STATE OF OREGON

DEPARTMENT OF CONSUMER & BUSINESS SERVICES

DIVISION OF FINANCIAL REGULATION

REPORT OF FINANCIAL EXAMINATION

OF

SAMARITAN HEALTH PLANS, INC.
CORVALLIS, OREGON

AS OF

DEC. 31, 2021

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NAIC COMPANY CODE 12257

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SALUTATION

June 6, 2023

Honorable Andrew Stolfi, director
Department of Consumer and Business Services
State of Oregon
350 Winter St. NE
Salem, OR 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

SAMARITAN HEALTH PLANS, INC.
3600 NW SAMARITAN DRIVE
CORVALLIS, OR 97330

NAIC Company Code 12257

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

SCOPE OF EXAMINATION

We have performed our regular, single-state, full-scope financial examination of Samaritan Health Plans Inc. The last examination of this health care service contractor was completed for the period ending Dec. 31, 2018. This examination covers the period of Jan. 1, 2019, through Dec. 31, 2021.

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

All accounts and activities of the plan were considered in accordance with the risk-focused examination process. This may include assessing significant estimates made by management and evaluating management's compliance with statutory accounting principles. The examination does not attest to the fair presentation of the financial statements included herein. If, during the course of the examination an adjustment is identified, the effect of such an adjustment will be documented separately following the plan's financial statements.

This examination report includes significant findings of fact, as mentioned in ORS 731.302 and general information about the insurer and its financial condition. There may be other items identified during the examination that, due to their nature (e.g., subjective conclusions and

proprietary information), are not included within the examination report, but separately communicated to other regulators and the plan.

COMPANY HISTORY

The plan is an Oregon private nonprofit mutual benefit corporation formed pursuant to Chapter 65 of the Oregon Revised Statutes with Samaritan Health Services Inc. (SHS) as its sole member. The plan was formed on May 16, 2004, and received a certificate of authority as a health care service contractor Jan. 31, 2005. In May, 2005 the plan received approval from the Centers for Medicare and Medicaid Services (CMS) to become a coordinated care plan. On July 24, 2013, the plan applied for, and received approval from, the Oregon Division of Financial Regulation to operate commercial small group insurance plans under the product names Samaritan Oregon Standard Bronze and Samaritan Standard Silver, and to operate a large group insurance plan under the product name Everyday Choices Plan. The plan was authorized by the Oregon Division of Financial Regulation to begin member sign-ups and plan operations on Jan. 1, 2015.

Capitalization

The plan was formed by SHS with paid-in and contributed surplus from SHS. These contributions totaled $3,950,000 and there were no changes during the period under examination. In addition, the plan issued two surplus notes, as follows:

Purchaser	Issued	Principal	Rate	Maturity
Samaritan Health Services, Inc.	03/28/2008	$ 1,500,000	3.00%	12/31/2022
Samaritan Health Services, Inc.	12/22/2014	600,000	3.00%	12/31/2023
Total		$ 2,100,000		

Both notes have annual payments due on Dec. 31. During the period under examination, all interest payments were made with the approval of the director. The entire principal amounts and any unpaid accrued interest shall be paid by the maturity dates, at the latest.

Dividends to stockholders and other distributions

During the period under examination, the plan did not declare or pay any dividends or make any distributions to its direct parent.

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 described 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 authorize the board to create one or more committees. The committees authorized by the board are an audit committee and an enterprise risk management (ERM) committee. The committees' actions are summarized and reported to the board of directors during their regular meetings. The audit committee is a subset of the board and consists of all members of the board. It is responsible for reviewing and approving all audit services performed by the external auditors. During the period under exam, the audit committee did not operate under a formal charter; however, the plan did formally appoint an external auditor.

The ERM Committee has a charter to develop an ERM framework that will identify, evaluate, report, and monitor all types of risks facing the plan. The committee appears to be following its charter.

The plan's board does not directly approve the compensation of all its senior officers. Instead, the parent's board sets compensation for the chief executive officer (CEO) and chief financial officer (CFO). The CEO sets the compensation for the other officers of the plan. The plan's board

approves an annual budget that includes salaries and compensation reimbursed under an intercompany agreement. This process complies with the provisions of ORS 732.320(3).

Articles of incorporation

The plan last amended its articles of incorporation on Dec. 19, 2016. The articles of incorporation conformed to the Oregon Insurance Code.

Bylaws

The plan's bylaws were last amended and restated as of Aug. 25, 2014. The plan's bylaws conformed to the Oregon Insurance Code.

