



STATE OF OREGON

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES

INSURANCE DIVISION

TARGET REPORT OF FINANCIAL EXAMINATION

OF

**MID ROGUE HEALTH PLAN, INC.
GRANTS PASS, OREGON**

NAIC COMPANY CODE 12253

AS OF

AUGUST 31, 2010

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SALUTATION

December 13, 2010

Honorable Cory Streisinger, Director
Department of Consumer and Business Services
State of Oregon
350 Winter Street NE
Salem, Oregon 97301-3883

Dear Director:

In accordance with your instructions and guidelines in the National Association of Insurance Commissioners (NAIC) Financial Condition Examiners Handbook, pursuant to ORS 731.300 and 731.302, respectively, we have examined the business affairs and financial condition of

MID ROGUE HEALTH PLAN, INC.

740 SE 7th Street

Grants Pass, Oregon 97526

NAIC Company Code 12253

hereinafter referred to as the "Plan." This report is a limited-scope examination, and is not intended to communicate all matters of importance for an understanding of the Plan's financial condition.

SCOPE OF EXAMINATION

This targeted examination of the Plan was conducted for the purpose of following up on the recommendations made as a result of the report of examination as of December 31, 2008, and to further investigate concerns noted during and subsequent to the examination. The previous report of examination was dated June 4, 2009, and showed the Plan was statutorily impaired pursuant to ORS 750.045(1). Reported surplus totaled \$1,434,838. Prior to completion of the fieldwork, the Plan filed a Risk Based Capital (RBC) report at December 31, 2008, with the Insurance Division which showed an RBC ratio placing the Plan in a Regulatory Action Level. With the capital and surplus amount determined as a result of the filed report, the examiners determined the adjusted RBC ratio actually fell within a Mandatory Action Level.

The report of examination also included in the subsequent events section a list of open items the Plan intended to address as a result of the RBC Action Plan submitted to the Oregon Insurance Division. The remainder of this report will focus on the concerns that have arisen due to actions taken by the Plan.

FOLLOW-UP REPORT

The December 31, 2008, report of examination made six recommendations. The Plan's CEO responded to the report in a letter dated October 30, 2009. As a result of this targeted examination, the examiners noted the following:

Recommendation #1: I recommend the Plan immediately file an insurance holding company system annual registration statement (Form "B") and a summary of registration statement (Form "C") in the format described in OAR 836-027-0030, as required by ORS 732.552 and 732.554, and OAR 836-027-0010 and 836-027-0012.

The Plan filed the registration statement (Forms B and C) for the 2008 calendar year, which was due on April 30, 2009, but was dated February 1, 2010. The 2009 registration statement

was submitted in a timely manner, however, the Oregon Insurance Division's Financial Analyst noted significant deficiencies in both of the filings, including repeated failure to submit audited financials of the ultimate controlling entity, Mid Rogue IPA Holding Company. The Plan submitted during July 2010 an amended 2009 registration statement that included audited financial statements of Mid Rogue IPA Holding Company. Based on this amended registration statement, the examiners determined the Plan is in compliance with this recommendation.

Recommendation #2: I recommend the Plan increase its employee fidelity coverage to at least \$500,000 per occurrence, and possibly higher if the premium income is forecasted to increase, to comply with the NAIC Financial Condition Handbook and ORS 731.547(6).

The Plan showed evidence it increased its fidelity coverage to \$1 million per occurrence, after a \$15,000 deductible. The Plan is in compliance with the recommendation.

Recommendation #3: I recommend the Plan disclose information on all reinsurance contracts in force in the statement filed with the Oregon Insurance Division, to comply with the NAIC Annual Statement Instructions for Health manual and ORS 731.574(1).

In Exhibit S of both the 2007 and 2008 annual statements, the Plan omitted information on an HMO Specific Excess Loss Reinsurance Agreement with ACE American Insurance Company. This agreement covered risks under the Oregon Health Plan business. Effective January 1, 2009, the Plan transferred the OHP business to its direct parent, Mid Rogue IPA Holding Company, and no longer needed to report the reinsurance information in its financial statements. The Plan is in compliance with the recommendation.

Recommendation #4: I recommend the Plan create procedures to identify and segregate uncashed checks, and to file an unclaimed property report in accordance with ORS 98.352.

The examiners noted the Plan has instituted procedures to identify uncashed checks. The Plan has currently identified approximately \$300.00 in checks eligible for escheatment. The Plan is in compliance with the recommendation.

