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

DEC. 31, 2022

STATE OF OREGON

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES

DIVISION OF FINANCIAL REGULATION

REPORT OF FINANCIAL EXAMINATION

OF

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

NAIC COMPANY CODE 95800

DEC. 31, 2022

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SALUTATION

May 1, 2024

Honorable Andrew Stolfi, 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 "Company" or 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 Dec. 31, 2017. This examination covers the period of Jan. 1, 2018, 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 731.312(1) and general information about the Company and its financial condition. There may be other items identified during the examination that, due to their nature, are not included within the examination report but separately communicated to other regulators and/or the Company.

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 Oct. 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, including the assumption of nearly $500 million in debt from Health Net, Inc. The Form A filing was approved by the director on Nov. 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	-	-	$164,941,403
2018	-	-	-
2019	-	-	$17,000,000
2020	-	-	-
2021	-	-	-
2022	-	-	-
Totals	1,000	$10	$181,941,403

Dividends 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 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 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 Corporation. 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 nor more than 10 directors.

As of Dec. 31, 2022, the Plan was governed by a three member board of directors as follows:

Name and Address	Principal Affiliation	Representative	Member Since
*Elizabeth Baier Johnson Tacoma, Washington.	Plan president & CEO Centene (Coordinated Care Health)	Company	2022
Sarah Brewer Silverton, Oregon.	President & CEO Health Net Health Plan of Oregon	Company	2022
Charles Alfred Terhune III Lake Oswego, Oregon.	President & CEO SAIF Corporation	Public	2022

* Chairperson

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

Officers

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

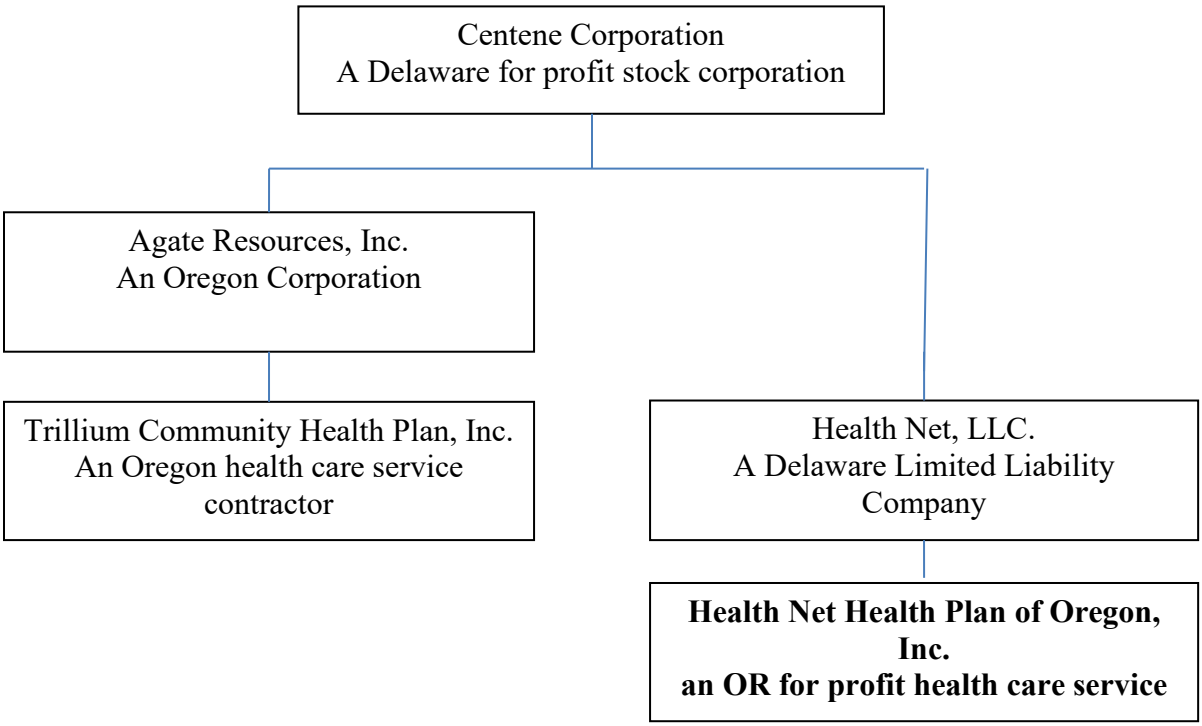
Name	Title
Sarah Brewer	President & CEO
Justin Taylor Lyman	CFO, treasurer and vice president
Janet Robey Alonzo	Secretary
Tricia Lynn Dinkelman	Vice president of tax
Steven Daniel Sickle	Assistant secretary
Elizabeth Baier Johnson	Board chairperson

