STATE OF OREGON

DEPARTMENT OF CONSUMER & BUSINESS SERVICES

DIVISION OF FINANCIAL REGULATION

REPORT OF FINANCIAL EXAMINATION

OF

PROVIDENCE HEALTH ASSURANCE
PORTLAND, OREGON

AS OF

DECEMBER 31, 2016

STATE OF OREGON

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NAIC COMPANY CODE 15203

AS OF

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SALUTATION

October 16, 2017

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

Dear Commissioner:

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

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

NAIC Company Code 15203

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

SCOPE OF EXAMINATION

We have performed our regular, full-scope, single state examination of Providence Health Assurance. The last examination of this health care service contractor was the qualifying examination as of March 31, 2013. This examination covers the period from March 31, 2013, through December 31, 2016.

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

All accounts and activities of the Plan were considered in accordance with the risk focused examination process. This may include assessing significant estimates made by management and evaluating management's compliance with Statutory Accounting Principles. The examination does not attest to the fair presentation of the financial statements included herein. If, during the course of the examination an adjustment is identified, the 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 Plan 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 Plan.

COMPANY HISTORY

The Plan was incorporated in Oregon on April 21, 2003, as a public benefit, non-profit corporation. The Company was formed to be a Managed Care Organization (MCO) under the Oregon Health Authority. All Medicaid business for Oregon members was transferred to the Plan from its direct parent, Providence Health Plan, on January 1, 2004.

During 2012 all of the Plan's members were reassigned to two newly formed and authorized Coordinated Care Organizations (CCOs), Health Share of Oregon (HSO) and Yamhill CCO. The Plan then entered into an agreement with HSO to provide administrative services and assume the financial risk for the same Medicaid members that the Plan previously serviced as well as future Medicaid participants assigned by HSO. The Plan obtained its Certificate of Authority as a Health Care Service Contractor on June 14, 2013, pursuant to the requirements of ORS 750.045.

Effective January 1, 2016, Providence Health Plan transferred its contract with CMS and related Medicare Advantage business to the Plan pursuant to a Novation Agreement between CMS, Providence Health Plan and the Plan together with an Affiliated Entity Transfer Agreement between Providence Health Plan and the Plan. All membership, assets, liabilities, receivables, payables, deferred revenue, other liabilities, and net worth associated with the Medicare Advantage Plan were transferred to the Plan during the first quarter of 2016. Providence Health Plan remains the sole member of the Plan.

Capitalization

The Plan was initially capitalized by Providence Health Plan. On January 16, 2014, Providence Health Plan contributed an additional $2 million to assure the Plan remained in compliance with capital and surplus requirements of ORS 750.045. During the first quarter of 2016, Providence Health Plan contributed $215,655,157 to the Plan, in association with the transfer of its Medicare

business to the Plan. This included a transfer of long term bonds with a book adjusted carrying value of $202,734,860 and a cash payment of $12,920,297.

Dividends and Other Distributions

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

CORPORATE RECORDS

Board Minutes

Prior to June 30, 2016, the Providence Health & Services Board of Directors served as the Board for the Plan. On July 1, 2016, a separate Board of Directors was formed specifically for the Providence Health Plan, the Plan, and Providence Plan Partners (PPP) by designating current serving PPP Board members as both the PHP's and the Plan's Board. In general, the review of the Board meeting minutes of the Plan indicated the minutes support the transactions of the Plan and that the Board adequately reviews, discusses, and approves significant decisions and transactions. A quorum, as defined by the Plan's Bylaws, was met at all of the meetings held during the period under review.

The Plan's Bylaws, in Article IV, authorize an Executive Committee and all other committees to be formed as are deemed necessary and appropriate. The Plan's Board has authorized an Audit & Finance Committee and created a formal charter. This committee's main responsibilities are to recommend financial policies, goals, and budgets and to oversee the Plan's audit, accounting and financial reporting processes and internal control systems. Other committees serving under the Board include: a Compliance and Risk Committee, which oversees the Plan's compliance program, including information privacy, information security, and enterprise risk management; a Governance Committee, which assists the Plan's Board in maintaining current best practices in nonprofit corporate governance and also recommends candidates for the Board; and a Quality

and Medical Management Committee, which assists the Board with respect to quality of care and medical management activities of the Plan. These three committees also have formal charters. The actions of the various committees are summarized and reported to the board of directors during their regular meetings.

