STATE OF OREGON

DEPARTMENT OF CONSUMER & BUSINESS SERVICES

DIVISION OF FINANCIAL REGULATION

REPORT OF FINANCIAL EXAMINATION

OF

PROVIDENCE HEALTH PLAN
PORTLAND, OREGON

AS OF

DECEMBER 31, 2016

STATE OF OREGON

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OF

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PORTLAND, OREGON

NAIC COMPANY CODE 95005

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

NAIC Company Code 95005

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 Plan. The last examination of this health care service contractor was completed as of December 31, 2012. This examination covers the period from January 1, 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

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

On January 6, 2016, the Director approved an Order of Exemption allowing the Combination of the upstream parent, Providence Health & Services, with St. Joseph's Health System, a California non-profit public benefit corporation. The two entities formed Providence St. Joseph Health, a Washington non-profit corporation, to become the new parent. On May 9, 2016, the Director approved an Order of exemption allowing a corporate reorganization to facilitate the consolidation of the hospital systems under one holding company, which includes the Plan's insurance business. Subsequent to the examination date, the parties filed a NAIC Form A filing to request the Division of Financial Regulation approve a change of control of the Plan.

Capitalization

The Plan was initially capitalized by the member hospitals of Sisters of Providence in Oregon. The Company commenced business with initial funding of $400,000. This funded amount was returned and currently no gross paid-in or contributed surplus was reported by the Plan. During the period under examination, the Plan's surplus was comprised entirely of unassigned funds.

Dividends and Other Distributions

During the period under examination, the Plan paid $6 million in cash distributions to its sole member based on a $9 million dividend declaration date of December 16, 2011. The Division of Financial Regulation approved the distribution on January 19, 2012, as follows:

Declared Date	Paid Date	Amount	Description
12/16/2011	3/22/2013	$3,000,000	Ordinary
12/16/2011	7/25/2014	$3,000,000	Ordinary

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 Plan, Providence Health Assurance (PHA), and Providence Plan Partners (PPP) by designating currently serving PPP Board members as both the Plan's and PHA'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 Board began directly approving the compensation of its CEO and senior officers. The Plan's Board approves an annual budget, which includes salaries and compensation of its officers that 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

The Plan last amended its Articles of Incorporation on July 1, 2016. The changes named the Plan as the Corporation, established the Plan's Board of Directors and Bylaws, and named its sole member as Providence Health & Services. 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 the 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) nor 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
Allison S. Schrupp	Chief Administrative Officer

Officer	Office
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.

