excess of 100% typically indicates an underwriting loss. The Plan reported a net loss from operations in each of the last five years.

REINSURANCE

Effective January 1, 2017 the Plan ceded to PartnerRe America Insurance Company (NAIC #11835, admitted in Oregon 12/22/1981) on an HMO specific excess loss reinsurance agreement. Under the policy, the reinsurer agrees to reimburse the Plan for losses up to $3,000,000 for each covered person, after retention of $1,250,000 for each risk. It was determined the reinsurance agreement clearly specified the risk taken by the reinsurer, with no unusual provisions reducing the reinsurer's risk.

Risk Retention

The examiners determined the reinsurance agreement provided for risk transfer in accordance with the requirements of SSAP No. 61R. The Plan's reinsurance agreement requires the Plan to retain

a maximum of $1,250,000 per risk. In view of the Plan's surplus at December 31, 2017, the Plan did not retain risk on any one subject of insurance in excess of 10% of its surplus to policyholders, and complied with the maximum risk retention set by ORS 731.504.

Insolvency Clause

The reinsurance agreements each contained a proper 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).

ACCOUNTS AND RECORDS

In general, the Company's records and source documentation supported the amounts presented in the Company's December 31, 2017, 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 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

To satisfy the statutory deposit requirements in Oregon for health care service contractors, the Plan maintained a US Treasury bond with the Oregon Division of Financial Regulation, Department of Consumer and Business Services, in the sum of $275,000 (par value), to maintain compliance with ORS 750.045. The deposit was verified from the records of the Division of Financial Regulation.

In addition, the Plan maintained a cash deposit with the Washington Office of the Insurance Commissioner in the amount of $150,000.

COMPLIANCE WITH PRIOR EXAMINATION RECOMMENDATIONS

There were no adjustments to surplus as a result of the examination as of December 31, 2013, and the examiners made no recommendations in the report of examination.

SUBSEQUENT EVENTS

Centene Corporation announced plans to enter the Affordable Care Act marketplaces in Pennsylvania, North Carolina, South Carolina and Tennessee in 2019. Its managed care insurers are also expanding its footprint in six existing markets: Florida, Georgia, Indiana, Kansas, Missouri and Texas.

FINANCIAL STATEMENTS

The following financial statements are based on the statutory financial statements filed by the Plan with the Division of Financial Regulation and present the financial condition of the Plan for the period ending December 31, 2017. 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

HEALTH NET HEALTH PLAN OF OREGON, INC.
ASSETS
As of December 31, 2017

Assets	Balance per Company	Examination Adjustments	Balance per Examination	Notes
Bonds	$ 137,020,541	$ -	$ 137,020,541	1
Cash, cash equivalents and short-term investments	4,411,693	-	4,411,693	1
Receivable for securities	275,000	-	275,000	
Aggregate write-ins for invested assets	-	-	-	
Subtotal, cash and invested assets	141,707,234	$ -	141,707,234	
Investment income due and accrued	1,031,039	-	1,031,039	
Premiums and considerations				
Uncollected premiums, agents' balances in course of collection	1,929,257	-	1,929,257	
Accrued retrospective premiums and contracts subject to redetermination	7,603,729	-	7,603,729	
Reinsurance				
Amounts recoverable from reinsurers	1,674,652	-	1,674,652	
Other amounts receivable under reinsurance contracts	6,355	-	6,355	
Amounts receivable related to uninsured plans	465,862	-	465,862	
Current FIT recoverable	4,892,173	-	4,892,173	
Health care and other amounts receivable	23,637,121	-	23,637,121	
Aggregate write-ins for other than invested assets	-	-	-	
Total Assets	$ 182,947,422	$ -	$ 182,947,422	

HEALTH NET HEALTH PLAN OF OREGON, INC.
LIABILITIES, CAPITAL AND SURPLUS
As of December 31, 2017

	Balance per Company	Examination Adjustments	Balance per Examination	Notes
Claims unpaid	$ 47,257,023	$ -	$ 47,257,023	2
Accrued medical incentive pool and bonus amounts	3,758,870	-	3,758,870	2
Unpaid claims adjustment expense	1,320,656	-	1,320,656	2
Aggregate health policy reserves	21,921,723	-	21,921,723	2
Premium received in advance	2,260,461	-	2,260,461	
General expenses due or accrued	5,021,139	-	5,021,139	
Payable to parent, subsidiaries and affiliates	25,296,175	-	25,296,175	
Liability for amounts held under uninsured plans	1,680,668	-	1,680,668	
Aggregate write-ins for liabilities	1,371,324	-	1,371,324	
Total Liabilities	$ 109,888,039	$ -	$ 109,888,039	
Aggregate write-ins for special surplus funds	$ 10,096,889	$ -	$ 10,096,889	3
Common capital stock	10	-	10	
Gross paid-in and contributed capital	164,941,403	-	164,941,403	
Unassigned funds (surplus)	(101,978,919)	-	(101,978,919)	
Surplus as regards policyholders	$ 73,059,383	-	$ 73,059,383	
Total Liabilities, Surplus and other Funds	$ 182,947,422	$ -	$ 182,947,422	