Effective July 1, 2016, the Plan's re-constituted Board of Directors assumed oversight with regard to the compensation of its CEO and senior leaders. The Plan's Board approves an annual budget, which includes both salaries and compensation of certain senior leaders, which are reimbursed under the Management Services Agreement between the Plan and PPP. This process complies with the provisions of ORS 732.320(3).

Articles of Incorporation

Amended Articles of Incorporation were established for the Plan effective July 1, 2016 as a result of the transfer of the Medicare Advantage business from PHP. The changes established a Board of Directors and Bylaws, and named its sole member. The Articles of Incorporation conformed to the Oregon Insurance Code.

Bylaws

The Plan's Bylaws were last amended and restated as of July 1, 2016. The changes named the Plan, established the composition of the Plan's Board of Directors as the same individuals currently serving on the PPP Board of Directors, established officer positions and appointed members to Board committees. The Plan's Bylaws conformed to the Oregon statutes.

MANAGEMENT AND CONTROL

Board of Directors

The Bylaws state the business and affairs of the corporation shall be managed and controlled by its Board of Directors. The Articles of Incorporation, under Article 6, and the Bylaws, in Article

I, Section 1, both state the number of directors shall be not less than five (5) or more than fifteen (15). As of December 31, 2016, the Plan was governed by a six member Board of Directors as follows:

Name and Address	Principal Affiliation	Member Since	Representative
Isiaah Crawford Seattle, Washington	President University of Puget Sound	2012	Public
Debra A. Canales Seattle, Washington	Executive Vice-President Providence Health & Services	2016	Company
Michael L. Cotton West Linn, Oregon	Chief Executive Officer Providence Health Plan	2016	Company
Rhonda M. Medows, MD * Issaquah, Washington	EVP – Population Health Providence Health & Services	2016	Company
Gilbert Rodriguez, MD Lake Oswego, Oregon	Retired Chief Medical Officer	2016	Medical
Heath Schiesser Austin, Texas	Founding Partner Pilot Wall Group	2016	Public

* Board Chair and Interim Audit & Finance Committee Chair

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

Officers

Principal Officers serving at December 31, 2016, were as follows:

Officer	Office
Michael L. Cotton	Chief Executive Officer
Michael G. White	Chief Financial Officer
Gregory D. Zamudio	Secretary, Chief Legal Counsel
Mark Jensen	Chief Service Operations Officer
Bradley S. Garrigues	Chief Sales & Marketing Officer

Officer	Office
Allison S. Schrupp	Chief Administrative Officer
Robert A. Gluckman	Chief Medical Officer
Jon R. McAnnis	Chief Information Officer
Carrie L. Smith	Chief Compliance Officer