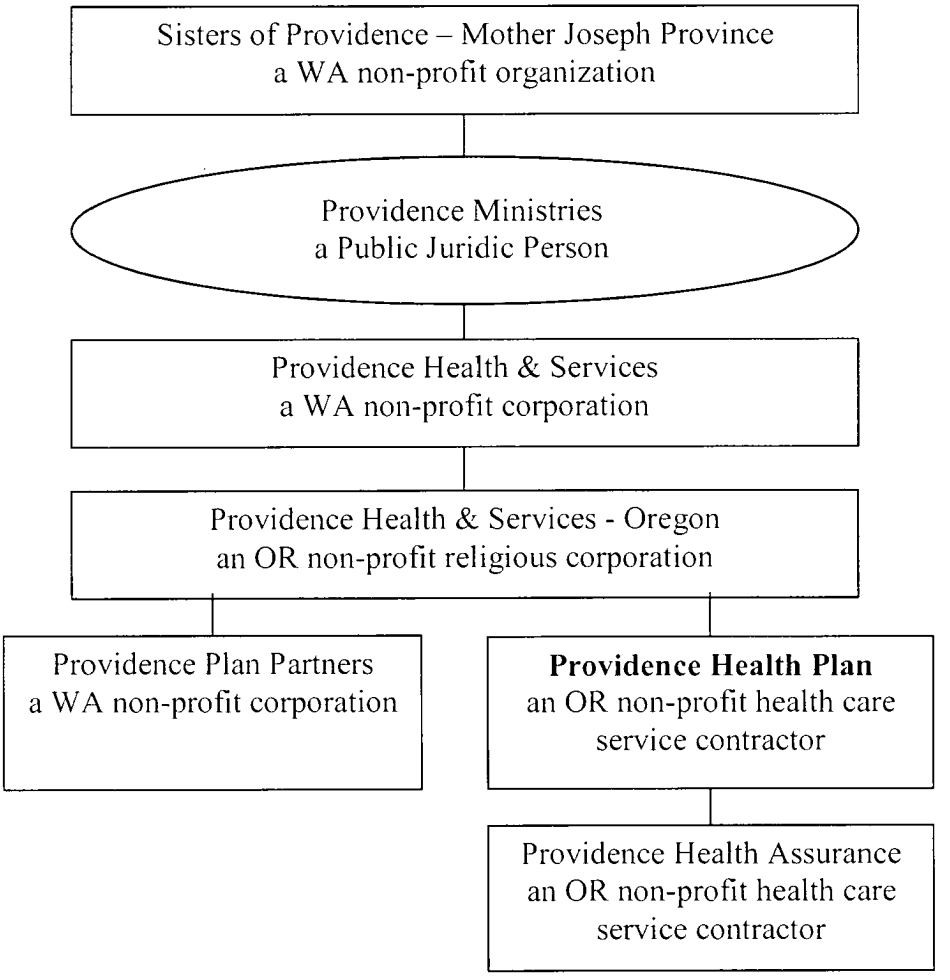
The Code of Conduct requires all employees at the director level and above, including Board members, and senior officers to complete and sign annual conflict of interest statements. Other employees are required to complete this form based on their roles within the organization. Additionally, any employee 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 remains 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 the Plan and the 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 Assurance (PHA) is an Oregon nonprofit organization which was formed to handle Medicaid business for Oregon members. All Medicaid business for Oregon members was transferred to PHA on January 1, 2004. 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. The Plan is the sole member of PHA.

INTERCOMPANY AGREEMENTS

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

Management Services and Agency Agreement – Effective January 1, 2005, the Plan entered into an agreement with PPP for overall management and administrative services. These services include employee staff, accounting, financial reporting, utilization review and cost controls, professional and quality control, patient referral procedures, marketing and sales support, and other administrative services. PHS-OR provides all employees and related business expenses to PPP at cost. PPP shall calculate the cost of all services provided to the Plan, which shall be paid prior to the close of each month's fiscal period. Cost shall be determined through PPP's cost accounting by product line and shall be updated on an annual basis. PPP may if it so chooses,

but is not required to, charge a reasonable fee for administering expenses on behalf of the Plan. This agreement was replaced by a Management Services Agreement effective January 1, 2011. The terms and conditions under the new agreement are substantially the same, but language was removed requiring a common paymaster using separate bank checking accounts.

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

TERRITORY AND PLAN OF OPERATION

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

Individual and family plans, including a child-only coverage, serve Oregon residents who are under age 65 and not eligible for Medicare. Service area includes the Portland metro area, Willamette Valley, Hood River, North Coast, Southern Oregon and Central Oregon. Coverages include a range of medical services at various benefit levels, including preventative and routine health care services for illness and injury. They include prescription drug benefits, wellness benefits and access to health resources.

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

Administrative Services include COBRA administration, third party self-funded or ASO contracts, and workers compensation management.

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

Line of Business	**2016**	**2015**	**2014**	**2013**	**2012**
Individual hospital & medical	104,996	29,855	12,017	13,782	13,647
Group hospital & medical	166,688	137,689	127,871	124,268	129,243
Medicare supplement	0	0	168	223	260
Vision only	0	2,633	2,392	1,742	1,565
Dental only	0	0	0	0	0
FEHBP	0	0	0	0	0
Medicare	0	48,244	44,963	43,790	41,029
Medicaid	0	0	0	0	0
Other	0	0	0	0	0
Total enrollment	271,684	218,421	187,411	183,805	185,744

GROWTH OF THE COMPANY

Growth of the Plan over the past five years 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 Division of Financial Regulation.

