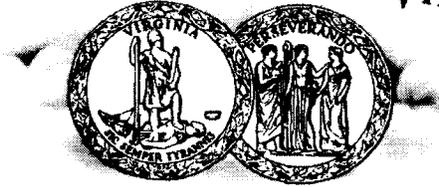


EXAMINATION REPORT
of
CARILION CLINIC MEDICARE RESOURCES, LLC
Roanoke, Virginia
as of
December 31, 2013

COMMONWEALTH OF VIRGINIA

JACQUELINE K. CUNNINGHAM
COMMISSIONER OF INSURANCE
STATE CORPORATION COMMISSION
BUREAU OF INSURANCE



P.O. BOX 1157
RICHMOND, VIRGINIA 23218
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I, Jacqueline K. Cunningham, Commissioner of Insurance of the Commonwealth of Virginia, do hereby certify that the annexed copy of the Examination Report of Carilion Clinic Medicare Resources, LLC as of December 31, 2013, is a true copy of the original report on file with this Bureau.

IN WITNESS WHEREOF, I have hereunto set my hand
and affixed to the original the seal of the Bureau at the City
of Richmond, Virginia this 13th day of November, 2014

A handwritten signature in cursive script that reads "Jacqueline K. Cunningham". The signature is written in black ink and is positioned above a horizontal line.

Jacqueline K. Cunningham
Commissioner of Insurance

(SEAL)

TABLE OF CONTENTS

Description	1
History	1
Capital and Surplus	1
Net Worth Requirement	3
Management and Control	3
Affiliated Companies	4
Transactions with Affiliates	6
Management Services Agreement	6
Administrative Services Agreement	7
Territory and Plan of Operation	8
Department of Medical Assistance Services Agreements	8
Conflict of Interest	9
Fidelity Bond and Other Insurance	9
Provider Agreements	9
Benefits	10
Growth of the Company	12
Excess Loss Insurance	13
Special Reserves and Deposits	13
Scope	14
Financial Statements	15
Recommendation for Corrective Action	21
Subsequent Events	22
Conclusion	22

Richmond, Virginia
August 7, 2014

Honorable Jacqueline K. Cunningham
Commissioner of Insurance
Richmond, Virginia

Dear Madam:

Pursuant to your instructions and by authority of Section 38.2-4315 of the Code of Virginia, an examination of the records and affairs of

CARILION CLINIC MEDICARE RESOURCES, LLC

Roanoke, Virginia

hereinafter referred to as the Company, has been completed. The report thereon is submitted for your consideration.

DESCRIPTION

The Company became licensed in Virginia on May 4, 2009 as a health maintenance organization ("HMO") pursuant to Chapter 43 of Title 38.2 of the Code of Virginia. The Company was last examined by representatives of the State Corporation Commission's Bureau of Insurance (the "Bureau") as of December 31, 2010. This examination covers the period from January 1, 2011 through December 31, 2013.

HISTORY

The Company was issued a certificate of organization as a limited liability company in the Commonwealth of Virginia on November 14, 2008. At December 31, 2013, Carilion Services, Inc. ("CSI") is the sole member of the Company.

CAPITAL AND SURPLUS

At December 31, 2013, the Company's capital and surplus was \$12,726,185. Capital and surplus was comprised of Gross paid in and contributed surplus of \$90,000, Surplus notes of \$56,000,000 and Unassigned funds of (\$43,363,815). Gross paid in and contributed surplus and surplus notes were provided to the Company by CSI.

At December 31, 2013, CSI had issued the following subordinated surplus notes to the Company:

<u>Issue Date</u>	<u>Surplus Note Principal</u>	<u>Amount Drawn</u>	<u>Date Drawn</u>
February 18, 2009	\$12,000,000	\$10,090,000 1,910,000	April 29, 2009 April 30, 2009
March 30, 2010	4,000,000	2,000,000 2,000,000	May 28, 2010 June 10, 2010
August 10, 2010	7,000,000	3,000,000 4,000,000	November 23, 2010 March 1, 2011
May 12, 2011	7,000,000	6,000,000 1,000,000	June 29, 2011 February 17, 2012
March 13, 2012	7,000,000	1,000,000 1,000,000 1,000,000 2,000,000 2,000,000	March 14, 2012 May 24, 2012 July 26, 2012 December 27, 2012 February 28, 2013
March 7, 2013	7,000,000	3,000,000 1,000,000 2,000,000 1,000,000	March 21, 2013 June 5, 2013 June 28, 2013 October 31, 2013
October 22, 2013	7,000,000	7,000,000	October 22, 2013
December 23, 2013	7,000,000	5,000,000	December 23, 2013

Interest on each surplus note is stated at six percent. At December 31, 2013, accrued interest on the surplus notes totaled \$7,333,310.