Conflict Of Interest

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

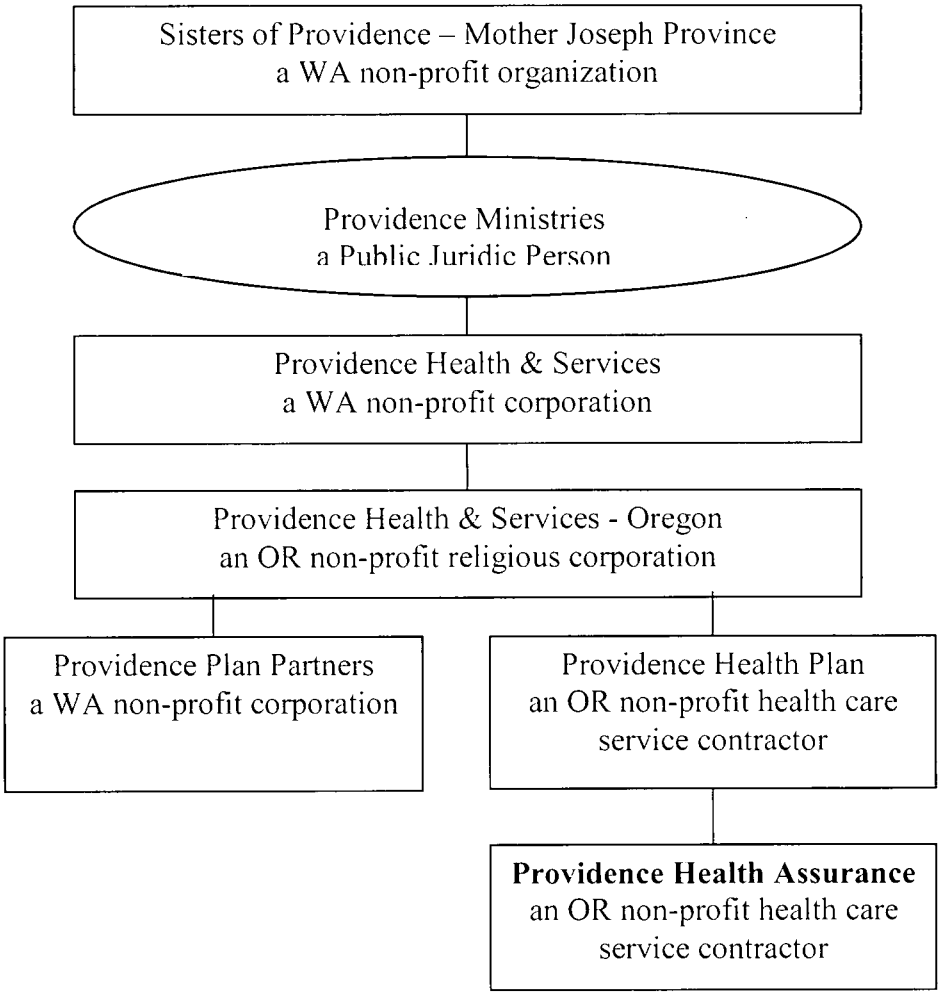
The Code of Conduct requires all employees at the director level and above, including Board members, and senior officers to complete and sign annual conflict of interest statements. Other employees are required to complete this form based on their roles within the organization. Additionally, any employee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

Insurance Company Holding System

Provincial Superior & Members of Provincial Council of Sisters of Providence, Mother Joseph Province (a Roman Catholic order based in Montreal, Canada) received permission from the Vatican in 2010 to form a five-member Public Juridic Person under the name Providence Ministries to be the sponsor of Providence Health & Services. These members, none of whom are employed by any Providence entity, assume some of the responsibilities of the Sisters of

Providence – Mother Joseph Province in governing Providence Health & Services. Sisters of Providence remain the ultimate controlling entity of the organization, as they appoint the Providence Ministries members.

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



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

Providence Health & Services (PH&S) is a Washington nonprofit organization which operates hospitals, schools and other facilities throughout the Northwest, Alaska and Southern California for Sisters of Providence.

Providence Health & Services - Oregon (PHS-OR), formerly Providence Health System – Oregon, is an Oregon nonprofit religious organization which operates the hospitals, schools and other facilities established by the Sisters of Providence in Oregon. PHS-OR provides all employees to PPP at cost under a Management Services Agreement described below. PHS-OR is the sole member of PHP and their direct parent.

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

Providence Health Plan (PHP) is an Oregon nonprofit health care service contractor. Effective January 1, 2016, the Plan transferred their contract with CMS and related Medicare Advantage business to PHA. All related membership, assets, liabilities, receivables, payables, deferred revenue, other liabilities, and net worth associated with the Medicare Advantage Plan were transferred to PHA during the first quarter of 2016. PHP is the sole member of the Plan.