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

The following organizational chart shows the relationship between the related entities of the Plan. Ownership is 100 percent unless otherwise indicated:



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

Centene Corporation is a Delaware stock corporation and a leading multi-national health care enterprise that provides fully integrated, high quality, and cost-effective programs and services to government sponsored and commercial health care programs, focusing on under-insured and uninsured individuals.

Agate Resources, Inc. (Agate) is an Oregon corporation formed on Dec. 12, 2003. It provides administrative services and leases employees and buildings for an affiliate, Trillium Health Plan and is a 100 percent owner of Trillium.

Trillium Community Health Plan, Inc. is a for-profit health care service contractor licensed in Oregon to market group and individual health plans, related products, and services to the general public. It also contracts with CMS to provide Medicare Advantage products.

Health Net, LLC is a limited liability company owning 100 percent of Health Net Health Plan of Oregon and a number of other Health Net entities.

INTERCOMPANY AGREEMENTS

The following agreements are in place between the Plan and its affiliates or subsidiaries within the insurance company holding system

Administrative services agreement

Effective Jan. 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, 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.

Administrative services agreement with Health Net of California

Effective Jan. 1, 2007, and most recently amended May 1, 2013, 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.

Agreement with Health Net Life Insurance Company

Effective Jan. 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.

Behavioral health services agreement

Effective Jan. 1, 2003, and last amended on Feb. 22, 2010, the Plan entered into an agreement for managed behavioral health care services, including substance abuse and mental health services, with MHN Services, LLC. Prepaid administrative fees are paid by the plan to MHN for services provided and the Plan reimburses MHN for the cost of claims incurred. The 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 agreement

Effective Oct. 1, 2020, the Plan entered into a PBM agreement with Centene Pharmacy Services, Inc. (f/k/a Envolve Pharmacy Solutions, Inc.), which replaced the PBM agreement between the Plan and Health Net Pharmaceutical Services. Under the terms of the agreement, Envolve will manage pharmacy benefits offered to Plan members, including claims processing, eligibility management, benefits management, utilization management, pharmacy network management, and call center services. Other services delegated to Envolve include credentialing and re-credentialing, claims adjudication, commercial provider appeals, prior authorization denials, and drug utilization review. PBM fees for both commercial products and Medicare products are specified in the agreement, including discounts, rebates, administrative

fees, and ancillary fees. This agreement was amended and restated as an Administrative Pharmacy Services Agreement, effective Jan. 1, 2023.

Vision services agreement

Effective Jan. 1, 2018, the Plan and Envolve Vision, Inc. entered into an agreement to provide vision services through participating vision providers under contract with Envolve. Responsibilities of Envolve are detailed through supplemental attachments to the agreement, which include provider complaints and grievances, provider credentialing and re-credentialing, and customer service/call center responsibilities for both member services and provider services. The agreement was amended effective Jan. 1, 2019, to add the Plan's Medicare population, to add the Plan to "Bundled Products" and to change the effective date to reflect the date of the amendment, and to change the rate of compensation to incorporate the addition of the Plan's Medicare population. The agreement was amended again effective Jan. 1, 2020, to update the language to clearly establish a responsible party for an organizational provider review process and to introduce a new vision benefit buy-up option for on plan. The agreement was amended again effective Jan. 1, 2022, to reflect changes to compensation rates for Medicare based on various benefit levels included in the 2022 Medicare bid submission to CMS.

Administrative radiology services agreement

The Plan entered into an agreement with National Imaging Associates, Inc. effective May 24, 2018, when the parties were not related. Under the agreement, NIA provides administrative support services for the Plan's radiology benefits. Effective January 2022, Plan's ultimate parent, Centene Corporation, acquired a controlling interest in National Imaging Associates' parent organization and the parties became affiliates. Centene divested its controlling interest in National Imaging Associates in January 2023.