NET WORTH REQUIREMENT

Section 38.2-4302 of the Code of Virginia states that an HMO licensed in Virginia shall maintain a minimum net worth in an amount at least equal to the sum of uncovered expenses, but not less than \$600,000, up to a maximum of \$4,000,000. 14 VAC 5-210-60 A requires that an HMO report the sum of its uncovered expenses for each three-month period ending December 31, March 31, June 30 or September 30. Because the sum of the Company's uncovered expenses for the three-month period ending December 31, 2013 was \$5,704,400 the Company's minimum net worth requirement at December 31, 2013 was \$4,000,000.

MANAGEMENT AND CONTROL

As of December 31, 2013, the restated operating agreement provides that CSI shall be the sole member. The restated operating agreement provides that the management, operation, and control of the Company and its business shall be vested in the Board of Directors (the "Board"). The number of directors on the Board shall be at least three but no more than nine and each director shall serve until such time as they resign or are removed by the sole member.

The Board may appoint from time to time one or more officers as they determine to be necessary or appropriate. Any such officers shall serve until their successors are duly appointed and qualified.

At December 31, 2013, the Board and Officers were as follows:

<u>Directors</u>	<u>Principal Occupation</u>
Alice D. Ackerman, M.D.	Physician Carilion Medical Center Roanoke, Virginia
Nancy H. Agee	President Carilion Clinic Roanoke, Virginia
John A. Bond	President Scott & Bond Insurance Bedford, Virginia
Carolyn H. Chrisman	Senior Vice President Carilion Clinic Roanoke, Virginia

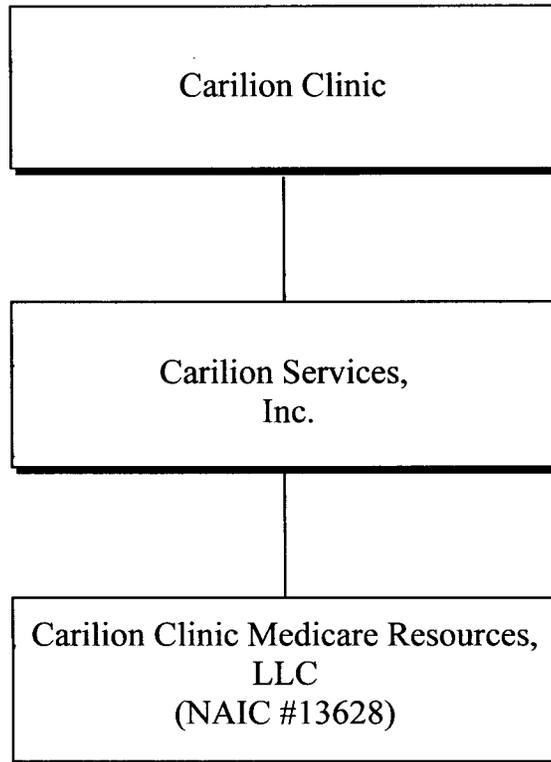
R. Wayne Gandee, M.D.	Executive Vice President and Chief Medical Officer Carilion Clinic Roanoke, Virginia
Donald B. Halliwill	Senior Vice President and Chief Financial Officer Carilion Clinic Roanoke, Virginia
Donald E. Lorton	Retired Roanoke, Virginia
Melina D. Perdue	Executive Vice President Carilion Clinic Roanoke, Virginia
Ralph E. Whatley, M.D.	Physician Carilion Medical Center Roanoke, Virginia

Officers

Donna M. Littlepage	President
Kerri Thornton	Treasurer
Briggs W. Andrews	Secretary
Nancy H. Agee	Executive Vice President

AFFILIATED COMPANIES

At December 31, 2013, CSI was the sole member of the Company and Carilion Clinic, a Virginia nonstock corporation, was the sole member of CSI. The chart on the following page illustrates the organizational structure of the Company and affiliated entities at December 31, 2013:



TRANSACTIONS WITH AFFILIATES

Administrative Support Agreement

Effective February 25, 2009, the Company entered into an Administrative Support Agreement with CSI. According to the provisions of the agreement, CSI shall arrange, at the Company's request, administrative services to support the following functions:

Financial Services
Tax and Audit
Legal Services
Personnel
Public Relations
Information Technology Services
Medical Management Services
Disease Management Services
Credentialing Services

As compensation, the Company reimburses CSI its actual expense in performing such services in accordance with accepted cost allocation models. The Company incurred \$255,180 and \$251,141 in fees related to this agreement in 2013 and 2012, respectively.

Support and Commitment Agreement

Effective April 19, 2011, the Company entered into a Support and Commitment Agreement with Carilion Clinic. According to the agreement, Carilion Clinic confirms its intent to continue to fund the Company at a level necessary to ensure regulatory and statutory compliance and its continued commitment to cover any future cash flow needs of the Company.

Provider Agreements

The Company contracts with several subsidiaries of Carilion Clinic and CSI to provide hospital, physician and other medical services to its members.

MANAGEMENT SERVICES AGREEMENT

Effective June 30, 2011, the Company entered into a Management Services Agreement with Schaller Anderson, LLC ("Schaller"), a subsidiary of Aetna, Inc. According to the provisions of the agreement, Schaller shall provide administrative services pertaining to the Company's Medicaid product to include:

1. Management of the day to day operations of the Company and the development and operation, on behalf of the Company, of a Medicaid managed care organization.
2. Development of the Medicaid application submitted by the Company to the Virginia Department of Medical Assistance Services and other governmental agencies.
3. Business planning services and the implementation of a business plan.
4. Administrative and management services in the areas of eligibility and enrollment; claims; customer and member services; provider contracting and relations; provider credentialing; accounting, finance and actuarial services; reinsurance administration; utilization management; pharmacy administration management; member and community outreach; preventive care and health education; network development; and disease management.
5. Adequate personnel, including a dedicated staff residing in Virginia, to perform the applicable administrative services.
6. Development and implementation of a unified care management program for all Medicaid members.

As compensation, the Company pays Schaller the greater of \$475,000 per month or ten percent of Company revenue for such month. The Company paid \$6,275,630 and \$6,133,619 in fees related to this agreement in 2013 and 2012, respectively

ADMINISTRATIVE SERVICES AGREEMENT

Effective March 18, 2009, the Company entered into an Administrative Services Agreement with TMG Health, Inc. ("TMG"). According to the provisions of the agreement, TMG shall provide administrative services pertaining to the Company's Medicare Advantage product to include all member enrollment services, member premium billing, claims processing and payment, member call center services and managed care information systems to support the preceding services. As compensation, the Company pays TMG a per-member per-month ("PMPM") rate based on enrollment with the minimum number of billable members equaling 1,500 as outlined below:

<u>Enrollment</u>	<u>PMPM Rate</u>
0 – 1,500 Members	\$20.40
1,501 – 2,500 Members	\$13.00
2,501 – 5,000 Members	\$9.75
5,001 – 10,000 Members	\$8.50
Over 10,000 Members	\$8.25

In addition, the Company pays certain transaction based service fees and information system access fees outlined in the agreement. The Company paid \$1,282,639 and \$672,246 in fees related to this agreement in 2013 and 2012, respectively.

TERRITORY AND PLAN OF OPERATION

At December 31, 2013, the Company's service area included the cities of Bedford, Buena Vista, Lexington, Radford, Roanoke and Salem and the counties of Bedford, Botetourt, Craig, Floyd, Franklin, Giles, Montgomery, Pulaski, Roanoke and Rockbridge.

Medical services are provided by physicians in independent practice within the Company's service area. Each member chooses a primary care physician ("PCP") from a list of the Company's primary providers. The PCP is responsible for coordinating all of the member's health care needs. Except in emergencies, a member must obtain services only from, or prearranged by, their PCP. Specialty physicians are available with a referral from a PCP. All hospital admissions must be arranged by the member's PCP and approved in advance by the Company.

During 2013, the Company offered four Medicare Advantage plans to members all with a prescription drug benefit. Each of the four plans offers varying monthly premiums, co-payments, benefit levels and access to services from providers outside of the Company's network.