INTERCOMPANY AGREEMENTS

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

Management Services Agreement – Effective May 1, 2013, the Plan entered into an agreement with Providence Plan Partners (PPP). The Agreement provides overall management and administrative services to the Plan at cost, and also provides employees to the Plan at cost. These services include staffing, accounting, financial reporting, utilization review and cost controls, professional and quality control, patient referral procedures, marketing and sales support, joint purchasing of certain services and supplies needed, and other administrative services. On a monthly basis, PPP shall calculate the cost of all services provided to the Plan and the amount shall be paid to PPP prior to the close of each month's fiscal period or no later

than within 60 days of receipt of invoice. Cost shall be determined through PPP's cost accounting by product line and shall be updated annually at minimum. PPP is also allowed to charge additional amounts, if necessary and if agreed upon by the Plan.

Medicare Compensation and Risk/Incentive Structure Agreement – Effective January 1, 2016, the company entered into an agreement with PHS to reimburse an enrollee's medical expenses allocated into seven distinct funds: a Primary Fund to reimburse the primary care practitioner (PCP); a Referral Fund to reimburse for specific services authorized by the PCP; an Institutional Fund for hospital, other facility and ancillary services; a Health Plan Risk Fund to reimburse for specific services; an ESRD Fund to reimburse costs for those enrollees with end-stage renal disease; a DME Fund to reimburse costs for durable medical equipment, and; a PCP Quality Fund. This agreement was not filed with the Division of Financial Regulation, as required by ORS 732.552(1)(c)(E) and OAR 836-027-0160.

I recommend the Plan immediately file a Form D – Notice of Proposed Transaction to have the Medicare Compensation and Risk/Incentive Agreement approved. I further recommend the Plan review all its internal operations for any agreement between related parties and submit them to the Division of Financial Regulation.

FIDELITY BOND AND OTHER INSURANCE

The examination of insurance coverages involved a review of adequacy of limits and retentions, and the solvency of the insurers providing the coverages. The Plan's insurance coverages are provided through insurance policies covering PHS, with the Plan and all subsidiaries named as an affiliate. The group as a whole is insured up to $15,000,000 per individual loss, after a $500,000 deductible, against losses from acts of theft, forgery or alteration and fraud by its employees and agents. Fidelity bond coverage was found to meet the coverage limits recommended by the NAIC.

Other insurance coverages in force at December 31, 2016, were found to be adequate, and included:

Commercial auto	Officers Employment Practices
Cyber, Security & Privacy liability	Crime Coverage
Management liability	Property Coverage
Excess Medical Professional liability	Professional & General Liability
Excess Workers' compensation	

TERRITORY AND PLAN OF OPERATION

The Plan offers Medicare Advantage plans including emergency coverage for illness or accidents, routine vision exams, medical advice hotline, routine physicals and preventative services, and wellness services and discount programs. Plan members have special access to a new patient appointment network with clinics in the Portland metro and Vancouver, WA areas. The Plan also writes Medicaid business for the Oregon Health Plan through the Oregon Health Authority.

The Plan reported total enrolled members since its inception as follows:

Line of Business	2016	2015	2014	2013
Medicare supplement	0	0	0	0
Medicare	50,395	0	0	0
Medicaid	34,995	36,463	37,224	20,176
Other	0	0	0	0
Total enrollment	85,390	36,463	37,224	20,176

GROWTH OF THE COMPANY

Growth of the Plan since its inception is reflected in the following table. Amounts were obtained 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)
2013	$ 13,955,821	$ 3,893,281	$ 10,062,540	$ (2,314,992)
2014	28,966,513	11,867,786	17,098,727	7,628,547
2015	40,163,889	18,892,605	21,271,284	4,509,445
2016*	376,481,706	114,066,561	262,415,145	24,452,951

*Per examination

LOSS EXPERIENCE

The following exhibit reflects the annual underwriting results of the Plan since its inception. The amounts were compiled from copies of the Plan's filed annual statements and, where indicated, from examination reports.