Affiliation agreement

Effective July 20, 2021, the Plan and Trillium Community Health Plan, Inc. entered into an affiliation agreement. Trillium, in its capacity as a Coordinated Care Organization (CCO)/Dual-Eligible Special Needs Program (DSNP) health plan in the State of Oregon, is required to have and to memorialize a relationship with a MA Plan that is in alignment with Trillium's CCO service area of Washington, Clackamas, and Multnomah counties to provide integrated care and processes for enrollees who are eligible for both Medicare and Medicaid, including enrollees who are eligible for full, comprehensive Medicaid benefits ("FBDE Members). Trillium (the Insurer), desires to coordinate with Health Net Health Plan of Oregon, Inc, (the Affiliate), and Health Net Health Plan of Oregon, Inc. desires to coordinate with Trillium, to provide integrated care and processes for FBDE Members, in accordance with the terms of this agreement.

Management services agreement

Effective Jan. 1, 2018, the Plan entered into an agreement with Centene Management Company, LLC (CMC). Under the terms of the agreement, CMC provides to the Plan services including, but not limited to program planning and development, management information systems, financial systems and services, claims administration, provider and enrollee services, utilization review, and quality assurance. The Plan pays CMC a fee on a percentage of net

revenues for services associated with providing these management services. The agreement was amended, effective Nov. 1, 2021, in order to fully comply with the changes to OAR 836-027-0160 and to comply with requirements made by the Oregon Health Authority. The agreement was amended and restated effective Jan. 1, 2023.

Dental services agreement

Effective Jan. 1, 2021, the Plan entered into an agreement with Envolve Dental, Inc. to provide dental services to Plan members. The agreement replaces the Dental Services Agreement between HNOR and Dental Benefit Providers, Inc. ("DBP"), a third-party nonaffiliated vendor. Under the terms of the agreement, Envolve Dental will provide or arrange for the provision of, through Envolve Dental Network Providers, the covered services specified in the agreement to covered persons, and under the terms and conditions, set forth in the agreement, which includes approximately 23,000 Medicare members. The agreement was amended, effective Jan. 1, 2022, to reflect changes to the compensation schedule based on compensation rate changes to reflect various benefit levels included in the 2022 Medicare bid submission to CMS.

Master services agreement

Effective Jan. 1, 2020, the Plan entered into a new agreement with Envolve PeopleCare, Inc. The agreement replaces an existing agreement and allows for better service to HNOR membership specifically, and eases administration needs between EPC and the Plan in service of the MSA. The agreement covers a telemedicine program, a nurse advice line program, and disease management programs including coaching services and mail-based intervention services for several medical conditions, including asthma, COPD, diabetes, and heart disease. The agreement was amended effective Jan. 1, 2021, to reflect adjusted rates for the nurse advice line, remove the disease management state of work, and add back in the online health content scope of work as a component of the disease management state of work. The agreement was terminated effective Jan. 1, 2022.

Tax allocation and indemnity agreement

The Plan entered into an agreement with Health Net, Inc. (HNI), effective April 1, 2017. The agreement reflects the merger agreement, whereby Centene Corporation acquired all of the outstanding equity of HNI and the current 100 percent ownership of Centene over HNI, the final surviving corporation. The agreement renames all references to HNI as the final surviving corporation renamed Health Net, Inc. All other terms and conditions of the 2007 tax allocation and indemnification agreement remain unchanged. Under the terms of the 2007 agreement, each subsidiary shall pay HNI an amount equal to its estimated separate tax liability for such year or estimated tax payment period and tax amounts allocated to the Plan are based on separate tax return calculations. Payments shall be made within 45 days following the end of each calendar month. All settlements shall be made within 30 days of the filing of the applicable estimated or actual consolidated federal corporate income tax return. Beginning on April 1, 2017, the Plans income was included in the consolidated return filed by Centene.

Inter-company loan agreement

Effective Aug. 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.

FIDELITY BOND AND OTHER INSURANCE

The Plan is covered by a $10 million crime policy with a $2.5 million deductible with Zurich American Insurance Company. 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 health care 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 Company's commercial products include exclusive provider organization (EPO), point of service (POS), preferred provider organization (PPO), indemnity, Medicare supplement, and dental products. The Company participates in the individual, small group, and large group segments. The Company's POS service area includes the entire State of Oregon and the southwest region of the State of Washington. The Company's PPO and indemnity products can be sold throughout the States of Oregon and Washington. The Company also entered into an annual "risk-based" Medicare contract with CMS.