MANAGEMENT AND CONTROL

Board of directors

The restated articles of incorporation state the affairs of the corporation shall be managed by a board of directors. In Article IV, Section 1, the number of directors shall be no less than seven and no more than 15. As of Dec. 31, 2021, the plan was governed by a five-member board of directors as follows:

Name and Address	Principal Affiliation	Representative	Member Since
Douglas Ross Boysen * Corvallis, Oregon	Executive VP and chief administrative officer Samaritan Health Services, Inc.	Company	2015
Bruce William Madsen, MD Albany, Oregon	Ophthalmologist EyeCare Associates	Medical	2011
Robert Turngren Corvallis, Oregon	Physician Samaritan Health Services	Public	1993
James Samuel Merryman Corvallis, Oregon	President Oregon Freeze Dry, Inc.	Public	2014

Doris Maye Mimnaugh Corvallis, Oregon	Retired educator	Public	2004

*Chairman

The directors, as a group, had experience in insurance, law, and management, in accordance with the provisions of ORS 731.386. The Insurance Code requires at least one-third of the board of directors be representatives of the public who are not practicing doctors, employees, or trustees of a participant hospital. The plan was in compliance with ORS 750.015.

Officers

Principal officers serving at Dec. 31, 2021, were as follows:

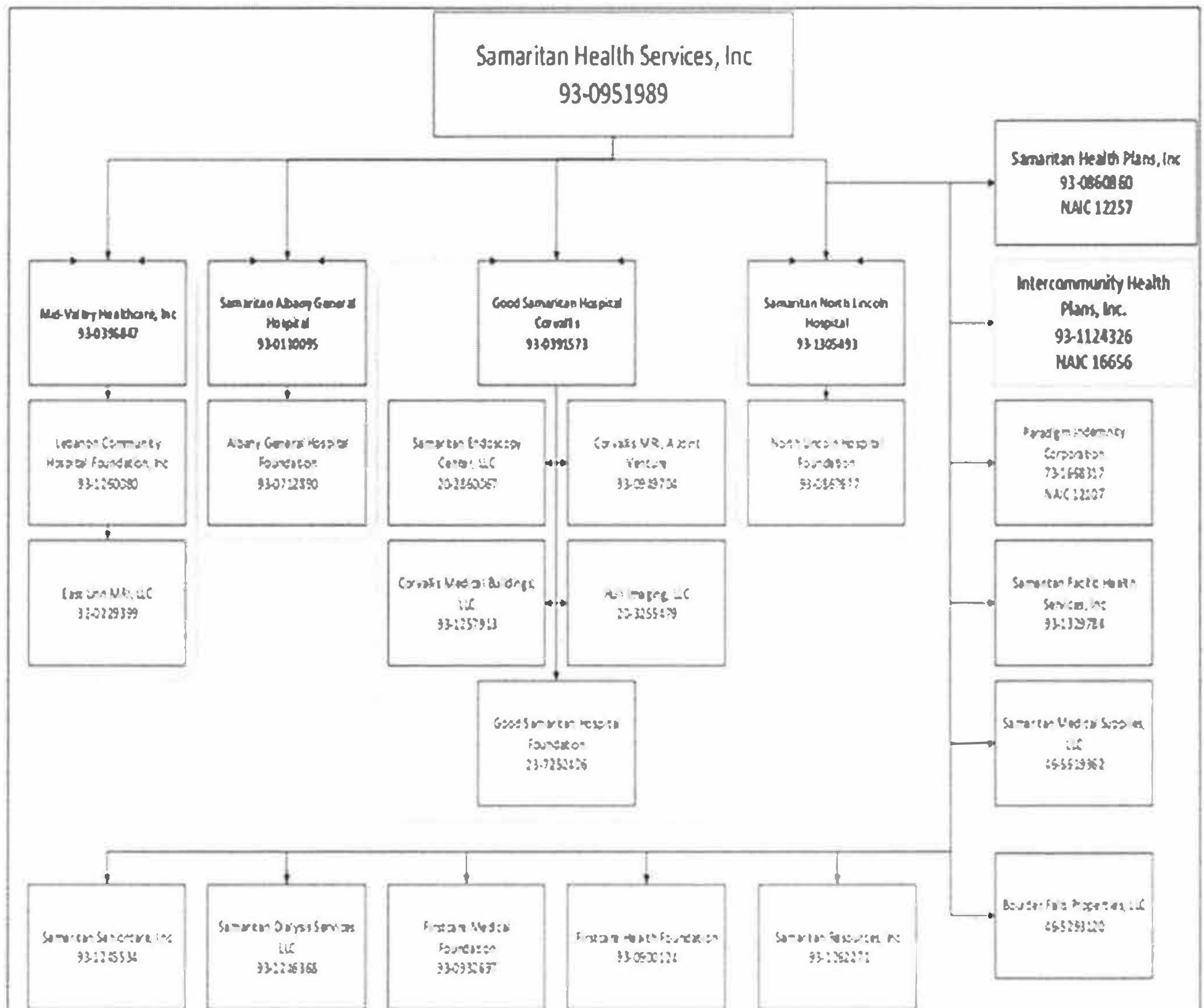
Name	Title
Bruce W. Butler	Chief executive officer
Daniel B. Smith	Chief financial officer

Conflict of interest

SHS's board adopted a code of conduct policy to guide ethical behavior and help reduce criminal conduct. The policy requires all board members, senior officers, and key employees to sign a conflict of interest statement annually. Further, employees are required to have annual ethics training, and a whistleblower program was established for employees to report any suspicious activity or concerns anonymously. From a review of the completed conflict of interest questionnaires, the plan did not perform due diligence in completing the conflict of interest statements as the board of directors and officers did not provide signed conflict of interest disclosure statements for 2021. As a result, the plan did not comply with its code of conduct policy.