Year	(1) Total Revenues	(2) Total Hospital and Medical	(2)/(1) Medical Loss Ratio	(3) Claim Adjustment and General Expenses	(2)+(3)/(1) Combined Loss Ratio
2013	$ 56,654,234	$ 55,745,993	98.4%	$ 5,456,868	108.0%
2014	117,623,490	101,819,997	86.6%	8,416,717	93.7%
2015	130,628,415	114,873,927	87.9%	11,783,325	97.0%
2016*	670,115,314	611,996,488	91.3%	39,573,388	97.2%

*Per examination

A combined loss incurred and expense to premium ratio of more than 100% would indicate an underwriting loss. The Plan reported an underwriting loss in 2013, and underwriting gains in 2014, 2015 and 2016.

REINSURANCE

Assumed

None.

Ceded

During the period under examination, the Plan entered into an annual Excess of Loss Reinsurance Agreement for each year, which was covered by annual policies with HM Life

Insurance Company (NAIC #93440), a Pennsylvania domiciled life and health insurer, authorized in Oregon on April 29, 1982. Under the 2016 policy, the reinsurer agrees to reimburse the Plan's Medicaid members for losses per member up to a maximum of $5,000,000 for each covered member after retention of $275,000. The Plan pays a fixed PMPM premium for each Medicaid member, due the first day of each month. The reinsurer shall reimburse amounts in excess of retention limits for inpatient hospitalization, outpatient services, subacute care, prescribed pharmaceuticals provided and billed as part of an inpatient hospital bill (with the exception of growth hormones and over-the-counter drugs) and 90% of approved transplants, (50% for non-approved transplants).

In view of the Plan's adjusted capital and surplus of $262,415,145 at December 31, 2016, it does not maintain risk on any one subject in excess of ten 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 December 31, 2016 annual statement and were maintained in a manner by which the financial condition was readily verifiable pursuant to the provisions of ORS 733.170.

STATUTORY DEPOSITS

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

COMPLIANCE WITH PRIOR EXAMINATION RECOMMENDATIONS

There were no recommendations made in the initial qualifying report of examination and no adjustments were made to surplus as a result of the examination findings.

SUBSEQUENT EVENTS

There were no events subsequent to the examination period that would have a material impact on the Plan's surplus position.

FINANCIAL STATEMENTS

The following financial statements are based on the statutory financial statements filed by the Plan with the Oregon Division of Financial Regulation and present the financial condition of the Plan as of December 31, 2016. The accompanying comments on financial statements reflect any examination adjustments to the amounts reported in the annual statement and should be considered an integral part of the financial statements.

Statement of Assets
Statement of Liabilities, Capital and Surplus
Statement of Revenue and Expenses
Reconciliation of Surplus since the Last Examination

PROVIDENCE HEALTH ASSURANCE
ASSETS
As of December 31, 2016

Assets	Balance per Company	Examination Adjustments	Balance per Examination	Notes
Bonds	$246,868,405	$ -	$246,868,405	1
Common stocks	3,583,465	-	3,583,465	1
Properties occupied by the company	0	-	0	
Cash, cash equivalents and short-term investments	77,132,288	-	77,132,288	1
Receivable for securities	7,121,034	-	7,121,034	
Aggregate write-ins for invested assets	0	-	0	
Subtotal, cash and invested assets	334,705,192	-	334,705,192	
Investment income due and accrued	969,357	-	969,357	
Premiums and considerations				
Uncollected premiums, agents' balances in course of collection	1,193,257	-	1,193,257	
Amounts recoverable from reinsurers	247,240	-	247,240	
Receivables from parent, subsidiaries and affiliates				
Receivable for provider risk sharing settlement	9,671,955	-	9,671,955	2
Other receivables from parent, subsidiaries and affiliates	5,482,648	-	5,482,648	
Health care receivable				
Receivable for estimated Rx Rebates	5,181,412	-	5,181,412	2
Receivable for estimated CMS payment	6,800,000	-	6,800,000	2
Other health care receivables	12,230,645	-	12,230,645	
Aggregate write-ins for other than invested assets	-	-	-	
Total Assets	$376,481,706	$ -	$376,481,706	