Medicare Advantage represented 33% of the Company's premium revenue in 2013.

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES AGREEMENTS

At December 31, 2013, the Company had entered into a Medallion II Medicaid Managed Care Agreement and a Family Access to Medical Security Insurance ("FAMIS") Agreement with the Virginia Department of Medical Assistance Services ("DMAS"). Pursuant to these agreements, the Company is responsible for directly providing, arranging, purchasing, or otherwise making available the full scope of services to which enrollees are entitled under the respective programs. As compensation for these

services, DMAS pays the Company a monthly capitation fee based on each enrollees number, age, and sex. These agreements with DMAS represented 67% of the Company's premium revenue in 2013.

CONFLICT OF INTEREST

The Company has adopted a conflict of interest policy. The objective of the policy is to ensure that directors, officers, employees and others acting on behalf of the Company avoid conflicts of interest or commitments that have the potential to significantly affect the Company's interests or compromise objectivity in carrying out Company responsibilities. To ensure compliance with the policy, the Company has established procedures which require directors, officers and any employee with a direct or indirect financial interest to sign a conflict of interest disclosure form annually.

FIDELITY BOND AND OTHER INSURANCE

At December 31, 2013, the Company was listed as a named insured on a commercial crime policy with a \$5,000,000 limit of liability, subject to a \$75,000 deductible, to insure against losses arising from dishonest acts of its officers and employees. Additionally, the Company was listed as a named insured on a commercial general liability policy, an umbrella liability policy, a commercial property insurance policy, a business automobile liability policy, a directors and officers liability policy, a managed care liability policy and a workers compensation and employers liability policy.

PROVIDER AGREEMENTS

Medical Services

The Company has entered into agreements with numerous PCPs and specialist physicians to render, provide or arrange for the provision of covered health care services to members. The Company compensates participating physicians in accordance with the current Medicare fee schedule attached to each individual agreement.

Hospital Care

The Company has entered into agreements with a number of Carilion Clinic affiliated hospitals in its service area to provide covered hospital services to its members. The Company compensates these hospitals in accordance with the current Medicare fee schedule attached to each individual agreement.

Other Health Care Services

The Company has entered into various ancillary service agreements. These agreements provide vision services, pharmacy services, laboratory services, transportation services, home health care, skilled nursing care and physical therapy. Compensation is based on arrangements set forth in each agreement.

BENEFITS

The general benefits available to the Company's Medicare Advantage members when provided by PCPs, specialist physicians and other professional providers and approved by the Company are as follows:

1. Physician Services
2. Preventive Care and Screening Tests
3. Hospital Services
4. Hospice Care
5. Vision and Hearing Services
6. Skilled Nursing Facility Services
7. Home Health Care Skilled Services
8. Orthopedic and Prosthetic Devices
9. Ambulance Services
10. Emergency Services
11. Mental Health Services
12. Durable Medical Equipment

Exclusions generally include any services considered not reasonable and necessary according to the standards of Original Medicare; experimental medical and surgical procedures, equipment and medications; private hospital rooms; private duty nurses; cosmetic surgery; routine dental care; eyeglasses and routine eye examinations; chiropractic care; and routine foot care.

The general benefits available to the Company's Medicaid members when provided by PCPs, specialist physicians and other professional providers and approved by the Company are as follows:

1. Inpatient Hospital Services
2. Outpatient Medical Care
3. Physician Services
4. Maternity Care
5. Maternal and Infant Care Coordination
6. Women's Wellness Program
7. Well Child Program
8. Rehabilitation Services
9. Home Health Services
10. Family Planning
11. Vision Care
12. Mental Health Services
13. Disease Management
14. Prescription Drugs
15. Durable Medical and Prosthetic Devices
16. Transportation Services
17. Health Education Programs

Exclusions generally consist of services obtained without prior written referral by the member's PCP; inpatient care in a long-term care institution; chiropractic services; experimental or investigational procedures; private duty nursing; and substance abuse services.

The above are general summaries of coverages and exclusions and are not intended to be all inclusive.

GROWTH OF THE COMPANY

The following data is representative of the growth of the Company for the five-year period ending December 31, 2013. The data is compiled from the Company's filed Annual Statements, the previous examination report, and the current examination report.