Year	Assets	Liabilities	Capital and Surplus	Net Income (Loss)
2012*	$ 654,409,981	$ 184,142,891	$ 470,267,090	$ 49,837,395
2013	692,937,767	186,093,090	506,844,677	47,206,004
2014	762,123,640	231,730,526	530,393,114	22,335,349
2015	799,297,273	334,677,556	464,619,718	(63,042,540)
2016*	750,735,770	284,543,396	466,192,374	(28,116,816)

*Per examination

LOSS EXPERIENCE

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

	(1)	(2)	(2)/(1)	(3)	(2)+(3)/(1)
Year	Total Revenues	Total Hospital and Medical	Medical Loss Ratio	Claim Adjustment and General Expenses	Combined Loss Ratio
2012*	$ 1,057,563,082	$ 936,529,310	88.6%	$ 89,416,809	97.0%
2013	1,076,191,333	957,438,364	88.9%	90,600,110	97.4%
2014	1,102,061,344	989,928,261	89.8%	112,155,602	100.0%
2015	1,193,246,524	1,148,437,939	96.2%	121,248,426	106.4%
2016*	1,107,647,527	1,101,916,822	99.4%	108,770,158	109.3%

*Per examination

A combined loss incurred and expense to premium ratio of more than 100% would indicate an underwriting loss. The Plan reported underwriting gains in 2012, 2013, and 2014 and underwriting losses in 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. In the period from 2013 to 2015, the Plan 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. In the period from 2014 to 2016, it was covered by annual policies with PartnerRe America Insurance Company (NAIC # 11835), a Delaware domiciled property & casualty insurer, authorized in Oregon on January 22, 1981. Both reinsurers are authorized to write health insurance in Oregon. Additionally, in the period from 2014 to 2016, the Plan was covered under the Federal Reinsurance Program with the U.S. Department of Health & Human Services as part of the Affordable Care Act.

Under the 2016 PartnerRe America Insurance Company policy, the reinsurer agrees to reimburse the Plan for losses per member up to an unlimited maximum for each covered member after a retention of $550,000. The Plan pays a fixed PMPM premium for each commercial HMO, PPO, POS Group, and commercial exchange covered 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, long term acute care, hospital based physician services, eligible pharmaceuticals, ambulance services, and retail prescription drugs.

In view of the Plan's adjusted capital and surplus of $466,192,374 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 two recommendations made in the 2012 report of examination, however, no adjustments were made to surplus as a result of the examination findings.

1) I recommend the Board formally approve all distributions by resolution, and that any future distributions be submitted to the Division of Financial Regulation within five business days after declaration by the Board, pursuant to ORS 732.554 and 732.576.
2) I recommend the Plan develop a procedure to have the Board of Directors, or the Audit and Compliance 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 733.740.

The current examination noted no instances of reoccurrence the first recommendation. No dividends or distributions were declared by the Plan during the period under examination. The second recommendation was not complied with during the period under examination.

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 PLAN
ASSETS
As of December 31, 2016

Assets	Balance per Company	Examination Adjustments	Balance per Examination	Notes
Bonds	$ 308,275,878	$ -	$308,275,878	1
Common stocks	266,916,159	-	266,916,159	1
Properties occupied by the company	59,559,734	-	59,559,734	
Cash, cash equivalents and short-term investments	61,312,891	-	61,312,891	1
Receivable for securities	7,438,718	-	7,438,718	
Aggregate write-ins for invested assets	-	-	-	
Subtotal, cash and invested assets	703,503,380	-	703,503,380	
Investment income due and accrued	1,342,446	-	1,342,446	
Premiums and considerations				
Uncollected premiums, agents' balances in course of collection	3,918,225	-	3,918,225	
Amounts recoverable from reinsurers	23,249,983	-	23,249,983	
Amounts receivable relating to uninsured plans	7,232,908	-	7,232,908	
EDP Equipment	1,008,894	-	1,008,894	
Health care receivable	10,479,934	-	10,479,934	
Aggregate write-ins for other than invested assets	-	-	-	
Total Assets	$ 750,735,770	$ -	$750,735,770	