PROVIDENCE HEALTH ASSURANCE
LIABILITIES, CAPITAL AND SURPLUS
As of December 31, 2016

Liabilities, Surplus and other Funds	Balance per Company	Examination Adjustments	Balance per Examination	Notes
Claims unpaid	$ 51,904,651	$ -	$ 51,904,651	3
Accrued medical incentive pool and bonus	20,795,165	-	20,795,165	3
Unpaid claim adjustment expenses	1,437,320	-	1,437,320	3
Aggregate health policy reserves	1,805,048	-	1,805,048	3
Premiums received in advance	1,150,105	-	1,150,105	
General expenses due or accrued	200,879	-	200,879	
Ceded reinsurance premiums payable	423,847	-	423,847	
Amounts due to parent, subsidiaries and affiliates	13,796	-	13,796	
Payable for securities	32,547,929	-	32,547,929	
Liability for amounts held under uninsured plans	0	-	0	
Aggregate write-ins for other liabilities	3,787,821	$ -	3,787,821	
Total Liabilities	$114,066,561	$ -	$114,066,561	
Common capital stock	$ -	$ -	$ -	
Gross paid in and contributed surplus	-	217,655,157	217,655,157	4
Unassigned funds (surplus)	262,415,145	(217,655,157)	35,088,033	
Surplus as regards policyholders	262,415,145	$ -	262,415,145	
Total Liabilities, Surplus and other Funds	$376,481,706	$ -	$376,481,706	

PROVIDENCE HEALTH ASSURANCE
STATEMENT OF REVENUE AND EXPENSES
For the Year Ended December 31, 2016

Revenue	Balance per Company	Examination Adjustments	Balance per Examination	Notes
Net premium income	$670,115,314	$ -	$670,115,314	
Change in unearned premium reserves and reserves for rate credit	-	-	-	
Fee-for-service	-	-	-	
Risk revenue	-	-	-	
Aggregate write-ins for health care related revenues	-	-	-	
Total revenues	670,115,314	-	670,115,314	
Hospital and Medical:				
Hospital/medical benefits	372,738,936	-	372,738,936	
Other professional services	103,091,625	-	103,091,625	
Outside referrals	35,730,918	-	35,730,918	
Emergency room and out-of-area	21,455,476	-	21,455,476	
Prescription drugs	69,015,424	-	69,015,424	
Aggregate write-ins for other hospital and medical	4,645,209	-	4,645,209	
Incentive pool, withhold adjustments and bonus amounts	5,318,900	-	5,318,900	
Subtotal	611,996,488	-	611,996,488	
Less:				
Net reinsurance recoveries	1,792,369	-	1,792,369	
Total medical and hospital	610,204,119		610,204,119	
Non-health claims	-	-	-	
Claim adjustment expenses	19,174,410	-	19,174,410	
General administrative expenses	20,398,978	-	20,398,978	
Increase in reserves for life and accident and health contracts	773,243	-	773,243	
Total underwriting deductions	650 550,750	-	650,550,750	
Net underwriting gain or (loss)	19,564,564	-	19,564,564	
Net investment income earned	3,536,289	-	3,536,289	
Net realized capital gains (losses)	1 352,098	-	1,352,098	
Net investment gains (losses)	4,888,387	-	4,888,387	
Net gain or (loss) from agents' or premium balances charged off	-	-	-	
Aggregate write-ins for other income or expense	-	-	-	
Federal income taxes incurred	-	-	-	
Net income (loss)	$ 24,452,951	$ -	$ 24,452,951	

PROVIDENCE HEALTH ASSURANCE
RECONCILIATION OF SURPLUS SINCE THE LAST EXAMINATION
For the Year Ended December 31,

	2016	2015	2014	2013
Surplus as regards policyholders, December 31, previous year	$ 21,271,284	$17,098,727	$10,062,540	$10,390,243
Net income (loss)	24,452,951	4,509,445	7,628,547	(2,314,992)
Change in net unrealized capital gains or (losses)	119,982	3,343	(3,672)	-
Change in net unrealized foreign exchange capital gain or (loss)	-	-	-	-
Change in net deferred income tax	-	-	-	-
Change in nonadmitted assets	915,771	(338,397)	(588,688)	(12,711)
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	215,655,157	-	-	2,000,000
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	-	(1,834)	-	-
Change in surplus as regards policyholders for the year	241,143,861	4,172,557	7,036,187	(327,703)
Surplus as regards policyholders, December 31, current year	$262,415,145	$21,271,284	$17,098,727	$10,062,540