Insurance company holding system

An insurance holding company registration statement was filed by the plan in accordance with the provisions of ORS 732.552, ORS 732.554, and Oregon Administrative Rule (OAR) 836-027-0020(1). SHS is the ultimate controlling entity that is the sole member of five Oregon hospitals and a number of health-related entities, including the plan. The following abbreviated organizational chart shows the relationship within the insurance holding company system.



A description of the entities within the holding company includes five affiliated hospitals, as follows:

Albany General Hospital, dba Samaritan Albany General Hospital, was formed on April 22, 1924. It serves the greater-Albany area as an acute care facility and health center.

Mid-Valley Healthcare Inc., dba Samaritan Lebanon Community Hospital, was formed on June 5, 1950. It is a critical access hospital serving the east Linn County communities of Lebanon, Sweet Home, Brownsville, and smaller neighboring towns.

Good Samaritan Hospital Corvallis, dba Good Samaritan Regional Medical Center, was formed on April 7, 1948. It is the largest hospital in Linn, Benton, and Lincoln counties.

Samaritan North Lincoln Hospital, was founded in 1967 and incorporated on Oct. 31, 2000. It is based in Lincoln City.

Samaritan Pacific Health Services Inc., dba Samaritan Pacific Communities Hospital, was founded in 1952 and incorporated on Nov. 7, 2001. It serves the communities of Newport, Waldport, Toledo, Depoe Bay, and Yachats in Lincoln County.

Other affiliates of the plan include:

InterCommunity Health Plans Inc., dba InterCommunity Health Network, was formed on April 30, 1993, by Albany General Hospital, Good Samaritan Hospital Corvallis, and Lebanon Community Hospital to write Oregon Health Plan business through the Division of Medical Assistance Program. It recently obtained authority to write business as a coordinated care organization through the Oregon Health Authority.

Paradigm Indemnity Corporation is a Hawaii domiciled nonprofit captive insurance company formed by SHS on May 1, 2003, to directly insure its subsidiary hospitals and employed or contracted physicians for professional liability and general liability coverage.

Samaritan Dialysis Services, LLC was formed on July 7, 1998, and is currently a shell company. It had been providing a dialysis program for SHS, but sold all its operating assets, including its license and personal property, to Fresenius Medical Care effective Oct. 23, 2011.

Samaritan Seniorcare, Inc. is a corporation that historically was a senior living facility. The building and related activity no longe exists; however, the legal entity is still active with the Oregon Secretary of State.

Firstcare Medical Foundation is a corporation that was affiliated with Albany General Hospital for physician activity, however, it was incorporated into AGH more than 10 years ago. The legal entity is still active with the Oregon Secretary of State.

Firstcare Health Foundation is the legal name for Albany In-reach Clinic

Samaritan Resources Inc. was a corporation that provided janitorial services for Samaritan Health Services; however, the activity is not part of other SHS entities. The legal entity still exists with the Oregon Secretary of State.

Samaritan Medical Supplies LLC is a limited liability company for durable medical equipment services that Samaritan provides to patients.

Boulder Falls Properties LLC is a limited liability company that holds the Samaritan portion of the lodges in Lebanon, Oregon, for the apartment rental joint venture there.

Intercompany Agreements

Management services are provided by SHS to staff operations and to efficiently manage the plan. The plan reimburses SHS for the actual salary costs plus benefits for its allocated portion of the utilized staff. Cost efficiencies are realized in creating a flexible workforce with cross-training and shared management.

Annually, as part of the budget process, the management of the plan's operations evaluates the shared expenses in relation to the past experience, effort, complexity, implementation issues, and membership estimates of each of its subsidiary health plans to determine the percentage allocation for the next budget year. These corporate expenses are recorded on the books of SHS Corporate department on a monthly basis, and then allocations are transferred to the individual entities entity through journal entries.

In 2014, a separate allocation was added related to claims payment-processing services that are used primarily based on the volume of claims processed. This allocates salaries, benefits, and specific expenses subject to claims volume for each plan. The allocation percentage will be adjusted quarterly based on claims processed. The corporate expenses will be recorded in the Samaritan Health Plan Operations (SHPO) corporate claims department. During the period under examination, the allocations were:

Entity	2021	2020	2019
Samaritan Health Plans, Inc. (Advantage Plan)	10.13%	13.81%	12.42%
InterCommunity Health Plans, Inc. (CCO)	78.49%	74.12%	72.87%
Samaritan Health Services, Inc. (Samaritan Choice Plans)	9.89%	11.96%	11.25%
Commercial – Small Group	0.23%	0.05%	0.24%
Commercial – Large Group	1.26%	0.06%	3.22%
Total	100%	100%	100%