HEALTH NET HEALTH PLAN OF OREGON, INC.
STATEMENT OF REVENUE AND EXPENSES
For the Year Ended December 31, 2017

	Balance per Plan	Examination Adjustments	Balance per Examination	Notes
Revenue				
Net premium income	$ 526,473,594	$ -	$ 526,473,594	
Aggregate write-ins for health care related revenues	-	-	-	
Total revenue	526,473,594	-	526,473,594	
Hospital and Medical:				
Hospital/medical benefits	353,700,364	-	353,700,364	
Other professional services	19,343,210	-	19,343,210	
Outside referrals	-	-	-	
Emergency room and out-of-area	64,281,058	-	64,281,058	
Prescription drugs	53,684,193	-	53,684,193	
Incentive pool, withhold adjustments and bonus amounts	4,720,065	-	4,720,065	
Subtotal	495,728,890	-	495,728,890	
Less:				
Net reinsurance recoveries	1,076,904	-	1,076,904	
Total medical and hospital	494,651,986	-	494,651,986	
Non-health claims	-	-	-	
Claim adjustment expenses	12,027,405	-	12,027,405	
General administrative expenses	58,728,753	-	58,728,753	
Increase in reserves for life and accident and health contracts	887,804	-	887,804	
Total underwriting deductions	566,295,947	-	566,295,947	
Net underwriting gain or (loss)	(39,822,354)	-	(39,822,354)	
Net investment income earned	3,177,881	-	3,177,881	
Net realized capital gains (losses)	20,606	-	20,606	
Net investment gains (losses)	3,198,487	-	3,198,487	
Net gain or (loss) from agents' or premium balances charged off	-	-	-	
Aggregate write-ins for other income or expense	-	-	-	
Federal income taxes incurred	(13,130,734)	-	(13,130,734)	
Net income	$ (23,493,133)	$ -	$ (23,493,133)	

HEALTH NET HEALTH PLAN OF OREGON, INC.
RECONCILIATION OF SURPLUS SINCE THE LAST EXAMINATION
For the Year Ended December 31,

	2017	2016	2015	2014
Surplus as regards policyholders, December 31, previous year	$ 99,661,246	$ 68,083,502	$ 55,747,288	$ 53,295,204
Net income (loss)	(23,493,133)	(31,842,735)	(25,390,633)	(43,820,219)
Change in net unrealized capital gains or (losses)	-	22,614	10,496	6,117
Change in net deferred income tax	-	(7,950)	(10,740,795)	9,813,687
Change in non-admitted assets	(3,108,732)	1,410,235	1,465,116	(2,572,934)
Change in provision for reinsurance	-	-	-	-
Change in surplus notes	-	-	-	-
Cumulative effects of changes in accounting principles	-	-	-	-
Capital changes:				
Paid in	-	-	-	-
Transferred from surplus (Stock Dividend)	-	-	-	-
Transferred to surplus	-	-	-	-
Surplus adjustments:				
Paid in	-	62,000,000	47,006,794	39,050,410
Transferred to capital (Stock Dividend)	-	-	-	-
Transferred from capital	-	-	-	-
Distributions to parent (cash)	-	-	-	-
Change in treasury stock	-	-	-	-
Examination adjustment	-	-	-	-
Aggregate write-ins for gains and losses in surplus	-	(4,420)	(17,464)	(24,977)
Change in surplus as regards policyholders for the year	(26,601,865)	31,577,744	12,336,214	2,452,084
Surplus as regards policyholders, December 31, current year	$ 73,059,381	$ 99,661,246	$ 68,083,502	$ 55,747,288

NOTES TO FINANCIAL STATEMENTS

Note 1 – Invested Assets

At year-end 2017, the Company's long-term bond investments were diversified in US obligations, US federal agency bonds, municipal obligations, and industrial and miscellaneous. The Company had a moderate exposure to mortgaged-backed and asset-backed securities. All MBS/ABS issues were investment rated at year-end 2017, and the carrying book value comprised 28.2% of the total long-term bond portfolio, or 27.2% of all invested assets.

Cash and short-term deposits consisted of cash on deposit in various banks and two money market mutual funds.