NOTES TO FINANCIAL STATEMENTS

Note 1 – Invested Assets

At year-end 2016, the Plan's long-term bond investments were in U.S. treasury securities, mortgage backed pass-through securities, and corporate issues. The Plan reported a moderate exposure in mortgaged-backed or asset-backed securities in the amount of $94,555,018, equal to 38.3% of total bonds and 36.2% of total invested assets.

The Plan reported common stocks consisting of two mutual funds and short-term investments consisting of eight corporate bonds maturing in less than one year. Cash on deposit was held in four accounts at US Bank and one account at the Northern Trust Company.

A comparison of the major investments since the Plan's inception shows the following:

	A	B	C	Ratio	Ratio	Ratio
Year	Bonds	Common Stocks	Cash and Short-term	A/ Total Assets	B/ Total Assets	C/ Total Assets
2013	-	-	12,615,432	n/a	n/a	90.4%
2014	13,831,724	-	12,401,408	47.7%	0%	42.8%
2015	16,985,305	-	9,599,733	42.3%	0%	23.9%
2016*	246,868,405	3,583,465	77,132,288	65.5%	1%	20.5%

* Balance per examination.

During 2016, the Plan received assets and cash from its parent, PHP, associated with the transfer the Medicare Advantage line of business, with the approval of the Centers for Medicare and Medicaid Services (CMS). The examiners confirmed the transfer of $202,734,860 in the book value of long-term bonds and $12,920,297 in cash, for a total investment in the amount of $215,655,157.

As of December 31, 2016, sufficient assets were invested in amply secured obligations of the United States, the State of Oregon, or in FDIC insured cash deposits in accordance with ORS 733.580.

Neither the Board nor any authorized committee approved the investment transactions in any of the years under review as required by ORS 733.730. The Plan uses a discretionary advisor, Pavilion Advisory Group as their investment consultant and TCW Investment Management Company, LLC. to actively manage their portfolio. Transactions are monitored by an investment officer with PHS, who reports the transactions to the CFOs of PHS and the Plan.

I recommend the Plan develop a procedure to have the Board of Directors, or a responsible Committee of the Board, approve all investment transactions on a regular basis, and that a formal resolution be voted on by the Board at the meetings, pursuant to ORS 733.730.

Effective January 1, 2014 the Plan entered into a custodial agreement with The Northern Trust Company located in Chicago, IL. The agreement did not contain relevant protections described in OAR 836-027-0200(4) (a) through (l). During the fieldwork, the examination team received an amended Custodial Agreement between the Plan and Northern Trust that complied with the provisions of the Administrative Rule. As a result, this Report will not make a formal recommendation.

Note 2 – Actuarial Items Presented as Assets

Indicated line items on the asset page were reviewed by David N. Ball, FSA, MAAA, life and health actuary for the Oregon Division of Financial Regulation with no adjustments to the Annual Statement amounts noted. The examiners noted the receivable for provider risk sharing settlement was for an agreement that was not filed with the Division of Financial Regulation on a Form D filing, nor was it noted in the annual Form B filings. The agreement given to the examiners did not include specific due dates, and thus amounts owed could be considered non-admitted as it was not settled within 90 days of the examination date per the requirements of SSAP No. 25, paragraph 7. Based on the terms of the Agreement, PHA recorded a YE 2016 receivable for Provider Risk Sharing Settlement in the amount of $9,671,955. The receivable was due from PHS and was partially settled in May, 2017, and the final settlement occurred in June, 2017. No adjustment will be made by the examiners.

Note 3 – Actuarial Reserves

A review of the unpaid claims and claim adjustment expense reserves for the Plan was performed by David N. Ball, FSA, MAAA, life and health actuary for the Oregon Division of Financial Regulation. As part of his review, he examined the Actuarial Report Supporting Statements as of December 31, 2016 prepared by Lynn F. Dong, FSA, MAAA, from Milliman.