Recommendation #5: I recommend the Plan reduce the balance in the Umpqua Repurchase Agreement account to a level below 10% of admitted assets as required by ORS 733.770 and ensure the balance does not exceed this limit at all times.

On August 3, 2010, the Plan received approval by the Oregon Insurance Division to treat both the checking account and the Repurchase Agreement account at Umpqua Bank as normal current operating accounts pursuant to ORS 733.520. Such accounts are therefore not subject to the limitations of ORS 733.770. The Plan is in compliance with the recommendation.

Recommendation #6: I recommend the Plan establish unpaid claim reserves and claim adjustment expense reserves that adequately cover their expected liabilities, in accordance with ORS 733-030(1).

In the 2008 annual statement, the Plan reported an unpaid claim reserve of \$12,507,613, together with a claims adjustment expense reserve of \$472,478. Upon a review of the loss triangles and run-out of the claims paid subsequent to January 1, 2009, the actuary for the Oregon Insurance Division determined the total of these reserves was deficient by \$1,798,770 to pay claims of 2008 and prior years.

As part of this targeted examination, the examiner asked the DCBS in-house life and health actuary to review the loss triangles and run-out of the unpaid claims reserve set at December 31, 2009. The Plan established an unpaid claim reserve of \$8,136,646 at December 31, 2009, which was again found to be deficient by \$1,445,524 when compared to 2009 and prior

claims paid through August 31, 2010. The Plan continues to post insufficient claim reserves, and is not in compliance with the recommendation.

Conclusion of the Follow Up

The Plan was only able to comply with five of the six recommendations made in the report of examination.

RISK BASED CAPITAL ACTION PLAN

On May 22, 2009, the Plan submitted an RBC action plan identifying five issues and the corrective actions to be taken. The examiner reviewed each item of the action plan, as follows:

- 1) The Plan moved OHP business up to the parent company, Mid Rogue IPA Holding Company, effective January 1, 2009.

This transfer was approved by the Division of Medical Assistance Program (DMAP). While this had the effect of moving approximately 13,000 enrollees out of the Plan and \$35 million of direct premiums (both figures based on 2008 annual statement amounts), the Plan continued to report adverse financial results during 2009. Losses from operations totaled \$2,107,892 at year-end 2009, resulting in a net loss of \$1,211,967. The Plan reported a decrease in net cash from operations of \$6,366,456 for the same period. Similar results are forecasted for 2010, and the unaudited financials as of August 31, 2010, showed underwriting losses of \$2,087,612 and net losses of \$2,000,874 year-to-date.

- 2) The Plan noted duplicate claims were being processed by its EZ-Cap software and contracted with Moss Adams Healthcare Consulting to perform an extensive audit of claims overpayments to providers.

During the fieldwork of the triennial examination, the examiners apprised the Plan of the concerns with reserve deficiencies posted in the financial statement. The Plan explained the problem was due to an upgrade to the EZ-CAP claims software, together with provider

identification number changes mandated by CMS, both of which resulted in unprecedented duplication of claim payments during 2008. In other words, the claims processors at the Plan were having difficulty paying claims with the new software, which caused delays. Medical providers would then submit a second billing on the claim. Normally, this would be caught by the software and identified as a duplicate. However, during this same period of time new rules by CMS required changing the provider ID number, which the Plan had been using to detect duplicates. As a result, the Plan estimated they paid approximately \$3 million in duplicate claim payments from January 1, 2008 through February 28, 2009.

The Plan hired Moss Adams Healthcare Consulting to audit and reconcile claim payments made to selected medical providers. The overall purpose of the audit was to identify claims overpayments made by the Plan to specific providers with the intent to recover or collect the erroneous payments. In their report, they confirmed overpayments were estimated to exceed \$3 million.

The examiners were able to identify duplicates recovered from two sources: 1) take backs, by which the Plan and the provider have agreed to reduce reimbursements from future billings, and; 2) direct reimbursements, particularly from out-of-network providers. The examiner was able to trace total recoverable amounts collected to date in the amount of \$4,547,938.

- 3) The Plan requested Moss Adams Healthcare Consulting conduct an assessment of the claims operations function for process improvements.