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

Lease agreement

Effective Jan. 1, 2020, the plan entered into a lease agreement with SHS. The agreement replaced, in its entirety, the existing series of agreements and amendments governing the lease of professional office space by SHP from SHS. The lease applies to approximately 52,216 square feet of office space in the Walnut Building at 2300 Walnut Boulevard, Corvallis, Oregon. Under the terms of the agreement, SHS (lessor) leases the above premises to SHP (lessee) for a term beginning on Jan. 1, 2020, and continuing until Dec. 31, 2024, with an option to extend the lease until Dec. 31, 2027. The monthly rental is determined on a per square foot basis with specified amounts per square foot. The amounts are specified for the period from Jan. 1, 2020, through Dec. 31, 2027. The monthly rental is payable on or before the first day of each calendar month throughout the lease term.

Administrative and staff reimbursement agreement

Effective Jan. 1, 2008, and amended annually, the plan and SHS entered into an agreement whereby SHS agrees to provide administrative services and staff services to the plan in exchange for a set monthly fee. Administrative services include human resources, payroll, accounting, risk management, investments, materials management, and stores. Staff services include medical director services and related support staff. Monthly administrative staff reimbursement amounts are updated annually. SHS will evaluate the reimbursement amounts in comparison with actual costs for fairness and reasonableness. Any required true-ups will be completed by March 31 following the agreement year.

Services agreement for credentialing services

Effective Jan. 15, 2016, SHS and its subsidiaries, including the plan, entered into an agreement to provide credentialing services as an independent contractor to maintain the plan's provider network. SHS agrees to participate in the quality assurance and performance improvement program and external quality review, credentialing, and utilization review system and beneficiary grievance procedures established by the plan. Compensation is a fixed amount per year, allocated based on the shared-expenses method described above. Services provided by SHS include:

- Primary and secondary source verification for all health plans contracted by providers
- Periodic monitoring of all credentialed providers
- Management of re-appointment and re-credentialing process
- Administration of the SHS Credentials Committee

Guaranty agreement

Effective Nov. 19, 2008, the plan and SHS entered into an agreement whereby SHS agrees to guarantee the financial obligations of the plan. SHS also agrees to guarantee to provide health care services to the plan's subscribers, enrollees, and dependents in the event the plan is discontinued prior to the expiration of its contracts.

Agreement with Intercommunity Health Plans

Effective Aug. 1, 2018, the plan entered an agreement with IHP, dba Intercommunity Health Network CCO. Under the agreement, IHP agrees to reimburse the plan 23 percent of the dual premium received throughout the year for the plan's management of the dually enrolled special needs members as long as costs incurred on IHN for these members do not exceed 23

percent of the dual premium received during the year. The reimbursement is due to the plan by June 1 of the following year.

2015 SHP and IHP dual eligible agreement

The plan is required through its annual contract with CMS to provide extensive, regulated, and labor intensive care management approaches through the "Model of Care" required for all special needs plan members. Effective Jan. 1, 2019, the agreement was amended to require IHP to reimburse SHP 13 percent of the dual premium received throughout the year for SHP's management of the dually enrolled special needs members as long as costs incurred on IHN for these members do not exceed 13 percent of the dual premium received during the year. Any saving above cost are due to SHP by June 1 of the following year. Effective Jan. 1, 2021, the requirement for IHP to reimburse SHP 13 percent of the dual premium received throughout the year for the plan's management of the dually enrolled special needs members was terminated.

Fee agreement with Intercommunity Health Plans

Effective calendar year 2014, the plan entered an agreement with IHP, dba Intercommunity Health Network CCO. Under the agreement the plan holds the relationship with vendors and providers necessary to perform the work needed of IHP, and is required through its contract with CMS to provide extensive, regulated, and labor intensive management approaches through compliance requirements, a compliance plan, regulatory affairs, members' rights and advocacy, provider education, health care effectiveness data and information set (HEDIS) reporting, and risk stratification. IHP agrees to pay the plan $5 per member per month on an annual basis. Effective Feb. 2, 2021 the agreement was amended to require IHP to pay the plan $3.90 per member per month on an annual basis.

FIDELITY BOND AND OTHER INSURANCE

The examination of insurance coverages involved a review of adequacy of limits and retentions, and the solvency of the insurers providing the coverages. The insurance coverages are provided through insurance policies issued by an unaffiliated carrier covering SHS and all majority-owned subsidiary companies as a named insured. The group, as a whole, is insured up to $5 million per individual loss, with a $250,000 retention against losses from acts of dishonesty 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 Dec. 31, 2021, were found to be adequate, and included:

Workers Compensation
Kidnapping and Extortion Coverage
Directors and Officers Liability
Managed Care Errors and Omissions
Automobile Coverage
Employed Lawyers Professional Liability
Professional Liability
Cyber Breach Coverage
Property Coverage