Mr. Ball reviewed the reconciliation of the data used in the Plan's Actuarial Report to the data in the actuarial work papers and found them to be consistent. He relied on work performed by the examiners who reviewed the underlying data used to create the Annual Statement filing, as well as prepared his own independent calculations. He determined the following:

	My Estimate	Annual Statement
Claims Unpaid	$ 39,872,822	$ 51,904,651
Accrued Medical Incentive Pool and Bonus Payments	20,795,165	20,795,165
Unpaid Claims Adjustment Expenses (CAE)	1,437,320	1,437,320
Aggregate Health Policy Reserves	1,805,048	1,805,048
Aggregate Health Claim Reserves	-	-
Total Actuarial Liabilities	$ 63,910,355	$ 75,942,184

The appointed actuary opined that the reserves for unpaid claims and CAE carried by the Plan as of December 31, 2016 were reasonable. Mr. Ball's total estimate was less than the appointed

actuary's estimate by $12.03 million, a difference of 23.2% indicating a reserve redundancy. He concurred that the reserves of the Plan were reasonably stated as of December 31, 2016.

Note 4 – Paid-in and Contributed Surplus

The Plan reported capital changes of $2,000,000 in 2013 and $215,655,157 in 2016, in the filed Annual Statements. In actuality, these amounts represent paid-in surplus contributions made by the direct parent, PHP. The examiner adjusted the balance to reflect the contributions and reduced unassigned funds (surplus) by an identical amount.

SUMMARY OF COMMENTS AND RECOMMENDATIONS

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

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13 I recommend the Plan immediately file a Form D – Notice of Proposed Transaction to have the Medicare Compensation and Risk/Incentive Agreement approved. I further recommend the Plan review all its internal operations for any agreement between related parties and submit them to the Division of Financial Regulation.

22 I recommend the Plan develop a procedure to have the Board of Directors, or a responsible Committee of the Board, approve all investment transactions on a regular basis, and that a formal resolution be voted on by the Board at the meetings, pursuant to ORS 733.730.

CONCLUSION

During the four year period covered by this examination, the surplus of the Plan has increased from $9,138,739, as presented in the March 31, 2013 Qualifying Report of Examination, to $262,415,145 as shown in this report of examination. The comparative assets and liabilities are:

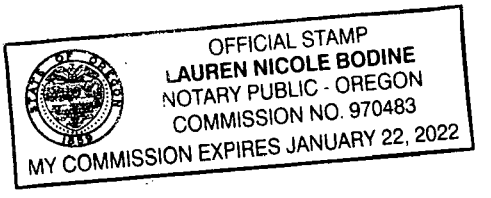
	December 31, 2016	March 31, 2013	Change
Assets	$ 376,481,706	$ 19,101,728	$ 357,379,978
Liabilities	114,066,561	9,962,988	104,103,573
Surplus	$ 262,415,145	$ 9,138,740	$ 253,276,405

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, Maanik Gupta, Khoa V. Nguyen, Michael P. Phillips, CPA, CFE, AES, insurance examiners, and David N. Ball, FSA, MAAA, Life and Health Actuary for the State of Oregon, Department of Consumer and Business Services, Division of Financial Regulation, participated on this examination. Additionally, Alea Talbert-Pence, CFE, CIA, from Risk and Regulatory Consulting, LLC participated on this examination.

Respectfully submitted,



Mark A. Giffin, CFE
Lead Financial Examiner
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 Providence Health Assurance, Portland, Oregon.

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

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

The affiant says nothing further.

Mark A. Giffin, CFE
Lead Financial Examiner
Department of Consumer and Business Services
State of Oregon

Subscribed and sworn to me this 7th day of May, 2018.

Lauren Nicole Bodine
Notary Public for the State of Oregon

My Commission Expires: 1/22/2022

OFFICIAL STAMP
LAUREN NICOLE BODINE
NOTARY PUBLIC - OREGON
COMMISSION NO. 970483
MY COMMISSION EXPIRES JANUARY 22, 2022