Moss Adams referred this assessment to HTMS, an Indianapolis-based healthcare IT consulting group. In a presentation given to the Board of Directors on October 10, 2009, the consultant reviewed the options of continuing with the EZ-CAP platform or migrating to one of three alternative platforms. His analysis indicated the current platform lacked a large

number of required functions and required a high level of manual intervention. Unfortunately, the number of alternative platforms is limited and potentially very expensive.

- 4) The Plan performed a risk score audit, through an independent auditing firm, which could result in a retroactive capitation increase of approximately \$1,637,000 for 2008 Medicare Advantage enrollees.

At year-end 2008, the Plan booked a recoverable based on a CMS risk revenue adjustment report in the amount of \$1,200,000. The report was completed on July 23, 2009, and concluded the Plan was to receive an adjustment of \$1,318,500, which the Plan received on July 31, 2009. In 2009, the Plan booked \$1,240,000, and was reimbursed by CMS for \$2,388,197, which the examiner traced to a payment received on July 30, 2010.

- 5) The Plan recorded a recoverable on its OHP business and petitioned DMAP to expedite payment of maternity benefit payments due as a result of an internal claims audit by DMAP.

This last item had no impact on the Plan as all Oregon Health Plan business was transferred to the direct parent, Mid Rogue IPA Holding Company, as described earlier in this report.

OTHER CONCERNS

During 2009, the Plan hired a new claims manager, and has increased its use of electronic auto-adjudication to approximately 75% of its claims. This has allowed the Plan to lower staff levels and allow more time for resolving problems with the EZ-CAP system. However, the report by Moss Adams noted the financial payment accuracy of the claims system was below 80% during this period, well below industry norms. They also found the Plan performed little or no claim audits and did little to identify cost containment procedures.

Claims Backlog

Effective December 31, 2009, the Plan received approval from the Centers for Medicare and Medicaid Studies (CMS) to discontinue the Medicare Advantage program in Coos County, Oregon. This affected the Plan's cash flow as no more premiums were being paid to the Plan related to this business, but claims and expenses from providers continued to be received for services rendered in 2009 and prior periods. As a result of testing the run-out claims database, the examiner noted that by May 2010, the overall lag time for claim payments had increased to an average of 45 days. ORS 746.230(1) and OAR 836-080-0225 require payment within 30 days of receipt, or notification to the insured as to why the claim will not be settled.

By July 2010 the cash flow situation improved and the Plan was able to focus on its claims backlog. By August the Plan reported its backlog of claims was down to a 14-15 day average. It does not appear that the March 31 or June 30 quarterly statements reflected any increase in unpaid claim reserves to recognize these claims in course of settlement. Claims had been submitted and had been processed by the Plan, but payment was not made, therefore, the reserve for unpaid claims should have been increased by the amount of the backlog.

FINANCIAL STATEMENTS

The following examination financial statements show the financial conditions of Mid Rogue Health Plan as of August 31, 2010:

Statement of Assets
Statement of Liabilities, Capital and Surplus
Statement of Revenues and Expenses

MID ROGUE HEALTH PLAN, INC.
BALANCE SHEET
As of August 31, 2010
(unaudited)

<u>ASSETS</u>	Balance per December 31, 2008 Examination Report	Balance per August 31, 2010 Statement	<u>Difference</u>
Bonds	\$ 2,118,108	\$ 0	\$(2,118,108)
Common Stocks	949,027	0	(949,027)
Cash and short-term investments	7,382,018	7,938,795	556,777
Investment income due and accrued	0	0	0
Uncollected premiums in the course of collection	3,164,875	109,088	(3,055,787)
Accrued retrospective premiums	234,167	191,370	(42,797)
Amounts recoverable from reinsurers	128,785	136,975	8,190
Amounts receivable relating to uninsured plans	810,438	1,812,382	1,001,944
FIT recoverable	0	594,429	594,429
Net deferred tax asset	86,949	299,430	212,481
Receivable from parent, subsidiaries and affiliates	262,300	0	(262,300)
Health care receivable	<u>2,095,984</u>	<u>151,617</u>	<u>(1,944,367)</u>
Total Assets	<u>\$17,232,651</u>	<u>\$ 11,234,087</u>	<u>\$(5,998,564)</u>
 <u>LIABILITIES</u>			
Claims unpaid	\$14,210,443	\$ 6,403,355	\$ 7,807,088
Accrued medical incentive pool and bonus amounts	0	226,070	(226,070)
Unpaid claims adjustment expense	568,418	186,000	382,418
General expenses due or accrued	892,310	0	892,310
FIT payable	126,643	0	126,643
Amounts due to parent, subsidiaries and affiliates	<u>0</u>	<u>311,138</u>	<u>(311,138)</u>
Total Liabilities	<u>15,797,814</u>	<u>7,126,563</u>	<u>(8,671,251)</u>
 <u>CAPITAL & SURPLUS</u>			
Common capital stock	150,000	150,000	0
Gross paid in and contributed surplus	10,650	2,010,650	2,000,000
Unassigned funds	<u>1,274,188</u>	<u>1,946,873</u>	<u>672,685</u>
Total Capital & Surplus	<u>1,434,838</u>	<u>4,107,523</u>	<u>2,672,685</u>
 Total Liabilities, Capital & Surplus	 <u>\$17,232,652</u>	 <u>\$11,234,086</u>	 <u>\$(5,998,564)</u>