TERRITORY AND PLAN OF OPERATION

The plan is authorized to conduct business as a health care service contractor in Oregon. The plan is a locally managed Medicare plan for eligible residents of Linn, Benton, and Lincoln counties under a contract with the Centers for Medicare and Medicaid Services (CMS). The plan contracts with certain SHS hospitals and medical groups to provide or arrange hospital and medical services to members, including hospitalization coverage, doctor office visits, emergency care, urgent care, routine physical exams, skilled nursing facility care, chiropractic and acupuncture services, vision services, and preventative and diagnostic services. In addition to the conventional Medicare Advantage coverage, the plan offers a premier plan, premier plus plan and special needs plan for an extra monthly premium. These offer additional benefits such as outpatient prescription

drugs, dental benefit, hearing aid benefit, and durable medical equipment. The plan sells commercial plans to small (50 employees or less) and large groups mainly residing in the Mid-Willamette Valley. On July 24, 2013, the plan applied for and received approval from the Oregon Division of Financial Regulation to operate commercial small group insurance plans under the product names Samaritan Oregon Standard Bronze and Samaritan Oregon Standard Silver and a large group insurance plan under the product name Everyday Choices Health Plan. The plan was authorized by the Oregon Insurance Division to begin member sign-ups and plan operations on Jan. 1, 2015.

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

Line of Business	2021	2020	2019	2018	2017
Indiv. hospital and medical	-	-	-	-	-
Group hospital and medical	1,616	3,270	4,757	5,816	5,251
Medicare supplement	-	-	-	-	-
Dental	-	-	-	-	-
Medicare	5,677	5,494	5,176	5,042	5,027
Total enrollment	7,293	8,764	9,933	10,858	10,278

GROWTH OF THE COMPANY

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

Year	Assets	Liabilities	Surplus and other funds	Net income (loss)
2017	30,764,164	15,448,026	15,316,137	5,084,041
2018 *	25,328,951	13,943,317	11,385,633	(3,062,532)
2019	24,566,145	12,795,321	11,770,824	489,564
2020	35,480,122	14,098,401	21,381,721	9,108,576
2021 *	33,299,600	12,495,456	20,804,144	(127,040)

*Per examination

LOSS EXPERIENCE

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

	(1)	(2)	(2)/(1)	(3)	(2)+(3)/(1)
Year	Total Revenues	Total Hospital and Medical	Medical Loss Ratio	Claim Adjustment and General Expenses	Combined Loss Ratio
2017	$92,195,782	$72,613,441	78.8%	$12,091,718	91.9%
2018 *	$89,061,540	$80,543,927	90.4%	$13,445,912	105.5%
2019	$96,619,711	$80,628,176	83.4%	$15,889,985	99.9%
2020	$99,399,128	$74,452,371	74.9%	$13,557,939	88.5%
2021 *	$84,726,528	$73,407,371	86.6%	$11,824,988	100.6%

*Per examination

A combined claims and expense to premium ratio in excess of 100 percent typically indicates an underwriting loss. The plan reported underwriting gains in three of the past five years.

REINSURANCE

During the period under examination, the plan had two excess of loss reinsurance policies with American Fidelity Assurance Company (NAIC No. 60410), an Oklahoma-domiciled life insurer authorized in Oregon on Dec. 15, 1971. Under the policies, the reinsurer reimbursed the plan for losses per member up to an unlimited maximum for each covered member after retention of $325,000 per member for Medicare business and $350,000 per member for a small (off-exchange) group and large- group business. The agreements contains a continuation of coverage provision providing unlimited coverage for Medicare, small-group, and large-group members, subject to limitations and exclusions in the event the plan goes insolvent. The liability of American Fidelity Assurance Company under the provision is unlimited.

The reinsurance agreements contained a proper insolvency clause that specified payments would be made to a statutory successor without diminution in the event of insolvency, as required by the provisions of ORS 731.508. Neither agreement contained a settlement clause, as required by OAR 836-012-0310, which required the reinsurer to pay all reinsured claims at least quarterly.

I recommend the plan amend its two reinsurance agreements with American Fidelity Assurance Company to include a settlement clause pursuant to the provisions of OAR 836-012-0310.

It was determined that the two reinsurance agreements did not provide for risk transfer in accordance with the requirements of the Accounting Practices and Procedures Manual, SSAP No. 61R, as there is no requirement for the reinsurer to pay the reinsured claims, or to pay them timely. ORS 731.302 states that in conducting the examination, each examiner shall consider the guidelines and procedures in the examiner handbook, or its successor publication, adopted by the National Association of Insurance Commissioners. The director may prescribe the examiner handbook or its successor publication and employ other guidelines and procedures that the director determines to be appropriate.

I recommend the plan amend the two agreements to provide for risk transfer, pursuant to the provisions of SSAP No.61R and ORS 731.302

The plan's reinsurance agreements requires the plan to retain a maximum of $350,000 per risk. In view of the plan's surplus, as adjusted for this examination, of $20,995,779 at Dec. 31, 2021, the plan did not retain risk on any one subject of insurance in excess of 10 percent of its surplus to policyholders, and complied with the maximum risk retention set by ORS 731.504.