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

Line of Business	2022	2021	2020	2019	2018
Health maintenance organizations	21,378	20,508	22,832	36,354	37,167

Provider service organizations	-	-	-	-	-
Preferred provider organizations	6,550	7,018	8,310	14,135	18,627
Point of service	2,212	3,714	5,338	6,337	6,924
Indemnity only	-	6	5	11	11
Exclusive provider organization	237	909	1,619	2,464	3,076
Total enrollment	30,377	32,155	38,104	59,301	65,805

In 2022, the Plan reported direct business in the following states:

State	Direct premiums written
Oregon	278,396,062
Washington	(1,967)
Total	$ 278,394,095

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 filed 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)
2018	155,551,443	81,821,125	73,730,318	(136,638)
2019	144,032,885	88,265,953	55,766,931	(23,377,489)
2020	133,119,049	60,593,259	72,525,790	8,171,396
2021	113,076,606	52,020,377	61,056,229	(16,235,280)
2022*	110,814,472	49,406,173,	61,408,299	1,227,684

*Per examination

LOSS EXPERIENCE

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

Year	(1) Total revenues	(2) Total hospital and medical	(2)/(1) Medical loss ratio	(3) Claim adjustment and general expenses	(2)+(3)/(1) Combined loss ratio
2018	498,952,615	451,434,830	90.4%	68,976,734	104.3%

2019	487,008,503	457,426,275	93.9%	52,751,125	104.7%
2020	352,400,177	292,842,515	83.1%	56,795,601	99.2%
2021	271,873,709	251,366,724	92.4%	37,536,241	106.2%
2022 *	278,376,338	254,335,239	91.3%	36,178,969	104.3%

*Per examination

A combined loss incurred and expense to premium ratio of more than 100 percent would indicate an underwriting loss. The Plan reported underwriting losses in four of the last five years.

REINSURANCE

Assumed

None.

Ceded

Effective Jan. 1, 2017, the Plan ceded to PartnerRe America Insurance Company (NAIC #11835, admitted in Oregon Dec. 12, 1981) on an HMO specific excess loss reinsurance agreement. Under the policy, the reinsurer agrees to reimburse the Plan for losses up to $3 million for each covered person, after retention of $1.25 million 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

It was determined the reinsurance agreements clearly specified the risks taken by the reinsurer, with no unusual provisions reducing the reinsurer's risk. The reinsurance agreement contained a proper insolvency clause in accordance with ORS 731.508(3) as required to take reserve credits for reinsurance ceded. The agreement also contained a settlement clause and an entire agreements clause, as required by OAR 836-012-0310 and OAR 836-012-0320, respectively. As a result, the reinsurance agreement provided for risk transfer in accordance with the requirements of SSAP No.61 R.

In view of the Company's reported surplus of $61,408,299 on Dec. 31, 2022, it appears the Company does not maintain risk on any one subject in excess of 10 percent of its surplus to policyholders, in compliance with ORS 731.504.

ACCOUNTS AND RECORDS

In general, the Plan's records and source documentation supported the amounts presented in the Plan'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. 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.

However, the Plan did not provide some specifically requested records. Additionally, the Plan did not provide some specifically requested records timely in order to properly facilitate the examination.

I recommend the Plan provide all record requests in accordance with ORS 731.308(2). Further, I recommend the Plan provide all record requests in a timely manner in order to properly facilitate the examination in accordance with ORS 731.308(3).

STATUTORY DEPOSIT

To satisfy the statutory deposit requirements in Oregon for health care service contractors, the Plan maintained a U.S. 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. However, the Oregon statutory deposit was included in columns five and six of Schedule E – Part 3 as a special deposit and not in columns three and four as a deposit for the benefit of all policyholders, as indicated on the statutory deposit.

I recommend that the statutory amount be recorded in columns three and four of Schedule E – Part 3 in accordance with the NAIC health annual statement instructions, ORS 731.574(1) and OAR 836-011-0000.

COMPLIANCE WITH PRIOR EXAMINATION RECOMMENDATIONS

There were no recommendations made as a result of the 2017 report of examination and no adjustments made to surplus.