<u>Year</u>	<u>Total Admitted Assets</u>	<u>Total Liabilities</u>	<u>Total Capital & Surplus</u>		
2009	\$4,062,729	\$6,865,601	(\$2,802,872)		
2010	10,933,115	5,244,483	5,688,632		
2011	11,893,289	2,537,698	9,355,591		
2012	18,042,460	12,127,759	5,914,701		
2013	28,464,518	15,738,333	12,726,185		

<u>Year</u>	<u>Total Revenue</u>	<u>Net Investment Gains</u>	<u>Medical & Hospital Expenses</u>	<u>Administrative Expenses</u>	<u>Pre-Tax Income (Loss)</u>
2009	\$0	\$7,902	\$0	\$6,460,500	(\$6,452,598)
2010	1,937,109	17,220	1,718,410	10,296,865	(10,060,946)
2011	5,055,588	8,274	4,552,711	2,539,136	(2,027,985)
2012	48,863,455	13,784	45,954,458	14,157,913	(11,235,132)
2013	76,196,699	18,702	77,412,320	9,340,717	(10,537,636)

The Company's enrollment data at year-end is illustrated as follows:

<u>Year</u>	<u>Number of Members</u>
2009	0
2010	280
2011	604
2012	13,173
2013	14,396

EXCESS LOSS INSURANCE

Effective January 1, 2013, the Company entered into Excess Loss Reinsurance Agreements with Zurich American Insurance Company ("Zurich"). One agreement covers Medicaid members while the other covers Medicare Advantage members. For eligible expenses in each contract year, the deductible is \$250,000 per member for Medicaid members and \$150,000 for Medicare Advantage members. Once the applicable deductible has been reached in a contract year, Zurich will reimburse the Company 90% of all eligible expenses for both Medicaid and Medicare Advantage members up to a maximum of \$3,000,000 per Medicaid member and a maximum of \$2,000,000 per Medicare Advantage member. The agreements include a continuation of coverage endorsement in the event of the Company's insolvency.

SPECIAL RESERVES AND DEPOSITS

At December 31, 2013, the Bureau required the Company to maintain a minimum deposit of \$1,910,000 with the Treasurer of Virginia.

SCOPE

This is a full scope financial condition examination initiated and conducted under the provisions of Article 4, Chapter 13 of Title 38.2 of the Code of Virginia. The examination covers the period from January 1, 2011 through December 31, 2013. Assets were verified and liabilities established at December 31, 2013.

The examination was conducted in accordance with the NAIC Financial Condition Examiners Handbook. The Handbook requires that the Bureau plan and perform the examination to evaluate the financial condition and identify prospective risks of the Corporation, assess corporate governance, identify and assess inherent risks within the Corporation, and evaluate system controls and procedures used to mitigate those risks. An examination also includes assessing the principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation, management's compliance with Statutory Accounting Principles and annual statement instructions when applicable to domestic state regulations.

All accounts and activities of the Company were considered in accordance with the risk-focused examination process.

FINANCIAL STATEMENTS

There follows a statement of financial condition at December 31, 2013; a statement of revenue and expenses for the year ending December 31, 2013; a reconciliation of capital and surplus for the period under review; and a statement of cash flow for the year ending December 31, 2013. The financial statements are presented in accordance with Statutory Accounting Principles.

ASSETS

	<u>Assets</u>	Nonadmitted <u>Assets</u>	Net Admitted <u>Assets</u>
Cash and short-term investments	<u>\$23,245,173</u>	<u> </u>	<u>\$23,245,173</u>
Subtotals, cash and invested assets	\$23,245,173	\$0	\$23,245,173
Investment income due and accrued	953		953
Uncollected premiums and agents' balances in course of collection	4,395,081		4,395,081
Amounts recoverable from reinsurers	206,457		206,457
Amounts receivable relating to uninsured plans	353,295		353,295
Health care and other amounts receivable	906,816	643,257	263,559
Aggregate write-ins for other than invested assets	<u>159,027</u>	<u>159,027</u>	<u>0</u>
Total assets	<u><u>\$29,266,802</u></u>	<u><u>\$802,284</u></u>	<u><u>\$28,464,518</u></u>