ACCOUNTS AND RECORDS

In general, the company's records and source documentation supported the amounts presented in the company's Dec. 31, 2021, 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 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, or did not provide the requested records in a timely manner, to properly facilitate the examination.

I recommend the plan provide all record requests, and provide them in a timely manner to properly facilitate the examination in accordance with the provisions of ORS 731.308(2) and ORS 731.308(3), respectively.

STATUTORY DEPOSIT

To satisfy the statutory deposit requirements in Oregon for health care service contractors, the plan has on deposit a $275,000 certificate of deposit with the Oregon Division of Financial Regulation, Department of Consumer and Business Services, to maintain compliance with ORS 750.045. This asset was confirmed directly by US Bank and properly disclosed on Schedule E – Part 3 in the 2021 annual statement.

COMPLIANCE WITH PRIOR EXAMINATION RECOMMENDATIONS

There was one recommendation made in the 2018 report of examination that required an adjustment to surplus as a result of the examination finding. The plan was unable to provide documentation to independently confirm the reported balance for other invested assets.

I recommend that the plan maintain independent records to confirm its other invested assets in accordance with ORS 733.170 and ORS 731.308(2) and comply with SSAP No. 4, paragraph 2.

The current examination noted that the company was not in compliance with the recommendation as the year-end 2021 balance for other invested assets could not be independently confirmed.

SUBSEQUENT EVENTS

Doug Albro joined the plan as vice president of Information Servicies in 2022.

FINANCIAL STATEMENTS

The following financial statements are based on the statutory financial statements filed by the plan with the Division of Financial Regulation and present the financial condition of the plan for the period ending Dec. 31, 2021. The accompanying comments on financial statements reflect any examination adjustments to the amounts reported in the annual statement and should be considered an integral part of the financial statements. These statements include:

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

SAMARITAN HEALTH PLANS, INC.
ASSETS
As of Dec. 31, 2021

Assets	Balance per Plan	Examination Adjustments	Balance per Examination	Notes
Bonds	$ 9,140,380	$ -	$ 9,140,380	1
Common stocks	2,045,930	-	2,045,930	1
Cash, cash equivalents and short-term investments	19,003,859	-	19,003,859	1
Other invested assets	191,635	(191,635)	-	2
Receivable for securities	-	-	-	
Aggregate write-ins for invested assets	-	-	-	
Subtotal, cash and invested assets	30,381,804	(191,635)	30,190,169	
Investment income due and accrued	62,530	-	62,530	
Premiums and considerations				
Uncollected premiums, agents' balances in course of collection	76,931	-	76,931	
Accrued Retrospective Premiums	90,555		90,555	
Amounts recoverable from reinsurers	107,092	-	107,092	
Amounts receivable related to uninsured plans	1,155,872	-	1,155,872	
Current FIT recoverable	970,643	-	970,643	
Net deferred tax asset	333,703	-	333,703	
Aggregate write-ins for other than invested assets	312,106	-	312,106	
Total Assets	$ 33,491,235	$ (191,635)	$ 33,299,600	

SAMARITAN HEALTH PLANS, INC.
LIABILITIES, CAPITAL AND SURPLUS
As of Dec. 31, 2021

	Balance per Plan	Examination Adjustments	Balance per Examination	Notes
Claims unpaid	$ 9,465,807	$ -	$ 9,465,807	3
Accrued medical incentive pool and bonus amounts	554,309	-	554,309	3
Unpaid claims adjustment expense	169,697	-	169,697	
Aggregate health policy reserves	-	-	-	
Premiums received in advance	41,690	-	41,690	
General expenses due or accrued	366,317	-	366,317	
Current FIT payable	-		-	
Amounts due to parent, subsidiaries and affiliates	1,027,465		1,027,465	
Liability for amounts held under uninsured plans	863,160	-	863,160	
Aggregate write-ins for liabilities	7,012	-	7,012	
Total Liabilities	$ 12,495,456	$ -	$ 12,495,456	
Common capital stock	$ -	$ -	$ -	
Gross paid-in and contributed capital	3,950,000	-	3,950,000	
Surplus notes	2,100,000	-	2,100,000	
Unassigned funds (surplus)	14,945,779	(191,635)	14,754,144	
Surplus as regards policyholders	$ 20,995,779	(191,635)	$ 20,804,144	
Total Liabilities, Surplus and other Funds	$ 33,491,235	$ (191,635)	$ 33,299,600	

SAMARITAN HEALTH PLANS, INC.
STATEMENT OF REVENUE AND EXPENSES
For the Year Ended Dec. 31, 2021