SUBSEQUENT EVENTS

The Company did not renew its reinsurance agreement with PartnerRe America Insurance Company in 2023, after determining that the cost of maintaining reinsurance was more detrimental than beneficial to policyholder surplus.

FINANCIAL STATEMENTS

The following examination financial statements show the financial condition of Health Net Health Plan of Oregon, Inc. as of Dec. 31, 2022:

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

HEALTH NET HEALTH PLAN OF OREGON, INC.
ASSETS
As of Dec. 31, 2022

Assets	Net admitted assets	Notes
Bonds	$ 58,630,210	1
Preferred stocks	-	
Common stocks	-	
Cash, cash equivalents and short-term investments	20,042,383	1
Receivable for securities	-	
Aggregate write-ins for invested assets	-	
Subtotal, cash and invested assets	$78,672,593	
Investment income due and accrued	378,103	
Premiums and considerations		
Uncollected premiums, agents' balances in course of collection	56,678	
Accrued retrospective premiums	11,344,731	
Amounts receivable relating to uninsured plans	3,631,667	
Current federal income tax recoverable	1,211,402	
Net deferred tax asset	1,806,108	
Receivable from parent, subsidiaries and affiliates	9,262,086	
Health care and other amounts receivable	4,302,646	
Aggregate write-ins for other than invested assets	148,458	
Total Assets	$110,814,472	

HEALTH NET HEALTH PLAN OF OREGON, INC.
LIABILITIES, CAPITAL AND SURPLUS
As of Dec. 31, 2022

Liabilities, surplus, and other funds	Current year total	Notes
Claims unpaid	$28,418,366	2
Accrued medical incentive pool and bonus amounts	6,868,876	2
Unpaid claim adjustment expenses	354,698	2
Aggregate health policy reserves	9,130,517	2
Premiums received in advance	645,587	
General expenses due or accrued	1,404,300	
Ceded reinsurance premiums payable	1,108	
Amounts withheld or retained for account of others	-	
Amounts due to parent, subsidiaries and affiliates	425,914	
Liability for amounts held under uninsured plans	2,156,807	
Total Liabilities	$49,406,173	
Aggregate write-ins for special surplus funds	-	
Gross paid in and contributed surplus	181,941,403	
Unassigned funds (surplus)	(120,533,114)	
Surplus as regards policyholders	61,408,299	
Total Liabilities, Surplus and other Funds	$110,814,472	

HEALTH NET HEALTH PLAN OF OREGON, INC.
STATEMENT OF REVENUE AND EXPENSES
For the Year Ended Dec. 31, 2022

Revenue	Current Year Total	Notes
Net premium income	$ 278,376,338	
Change in unearned premium reserve and reserve for rate credits	-	
Fee-for-service	-	
Risk revenue	-	
Aggregate write-ins for non-health care related revenues – gain on sale of fixed assets	-	
Total revenue	278,376,338	
Hospital and medical		
Hospital/medical benefits	211,479,479	
Other professional services	8,220,154	
Outside referrals	-	
Emergency room and out-of-area	14,489,813	
Prescription drugs	14,444,822	
Incentive pool, withhold adjustments and bonus amounts	5,700,971	
Subtotal	254,335,239	
Less:		
Net reinsurance recoveries	-	
Total hospital and medical	254,335,239	
Non-health claims	-	
Claim adjustment expenses	2,942,699	
General administrative expenses	33,236,270	
Increase in reserves for life and accident and health contracts	(9,468,075)	
Total underwriting deductions	281,046,133	
Net underwriting gain or (loss)	(2,669,795)	
Net investment income earned	1,736,624	
Net realized capital gains (losses)	(2,823)	
Net investment gains (losses)	1,736,624	
Net realized capital gains (losses) less capital gains tax	(2,823)	
Net investment gains (losses)	1,733,801	
Net gain or (loss) from agents' or premium balances charged off	(84,632)	
Aggregate write-ins for other income or expense	(3,266)	
Net income (loss) after capital gains tax and before all other federal income taxes	(1,023,892)	
Federal income taxes incurred	(2,251,576)	
Net income (loss)	$ 1,227,684	