Immaterial differences are due to rounding.

MID ROGUE HEALTH PLAN, INC.
STATEMENT OF REVENUE AND EXPENSES
For Year-to-Date August 31, 2010
(unaudited)

	Balance per December 31, 2008 Examination Report	Balance per August 31, 2010 Statement
Net premium income	\$65,565,009	\$ 29,984,193
Management fee income	<u>21,256</u>	<u>0</u>
Total revenues	<u>65,586,265</u>	<u>29,984,193</u>
Hospital/medical benefits	46,716,495	26,233,093
Other professional services	593,723	0
Emergency room and out-of-area	775,578	0
Prescription drugs	5,916,484	3,337,416
Incentive pool withhold adjustments	<u>0</u>	<u>226,070</u>
Subtotal	<u>54,002,280</u>	<u>29,796,579</u>
Less:		
Net reinsurance recoveries	<u>364,887</u>	<u>483,345</u>
Total medical and hospital	<u>53,637,393</u>	<u>29,313,234</u>
Claims adjustment expenses	3,206,001	1,174,812
General administrative expenses	<u>6,450,308</u>	<u>1,583,758</u>
Total underwriting deductions	<u>63,293,702</u>	<u>32,071,805</u>
Net underwriting gain/(loss)	<u>2,292,563</u>	<u>(2,087,612)</u>
Net investment income earned	276,583	86,738
Net realized capital gains or (losses)	<u>0</u>	<u>0</u>
Net investment gains or (losses)	<u>276,583</u>	<u>86,738</u>
Net income or (loss) before federal income taxes	2,569,146	(2,000,874)
Federal and foreign income taxes incurred	<u>553,354</u>	<u>0</u>
Net income (loss)	<u>\$ 2,015,792</u>	<u>\$ (2,000,874)</u>

CONCLUSION

The Plan complied with five of the six recommendations made in the last report of examination.

- The Plan needs to improve its accuracy in setting claims unpaid and unpaid claims adjustment expense reserves. The analysis by the DCBS actuary, Scott Fitzpatrick, indicated the reserves were deficient in both 2008 and 2009.

The Plan has followed its Risk Based Capital report filed with the Insurance Division, but continues to report significant financial strain. Estimates of the RBC ratio, based on monthly financial statements submitted to the financial analyst, indicate the Plan continues to be in a Regulatory Action Level.

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, Timothy Hurley, CFE, insurance examiner, and Scott Fitzpatrick, FSA, MAAA, actuary for the Department of Consumer and Business Services, participated in the examination.

Respectfully submitted,

Greg A. Lathrop, CFE
Supervising Insurance Examiner
Insurance Division
Department of Consumer and Business Services
State of Oregon

AFFIDAVIT

STATE OF OREGON)
) ss
County of Marion)

Greg A. Lathrop, CFE, being duly sworn, states as follows:

1. I have authority to represent the state of Oregon in the target financial examination of Mid Rogue Health Plan, Inc.
2. The Insurance Division 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, and the target financial examination of Mid Rogue Health Plan, Inc., was performed in a manner consistent with the standards and procedures required by the Oregon Insurance Code.

The affiant says nothing further.

Greg A. Lathrop, CFE
Supervising Insurance Examiner
Insurance Division
Department of Consumer and Business Services
State of Oregon

Subscribed and sworn to before me this _____ day of _____, 2010.

NOTARY PUBLIC for the State of Oregon

My Commission Expires: _____