PROVIDENCE HEALTH PLAN
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	$ 108,284,446	$ -	$ 108,284,446	2
Accrued medical incentive pool and bonus	0	-	0	
Unpaid claim adjustment expenses	3,178,841	-	3,178,841	2
Aggregate health policy reserves	0	-	0	2
Premiums received in advance	32,227,637	-	32,227,637	
General expenses due or accrued	4,589,672	-	4,589,672	
Ceded reinsurance premiums payable	3,680,460	-	3,680,460	
Amounts due to parent, subsidiaries and affiliates	21,070,266	-	21,070,266	
Payable for securities	36,729,719	-	36,729,719	
Liability for amounts held under uninsured plans	22,295,784	-	22,295,784	
Aggregate write-ins for other liabilities	52,486,571	-	52,486,571	
Total Liabilities	$ 284,543,396	$ -	$ 284,543,396	
Common capital stock	$ -	$ -	$ -	
Gross paid in and contributed surplus	-	-	-	
Unassigned funds (surplus)	466,192,374	-	466,192,374	
Surplus as regards policyholders	466,192,374	-	466,192,374	
Total Liabilities, Surplus and other Funds	$ 750,735,770	$ -	$ 750,735,770	

PROVIDENCE HEALTH PLAN
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	$1,107,647,527	$ -	$1,107,647,527	
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	1,107,647,527	-	1,107,647,527	
Hospital and Medical:				
Hospital/medical benefits	580,360,695	-	580,360,695	
Other professional services	239,273,066	-	239,273,066	
Outside referrals	96,639,546	-	96,639,546	
Emergency room and out-of-area	37,920,687	-	37,920,687	
Prescription drugs	143,912,881	-	143,912,881	
Aggregate write-ins for other hospital and medical	3,828,224	-	3,828,224	
Incentive pool, withhold adjustments and bonus amounts	(18,277)	-	(18,277)	
Subtotal	1,101,916,822	-	1,101,916,822	
Less:				
Net reinsurance recoveries	33,360,042	-	33,360 042	
Total medical and hospital	1,068,556,780		1,068,556,780	
Non-health claims	-	-	-	
Claim adjustment expenses	27,152,150	-	27,152,150	
General administrative expenses	81,618,008	-	81,618,008	
Increase in reserves for life and accident and health contracts	(28,281,000)	-	(28,281,000)	
Total underwriting deductions	1,149,045,938	-	1,149,045,938	
Net underwriting gain or (loss)	(41,398,411)	-	(41,398,411)	
Net investment income earned	11,317,077	-	11,317,077	
Net realized capital gains (losses)	1,964,518	-	1,964,518	
Net investment gains (losses)	13,281,595	-	13,281,595	
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)	$ (28,116,816)	$ -	(28,116,816)	

PROVIDENCE HEALTH PLAN
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	$464,619,717	$530,393,114	$506,844,677	$470,267,090
Net income (loss)	(28,116,816)	(63,042,540)	22,335,349	47,206,004
Change in net unrealized capital gains or (losses)	241,295,222	4,177,836	6,988,803	(2,380,158)
Change in net unrealized foreign exchange capital gain or (loss)	-	-	-	-
Change in net deferred income tax	-	-	-	-
Change in nonadmitted assets	4,049,408	(6,908,693)	(2,775,715)	(5,248,259)
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	-	-	-	-
Transferred to capital (Stock Dividend)	-	-	-	-
Transferred from capital	-	-	-	-
Distributions to parent (cash)	-	-	(3,000,000)	(3,000,000)
Change in treasury stock	-	-	-	-
Examination adjustment	-	-	-	-
Aggregate write-ins for gains and losses in surplus	(215,655,157)	-	-	-
Change in surplus as regards policyholders for the year	1,572,657	(65,773,397)	23,548,437	36,577,587
Surplus as regards policyholders, December 31, current year	$466,192,374	$464,619,717	$530,393,114	506,844,677

NOTE: The aggregate write-ins for gains and loses in surplus in 2016 represents amounts contributed to PHA upon transfer of Medicare Advantage line of business. See Note 1.