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

	2022	2021	2020	2019	2018
Surplus as regards policyholders, Dec. 31, previous year	$61,056,226	$72,525,790	$55,766,931	$73,730,318	$73,059,381
Net income (loss)	1,227,684	(16,235,280)	8,171,396	(23,377,489)	(136,638)
Change in net unrealized capital gains or (losses)	-	-	-	-	-
Change in net deferred income tax	(1,227,898)	40,603	3,063,404	-	-
Change in non-admitted assets	422,287	4,725,113	5,524,059	(11,585,898)	807,575
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	-	-	-	17,000,000	-
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	-	-	-	-	-
Change in surplus as regards policyholders for the year	352,073	(11,469,564)	16,758,859	(17,963,387)	670,937
Surplus as regards policyholders, Dec. 31, current year	$61,408,299	$61,056,226	$72,525,790	$55,766,931	$73,730,318

NOTES TO FINANCIAL STATEMENTS

Note 1 – Invested assets

At year-end 2022, the Plan's long-term bond investments were in diversified in U.S. obligations, U.S. special revenue and special assessment obligations, municipal obligations, and industrial & miscellaneous. The Company had moderate exposure to mortgage backed and asset-backed securities. All MBS/ABS issues were investment rated at year-end 2022, and the carrying book value comprised 34.3 percent of the total long-term bond portfolio, or 34.2 percent of all invested assets.

Cash and cash equivalents consisted of cash on deposit at various banks and one money market mutual fund. The Company did not hold any short-term investments.

A comparison of the major investments over the past five years is as follows:

Year	A Bonds	B Cash and short term	Ratio A/ Total assets	Ratio B/ Total assets
2018	118,569,276	8,305,294	76.2%	5.3%
2019	72,235,930	8,350,299	50.1%	5.8%
2020	75,991,764	23,271,771	57.1%	17.5%
2021	62,646,051	24,653,694	55.4%	21.8%
2022*	58,630,210	20,042,383	52.9%	18.1%

* 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 Plan was in compliance with ORS 733.580.

A review of board of director minutes indicated the board of directors formally approved all investment transactions for the years under review as required by ORS 733.730. The Plan uses Allspring Global Investment (formerly known as Wells Fargo Capital Advisors), DWS Investment Management (part of Deutsche Bank), Wellington Management Company, New England Asset Management, and Brown Brothers Harriman (BBH) to provide investment advisory services, including actively managing the Plan's fixed income and short-term investment (cash equivalents) portfolios in accordance with the Plan's investment policy.

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

Note 2 – Actuarial reserves

Andrew Bux, FSA, MAAA, Oregon Division of Financial Regulation life and health 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 2022. The work done included reviews of the companies' annual statements, actuarial opinions,

actuarial memorandums, 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 82 companies in the Centene Group, with two domiciled in Oregon: Trillium Health Plans, Inc. and the Plan.

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

SUMMARY OF COMMENTS AND RECOMMENDATIONS

The examiner made no changes to surplus as a result of this examination. The following is a summary of the recommendations made in this report of examination:

Page:

15 I recommend the Plan provide all record requests in accordance with ORS 731.308(2). Further, I recommend the Plan provide all record requests in a timely manner in order to properly facilitate the examination in accordance with ORS 731.308(3)

15 I recommend that the statutory amount be recorded in columns three and four of Schedule E – Part 3 in accordance with the NAIC health annual statement instructions, ORS 731.574(1), and OAR 836-011-0000.

CONCLUSION

During the five-year period covered by this examination, the surplus of the Plan has decreased from $73,059,383 as presented in the Dec. 31, 2017, report of examination, to $61,408,299, as shown in this report. The comparative assets and liabilities are:

	Dec. 31		
	2022	2017	Change
Assets	$110,814,472	$182,947,422	$(72,132,950)
Liabilities	49,406,173	109,888,039	(60,481,866)
Surplus	$ 61,408,299	$ 73,059,383	$(11,651,084)

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, Tho Le, CFE, PIR, senior insurance examiner, Jordan Mills, AFE, David Lorenz, APIR, and Chivonne Bradley, insurance examiners, and Andrew 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 A. 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)
) ss
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 Health Net Health Plan of Oregon, Inc., Tigard, 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 Health Net Health Plan of Oregon, 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 A. Giffin
Mark A. Giffin, CFE
Senior insurance examiner
Department of Consumer and Business Services
State of Oregon

Subscribed and sworn to me this 19th day of September, 2024.

/s/ Cindy Engle
Notary Public for the State of Oregon

My commission expires: July 9, 2027