	Balance per Plan	Examination Adjustments	Balance per Examination	Notes
Revenue				
Net premium income	$ 81,396,614	$ -	$ 81,396,614	
Change in unearned premium reserves and reserves for rate credits	-	-	-	
Aggregate write-ins for health care related revenues	3,329,914	-	3,329,914	
Total revenue	84,726,528	-	84,726,528	
Hospital and Medical:				
Hospital/medical benefits	45,512,721	-	45,512,721	
Other professional services	21,190,125	-	21.190.125	
Outside referrals	103,535	-	103,535	
Emergency room and out-of-area	1,868,685	-	1,868,685	
Prescription drugs	6,523,676	-	6,523,676	
Aggregate write-ins for other hospital and medical	-		-	
Incentive pool, withhold adjustments and bonus amounts	944,091	-	944,091	
Subtotal	76,142,833	-	76,142,833	
Less:				
Net reinsurance recoveries	2,735,462	-	2,735,462	
Total medical and hospital	73,407,371	-	73,407,371	
Non-health claims	-	-	-	
Claim adjustment expenses	4,455,630	-	4,455,630	
General administrative expenses	7,369,358	-	7,369,358	
Increase in reserves for life and accident and health contracts	-	-	-	
Total underwriting deductions	85,232,359	-	85,232,359	
Net underwriting gain or (loss)	(505,830)	-	(505,830)	
Net investment income earned	265,129	-	265,129	
Net realized capital gains (losses)	(23,498)	-	(23,498)	
Net investment gains (losses)	241,632	-	241,632	
Net gain or (loss) from agents' or premium balances charged off	-	-	-	
Aggregate write-ins for other income or expense	-	-	-	
Federal income taxes incurred	(137,158)	-	(137,158)	
Net income (loss)	$ (127,040)	$ -	$ (127,040)	

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

	2021	2020	2019
Surplus as regards policyholders, Dec. 31, previous year	$ 21,381,722	$11,770,824	$ 11,530,681
Net income (loss)	(127,040)	9,108,876	489,564
Change in net unrealized capital gains or (losses)	302,481	(37,898)	64,133
Change in net deferred income tax	77,108	(87,326)	36,056
Change in non-admitted assets	(638,491)	627,547	(349,611)
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)	-	-	-
Change in treasury stock	-	-	-
Examination adjustment	(191,635)	-	-
Aggregate write-ins for gains and losses in surplus	-	-	-
Change in surplus as regards policyholders for the year	(577,577)	9,610,899	240,142
Surplus as regards policyholders, Dec. 31, current year	$ 20,804,144	$ 21,381,722	$ 11,770,824

NOTES TO FINANCIAL STATEMENTS

Note 1 – Invested assets

At Dec. 31, 2021, the plan's long-term bond investments were mainly in a diversified portfolio of U.S. obligations and corporate issues. The company did not hold any mortgaged-backed or asset-backed securities. Common stocks consisted of two mutual funds.

Short-term investments consisted of one U.S. Treasury bond acquired on May 25, 2021, and maturing on Feb. 15, 2022. Cash equivalents consisted of one money market mutual fund.

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

Year	A Bonds	B Common Stocks	C Cash and Short-term	Ratio A/ Total Assets	Ratio B/ Total Assets	Ratio C/ Total Assets
2017	$9,208,155	$1,388,666	$19,462,189	29.9%	4.5%	63.3%
2018 *	$9,353,416	$1,279,490	$11,958,373	36.7%	5.0%	46.9%
2019	$9,527,090	$1,605,483	$10,664,372	38.8%	6.5%	43.4%
2020	$9,428,404	$1,625,412	$21,902,945	26.6%	4.6%	61.7%
2021 *	$9,140,380	$2,045,930	$19,003,859	27.3%	6.1%	56.7%

* Balance per examination

As of Dec. 31, 2021, sufficient assets were invested in amply secured obligations of the United States, the State of Oregon, or in FDIC insured cash deposits. As a result, the plan was in compliance with ORS 733.580. However, during the period under examination the plan held investments in two cash accounts that exceeded the 10 percent net admitted assets limit pursuant to ORS 733.770, meaning the plan was not diversifying its investment portfolio.

Neither the board nor any authorized committee approved the investment transactions for years 2020 and 2021, as required by ORS 733.730.

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 Jan. 26, 2005, the plan entered into a custodial agreement with US Bank, NA. The agreement contained all of the relevant protections described in OAR 836-027-0200(4)(a) through (n).

Note 2 – Other invested assets

The other invested assets consist of the an ownership interest in a limited partnership that brings provider-sponsored and independently owned health plans together with their health system and group leaders for unparalleled peer-to-peer collaboration. The plan was unable to provide documentation to independently confirm the reported balance.

Further, ORS 731.302 states that in conducting the examination, each examiner shall consider the guidelines and procedures in the examiner handbook, or its successor publication, adopted by the National Association of Insurance Commissioners. The director may prescribe the examiner handbook or its successor publication and employ other guidelines and procedures that the director determines to be appropriate. Per the Accounting Practices and Procedures Manual, SSAP No. 4-Definition of Assets and Nonadmitted Assets, paragraph 3:

The ability to meet policyholder obligations is predicated on the existence of readily marketable assets available when both current and future obligations are due. Assets having economic value other than those that can be used to fulfill policyholder obligations, or those assets that are unavailable due to encumbrances or other third-party interests should not be recognized on the balance sheet, and are, therefore, considered nonadmitted. The plan's investment in Health Plan Alliance LLC. does not qualify as an admitted asset per the requirements of SSAP No. 4, paragraph 3, as it is not readily marketable and is unavailable for use to fulfill policyholder obligations due to encumbrances and other third-party interests.