LIABILITIES, CAPITAL AND SURPLUS

	<u>Covered</u>	<u>Uncovered</u>	<u>Total</u>
Claims unpaid	\$9,822,318		\$9,822,318
Accrued medical incentive pool and bonus amounts	303,091		303,091
Unpaid claims adjustment expenses	318,434		318,434
Aggregate health policy reserves	209,960	1,930,000	2,139,960
Premiums received in advance	21,650		21,650
General expenses due or accrued		3,001,500	3,001,500
Amounts due to parent, subsidiaries and affiliates		122,710	122,710
Aggregate write-ins for other liabilities		8,670	8,670
Total liabilities	<u>\$10,675,453</u>	<u>\$5,062,880</u>	<u>\$15,738,333</u>
Gross paid in and contributed surplus			\$90,000
Surplus notes			56,000,000
Unassigned funds (surplus)			<u>(43,363,815)</u>
Total capital and surplus			<u>\$12,726,185</u>
Total liabilities, capital and surplus			<u><u>\$28,464,518</u></u>

STATEMENT OF REVENUE AND EXPENSES

	<u>Uncovered</u>	<u>Total</u>
Net premium income	XXX	\$76,196,699
Total revenues	XXX	\$76,196,699
Hospital and Medical		
Hospital/medical benefits		\$47,877,730
Other professional services (hospital and medical)		9,261,379
Outside referrals (hospital and medical)	429,624	429,624
Emergency room and out-of-area	547,707	4,256,731
Prescription drugs		15,463,709
Incentive pool, withhold adjustments and bonus amounts		312,556
Subtotal	\$977,331	\$77,601,729
Net reinsurance recoveries		189,409
Total hospital and medical	\$977,331	\$77,412,320
Claims adjustment expenses	2,249,800	2,249,800
General administrative expenses	10,377,917	10,377,917
Increase in reserves for life and accident and health contracts	(3,287,000)	(3,287,000)
Total underwriting deductions	\$10,318,048	\$86,753,037
Net underwriting gain	XXX	(\$10,556,338)
Net investment income earned		\$18,702
Net investment gains or (losses)		\$18,702
Net income or (loss) before federal income taxes	XXX	(\$10,537,636)
Federal income taxes incurred	XXX	0
Net income (loss)	XXX	(\$10,537,636)

CASH FLOW**Cash from Operations**

Premiums collected net of reinsurance	\$76,122,218
Net investment income	17,819
Total	<u>\$76,140,037</u>
Benefits and loss related payments	\$73,632,251
Commissions, expenses paid and aggregate write-ins for deductions	11,150,153
Total	<u>\$84,782,404</u>
Net cash from operations	<u><u>(\$8,642,367)</u></u>

Cash from Financing and Miscellaneous Sources

Cash provided (applied):	
Surplus notes, capital notes	\$19,000,000
Other cash provided	1,332,481
	<u>1,332,481</u>
Net cash from financing and miscellaneous sources	<u>\$20,332,481</u>

RECONCILIATION OF CASH AND SHORT-TERM INVESTMENTS

Net change in cash and short-term investments	\$11,690,114
Cash and short-term investments:	
Beginning of the year	11,555,059
	<u>11,555,059</u>
End of the year	<u><u>\$23,245,173</u></u>

RECOMMENDATION FOR CORRECTIVE ACTION

Management and Control

1. The data below represents the Company's net losses, by calendar year, since its inception in 2009:

<u>Year</u>	<u>Net Loss</u>
2009	(\$6,452,598)
2010	(10,060,946)
2011	(2,027,985)
2012	(11,235,132)
2013	(10,537,636)

Through December 31, 2013, the Company has received \$56,000,000 in capital contributions from its parent, CSI, in the form of subordinated surplus notes, to fund initial capitalization and losses from 2009 through 2013. The Company's continued existence appears to depend, at least in the foreseeable future, on the willingness of CSI to fund the Company's losses. It is imperative that management develop a plan in which dependency on CSI ceases and which moves the Company to profitability. This is the second consecutive examination in which a Recommendation for Corrective Action regarding the Company's dependency on CSI to fund its losses has been included in the examination report.