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

	A	B	Ratio	Ratio
			A/	B/
		Cash and	Total	Total
Year	Bonds	Short-term	Assets	Assets
2013*	$ 95,891,143	$(10,036,442)	101.3%	(10.6)%
2014	91,866,117	11,111,453	69.8%	8.4%
2015	93,827,824	32,901,512	61.7%	21.6%
2016	121,888,228	21,782,983	67.1%	12.0%
2017*	137,020,541	4,411,693	74.9%	2.4%

* Balance per examination

The Board approved the investment transactions in each of the years under review, as required by ORS 733.740. The Plan used New England Asset Management as its discretionary advisor to actively manage its portfolio. As of December 31, 2017, sufficient assets were invested in amply secured obligations of the United States, the State of Oregon, or in FDIC insured cash deposits, and the Company was in compliance with ORS 733.580.

Effective August 19, 2010, the Plan entered into a custodial agreement with US Bank, NA. The agreement contained all of the relevant protections described in OAR 836-027-0200(4)(a) through (l).

Note 2 – Actuarial Reserves

David N. Ball, FSA, MAAA, Oregon Division of Financial Regulation actuary, did a peer review of the review by Aaron J. Hodges, ASA, MAAA, Life & Health Actuary of the Texas Department of Insurance (TDI), and covered a five-year period ending with 2017. The work done included reviews of the companies' annual statements, actuarial opinions, actuarial memorandums, and

internal management reports and documentation, discussions with company actuaries and other employees, reviews of claim triangles, reviews of methodology, reviews of ACA-required calculations, and reviews of work done by outside consultants. Independent calculations of reserves for claims IBNR were done as well.

The coordinated examination covered all 28 companies in the Centene Group, with two domiciled in Oregon: Trillium Health Plans, Inc. and the Plan. Each company developed its base claim reserves for each coverage and line of business using a standard completion methodology, as well as an additional provision for adverse deviation. Mr. Hodges' calculated liability reported a reserve redundancy of the original booked value for the group, consistent with the historical reserve redundancy. The external CPA firm, KPMG LLP, reserve analysis was reviewed as well, and was consistent with the actuarial findings.

Mr. Hodges concluded the assumptions and methodologies used by Centene to develop the reserves are reasonable. Recasts of their reserves have shown that the reserve levels set by Centene tend to be sufficient and a little conservative where appropriate. No adjustments to the booked numbers are recommended.

Note 3 – ACA Fee Assessment:

Each year, the Plan is subject to an annual HIT Tax under section 9010 of the Federal Affordable Care Act (PPACA). This annual fee is allocated based on the ratio of the amount of the entity's net premiums written during the preceding calendar year to the amount of health insurance for any U.S. health risk that was written during the preceding calendar year. A health insurance entity's portion of the annual fee are payable once the entity provides health insurance for any U.S. health risk for each calendar year beginning on or after January 1 of the year the fee is due. As of December 31, 2017, the Plan has written health insurance subject to the ACA assessment, expects to conduct health insurance business in 2018, and estimates its' portion of the annual health insurance industry fee to be $10,096,889. The amount was reflected in the Aggregate Write-ins for Special Surplus Funds. Reporting the ACA assessment as of December 31, 2017, would not trigger an Risk Based Capital (RBC) action level.

SUMMARY OF COMMENTS AND RECOMMENDATIONS

There were no adjustments to surplus as a result of this examination, and the examiners made no recommendations in this report of examination.

CONCLUSION

During the four year period covered by this examination, the surplus of the Plan has increased from $53,295,204, as presented in the December 31, 2013, report of examination to $73,059,383, as shown in this report. Assets, liabilities and surplus are compared below:

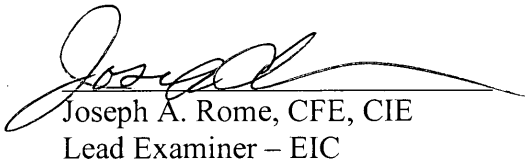
	December 31, 2017	2013	Change
Assets	$ 182,947,422	$ 94,617,882	$ 88,329,540
Liabilities	109,888,039	41,322,678	68,565,361
Surplus	$ 73,059,383	$ 53,295,204	$ 19,764,179

ACKNOWLEDGMENT

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

In addition to the undersigned, Tho Le, AFE, Brandon K. Lau, staff examiners, and David Ball, FSA, MAAA, actuary, for the State of Oregon, Department of Consumer and Business Services, Division of Financial Regulation, participated in the examination. In addition, examiners and contractors representing the various Departments of Insurance participated in the examination, with the Texas Department of Insurance leading the coordinated effort, and their cooperation during this coordinated examination is greatly appreciated.

Respectfully submitted,



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