I recommend the plan non-admit its investment in Health Plan Alliance LLC, as the investment does not qualify an an admitted asset per the requirements of ORS 731.302 and SSAP No. 4 – paragraph 3.

I further recommend the plan submit an amended year-end 2022 annual statement to the Division of Financial Regulation that non-admits the year-end 2022 book value amount for Health Plan Alliance LLC, and reflects the appropriate reduction to the policyholder surplus.

Note 3 – Actuarial reserves

A review of the unpaid claims and claim adjustment expense reserves for the plan was performed by Andrew Bux, FSA, MAAA, life and health actuary for the Oregon Division of Financial Regulation. As part of his review, he examined the Statement of Actuarial Opinion and supporting actuarial memorandum as of Dec. 31, 2021, prepared by Christopher S. Carlson, FSA, MAAA, of Oliver Wyman Actuarial Consulting.

Mr. Bux reviewed the reconciliation of the data used in the company'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 analysis on the actuarial liabilities and assets included in the 2021 actuarial opinion as supported by the actuarial memorandum. Further, he prepared an

independent actuarial estimate for Medical IBNR. He also had access to lag triangles for nine months in 2022, allowing him to check Mr. Carlson's estimates with more recent data in terms of claims runout. Based on his review, he determined that the reserves were developed according to Actuarial Standards of Practice (ASOP) and were within a reasonable range to be sufficient to cover expected liabilities as follows:

	Andrew Bux Estimate	Annual Statement
Claims Unpaid	$ 9,516,390	$ 9,465,807
Accrued Medican Incentive Pool	554,309	554,309
Unpaid Claim Adjustment Expenses (CAE)	169,697	169,697
Premium Deficiency Reserves	-	-
Total Actuarial Liabilities	$ 10,240,396	$ 10,189,813

The appointed actuary opined that the reserves for unpaid claims and unpaid claim adjustment expenses carried by the company as of Dec. 31, 2021, were reasonable. Mr. Bux concluded that his review arrived at a Medical IBNR $50,583 more than the company's estimate, which was concluded to be reasonable. His overall conclusion was that the reserves of the plan were reasonably stated.

SUMMARY OF COMMENTS AND RECOMMENDATIONS

The examination resulted in a reduction of surplus by $191,635. The following is a summary of the recommendations made in this report of examination:

Page

20 I recommend the plan amend its two reinsurance agreements with American Fidelity Assurance Company to include a settlement clause pursuant to the provisions of OAR 836-012-0310.

20 I recommend the plan amend its two reinsurance agreements with American Fidelity Assurance Company to provide for risk transfer, pursuant to the provisions of SSAP No.61R and ORS 731.302.

21 I recommend the plan provide all record requests, and provide them in a timely manner to properly facilitate the examination in accordance with the provisions of ORS 731.308(2) and ORS 731.308(3), respectively.

27 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.

28 I recommend the plan non-admit its investment in Health Plan Alliance LLC, per the requirements of ORS 731.302 and SSAP No.4, paragraph 3.

28 I further recommend the plan submit an amended year-end 2022 annual statement to the Division of Financial Regulation that non-admits the year-end 2022 book value amount for Health Plan Alliance LLC, and reflects the appropriate reduction to the policyholder surplus.

CONCLUSION

During the three-year period covered by this examination, the surplus of the plan has increased from $11,385,633, as presented in the Dec. 31, 2018, report of examination, to $20,804,144 as shown in this report. The comparative assets and liabilities are:

	Dec. 31, 2021	Dec. 31, 2018	Change
Assets	$ 33,299,600	$ 25,328,951	$ 7,970,649
Liabilities	12,495,456	13,943,317	(1,447,861)
Surplus	$ 20,804,144	$ 11,385,633	$ 9,418,510

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, CFE, senior insurance examiner; Tho Le, CFE, PIR senior insurance examiner; Jordan Mills, AFE insurance examiner; David Lorenz, insurance examiner; Savannah Durr, JD, MBA, financial analyst; and Andrew Bux, FSA, MAAA, life and health actuary for the State of Oregon, Department of Consumer and Business Services, Division of Financial Regulation, 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

<u>**AFFIDAVIT**</u>

STATE OF OREGON)

County of Marion)

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

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

The affiant says nothing further.

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

Subscribed and sworn to before me this 20th day of June, 2023.

/s/ Lauren Nicole Bodine
Notary Public in and for the State of Oregon

My Commission Expires: 3/10/2026

OFFICIAL STAMP
LAUREN NICOLE BODINE
NOTARY PUBLIC - OREGON
COMMISSION NO. 1021742
MY COMMISSION EXPIRES MARCH 10, 2026