SUBSEQUENT EVENTS

1. The Company is subject to an annual fee under Section 9010 of the Affordable Care Act ("ACA"). The annual fee is allocated to individual health insurers based on the ratio of the amount of the entity's net premium written during the preceding calendar year to the amount of health insurance for any U.S. health risk that is written during the preceding calendar year. SSAP No. 35R does not require an accrual for this known liability until January 1 of the payment year. The Company estimates the amount of the ACA fee payable on September 30, 2014 to be \$600,000. Therefore, total capital and surplus at December 31, 2013, as reported in the examination report, was decreased from \$12,726,185 to \$12,126,185 on January 1, 2014. The Company's risk-based capital is expected to decrease 14.2% from \$4,231,397 at December 31, 2013 to \$3,630,538 at January 1, 2014.
2. Effective January 1, 2014, the Company no longer offered Medicare Advantage.
3. On July 21, 2014, the Company's Board voted to terminate its Medallion II Medicaid Managed Care Agreement and its FAMIS Agreement with DMAS. The Company's current Medicaid members will be transferred by DMAS to other managed care organizations offering these products in the Company's service area. The transfer is expected to occur on or prior to December 1, 2014.

CONCLUSION

The courteous cooperation extended by the Company's officers and employees during the course of the examination is gratefully acknowledged.

In addition to the undersigned, Darrin Bailey, CFE, and Milton Parker, AFE, participated in the work of the examination.

Respectfully submitted,



Kenneth G. Campbell, CFE
Assistant Chief Examiner

STATE CORP. COMMISSION

2014 OCT 21 AM 7:18

BUREAU OF INSURANCE



CARILION CLINIC
MEDICARE HEALTH PLAN

October 15, 2014

David H. Smith CFE, CPA, CPCU
Chief Examiner
State Corporation Commission
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218

RE: Carilion Clinic Medicare Resources, LLC
Examination Report as of December 31, 2013

Dear Mr. Smith,

We respectfully acknowledge receipt of the Examination Report as of December 31, 2013. Thank you for the opportunity to respond to the recommendation for corrective action included in this report.

The Company wishes to thank the Commission and the examination staff for the courtesy extended and we appreciate the cooperation extended to us during the exam. Should you have any further questions or concerns, please do not hesitate to contact us.

In addition, Carilion Clinic Medicare Resources would like to request an electronic copy, plus five (5) printed copies of the report.

Sincerely,

Donna M. Littlepage
President
Carilion Clinic Medicare Resources, LLC

**Carilion Clinic Medicare Resources, LLC
December 31, 2013 Examination
Recommendation of Corrective Action**

The recommended corrective action stated:

Management and Control

1. The data below represents the Company's net losses, by calendar year, since its inception in 2009:

<u>Year</u>	<u>Net Loss</u>
2009	(\$6,452,598)
2010	(10,060,946)
2011	(2,027,985)
2012	(11,235,132)
2013	(10,537,636)

Through December 31, 2013, the Company has received \$56,000,000 in capital contributions from its parent, CSI, in the form of subordinated surplus notes, to fund initial capitalization and losses from 2009 through 2013. The Company's continued existence appears to depend, at least in the foreseeable future, on the willingness of CSI to fund the Company's losses. It is imperative that management develop a plan in which dependency on CSI ceases and which moves the Company to profitability. This is the second consecutive examination in which a Recommendation for Corrective Action regarding the Company's dependency on CSI to fund its losses has been included in the examination report.

Following the Virginia Bureau of Insurance examination report as of December 31, 2010 efforts have been made to ease the Company's reliance on surplus notes from CSI. These efforts included the following corrective actions:

1. The Company enhanced the Medicare Advantage plans to make the plans more attractive to consumers and increase membership growth.
2. CCMR entered into a Medallion II Medicaid Management Care Agreement and a Family Access to Medical Security Insurance (FAMIS) Agreement with the Virginia Department of Medical Assistance Services (DMAS) to provide Medicaid benefits beginning with the 2012 plan year.
3. In an attempt to lower the general administration expenses and bring costs more in line with the market average, the Company entered into a management agreement and partnership with Schaller Anderson, LLC, an Aetna company.

Although CSI supplemented these initiatives and provided the funds needed to allow the Company to flourish, it became apparent the Medicare and Medicaid lines of business provided by CCMR were unsustainable given current market conditions. In the interest of plan membership and the community as a whole, CCMR's Board voted to withdraw the Medicare line of business from the market effective January 1, 2014 and withdraw the Medicaid line of business from the market effective December 1, 2014.

In regards to the recommendation for corrective action in the Examination Report as of December 31, 2013, the dependency on CSI to fund the Company's losses has been eliminated through the voluntary termination of all Medicare and Medicaid lines of business.