NOTES TO FINANCIAL STATEMENTS

Note 1 – Invested Assets

At year-end 2016, the Plan's long-term bond investments were in a diversified portfolio of US obligations, US federal agency bonds, municipal obligations and corporate issues. The Plan reported direct exposure in mortgaged-backed or asset-backed securities in the amount of $134,250,974, equal to 43.5% of total bonds and 19% of total invested assets.

In the 2016 filed Annual Statement, 98% percent of the common stocks balance consisted of an investment in a wholly-owned subsidiary.

The Plan reported $4,214,417 in short-term investments. Cash on deposit was held in fifteen accounts at US Bank, one account at Albina Bank and one account at the Northern Trust Company.

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

Year	A Bonds	B Common Stocks	C Cash and Short-term	Ratio A/ Total Assets	Ratio B/ Total Assets	Ratio C/ Total Assets
2012*	510,242,875	10,390,243	39,754,456	78.0%	1.6%	6.1%
2013	542,329,872	10,062,540	49,103,579	78.3%	1.4%	7.1%
2014	583,020,335	17,098,727	56,679,010	76.5%	2.2%	7.4%
2015	547,387,453	21,271,284	130,320,157	68.5%	2.7%	16.3%
2016*	308,275,878	266,916,159	61,312,891	41.1%	35.5%	8.2%

* Balance per examination.

During 2016, the Plan contributed assets and cash to its subsidiary, PHA, to 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 733.740. The Plan uses a discretionary advisor, Pavilion Advisory Group as its investment consultant and TCW Investment Management Company, LLC to actively manage its portfolio. Transactions are monitored by an investment officer with PHS, who reports the transactions to the CFOs of PHS and the Plan.

As a repeat from the 2012 examination, I again recommend the Plan develop a procedure to have the Board of Directors, or a responsible Committee of the Board, approve all

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

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 most of the 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 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	$ 90,591,606	$ 108,284,446
Accrued Medical Incentive Pool and Bonus Payments	-	-
Unpaid Claims Adjustment Expenses (CAE)	3,178,841	3,178,841
Aggregate Health Policy Reserves	-	-
Aggregate Health Claim Reserves	-	-
Rate Stabilization Reserve for Groups	5,847,216	5,847,216
ACA Risk Adjustment Payable	35,300,000	35,300,000
Total Actuarial Liabilities	$ 134,917,663	$ 152,610,503

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 $17.7 million, a difference of 16.4%, indicating a reserve redundancy. He concurred that the reserves of the Plan were reasonably stated as of December 31, 2016.

SUMMARY OF COMMENTS AND RECOMMENDATIONS

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

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26 As a repeat from the 2013 examination, I again recommend the Plan develop a procedure to have the Board of Directors, or a responsible Committee of the Board, approve all investment transactions on a regular basis, and that a formal resolution be voted on by the Board at the meetings, pursuant to ORS 733.730.

CONCLUSION

During the four year period covered by this examination, the surplus of the Plan has decreased from $470,267,090, as presented in the December 31, 2012, report of examination, to $466,192,374, as shown in this report. The comparative assets and liabilities are:

	December 31,		
	2016	2012	Change
Assets	$ 750,735,770	$ 654,409,981	$ 96,325,789
Liabilities	284,543,396	184,142,891	100,400,505
Surplus	$ 466,192,374	$ 470,267,090	$ (4,074,716)

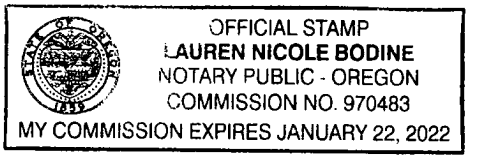
ACKNOWLEDGMENT

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 Plan, Portland, Oregon.

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

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

The affiant says nothing further.

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