

STATE OF ALABAMA
DEPARTMENT OF INSURANCE
MONTGOMERY, ALABAMA

REPORT OF
EXAMINATION

OF

FIRSTCOMMUNITY HEALTH PLAN, INC.

HUNTSVILLE, ALABAMA

AS OF

DECEMBER 31, 2011

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EXAMINER'S AFFIDAVIT

**STATE OF ALABAMA
COUNTY OF MADISON**

Lori Brock, CFE, being first duly sworn, states as follows:

1. I have the authority to represent the State of Alabama in the examination of FirstCommunity Health Plan, Inc.
2. The Alabama Department of Insurance is accredited under the National Association of Insurance Commissioners Financial Regulation Standards and Accreditation.
3. I have reviewed the examination workpapers and examination report, and the examination of FirstCommunity Health Plan, Inc. was performed in a manner consistent with the standards and procedures required by the State of Alabama.

The affiant says nothing further.



Examiner-in-Charge

Subscribed and sworn before me by Lori Brock on this
26 day of October, 2012.

(SEAL)



(Signature of Notary Public)

My Commission expires 10/12/16.



ROBERT BENTLEY
GOVERNOR

JIM L. RIDLING
COMMISSIONER

STATE OF ALABAMA
DEPARTMENT OF INSURANCE
201 MONROE STREET, SUITE 502
POST OFFICE BOX 303351
MONTGOMERY, ALABAMA 36130-3351
TELEPHONE: (334) 269-3550
FACSIMILE: (334) 241-4192
INTERNET: WWW.ALDOI.GOV

DEPUTY COMMISSIONER
CHARLES M. ANGELL (acting)
CHIEF OF STAFF
RAGAN INGRAM
CHIEF EXAMINER
RICHARD L. FORD
STATE FIRE MARSHAL
EDWARD S. PAULK
GENERAL COUNSEL
REYN NORMAN

October 26, 2012

Honorable Jim L. Ridling, Commissioner
Alabama Department of Insurance
201 Monroe Street, Suite 1700
Montgomery, Alabama 36104

Dear Commissioner:

Pursuant to your authorization and in compliance with the statutory requirements of the State of Alabama and the resolutions adopted by the National Association of Insurance Commissioners, an examination has been made of the affairs and financial condition of

FirstCommunity Health Plan, Inc.

at its home office located at 699 Gallatin Street Southwest, Suite A-2, Huntsville, Alabama 35801, as of December 31, 2011. The Report of Examination is submitted herewith. Where the description "Company" appears herein without qualification, it will be understood to indicate FirstCommunity Health Plan, Inc.

SCOPE OF EXAMINATION

The Company was last examined for the five-year period ended December 31, 2008, by examiners representing the State of Alabama. The current examination covers the intervening period from the date of the last examination through December 31, 2011 and was conducted by examiners representing the State of Alabama. Where deemed appropriate, transactions, activities and similar items subsequent to December 31, 2011 were reviewed.

The examination was conducted in accordance with applicable statutory requirements of the State of Alabama for a Health Care Service Plan as provided for in ALA. CODE § 10A-20-6.01 through § 10A-20-6.16, and in accordance with Alabama Insurance Department regulations and bulletins in addition to the procedures and guidelines promulgated by the National Association of Insurance Commissioners (NAIC), as deemed appropriate, and in accordance with generally accepted examination standards and practices.

The examination was conducted in accordance with the NAIC *Financial Condition Examiners Handbook*. The examination was planned and performed to evaluate the financial condition of the Company as of December 31, 2011 and to identify the Company's prospective risks by obtaining information about the Company including corporate governance. In addition, the examination was planned and performed to identify and assess inherent risks within the Company and to evaluate system controls and procedures used to mitigate those risks. The examination also included 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.

An examination of the Company's information systems (IS) was conducted concurrently with the financial examination. The IS examination included a review of management and organizational controls, logical and physical security controls, changes in applications controls, system and program development controls, contingency planning controls, service provider controls, operations controls, processing controls, e-commerce controls and network and internet controls.

A market conduct examination was performed concurrently with the financial examination. The market conduct examination included a review of the Company's territory and plan of operation, advertising, producers, claims processing, marketing and sales, policy forms and underwriting, policyholder

complaints and privacy standards. See page 11 for further discussion of the market conduct examination.

The Company's annual statements for each year under examination were compared with or reconciled to the corresponding general ledger account balances.

The Company was audited annually by Beason & Nalley, certified public accountants (CPA's) from 2009 - 2011. The CPAs' workpapers were reviewed for all years under examination and were used in the examination as deemed appropriate by the examiners.

A signed certificate of representation was obtained during the examination. In this certificate, management attested to having valid title to all assets and to the nonexistence of unrecorded liabilities as of December 31, 2011.

ORGANIZATION AND HISTORY

The Company was formed on February 3, 1995 pursuant to the provisions of laws of the State of Alabama providing for the organization and regulation of nonprofit corporations for the establishment of health service plans. The Company was incorporated under the laws of the State of Alabama on July 23, 1996. The Bylaws provided for the Board of Directors to manage the property and business of the Company. The Bylaws further provided that the sole member of the Company would be the Health Care Authority of Huntsville, Alabama doing business as Huntsville Hospital. In its capacity as member, Huntsville Hospital would pay such dues and assessments as may be established by the Board.

A certificate of authority was issued on August 24, 1995, and the Company commenced business as "Tennessee Valley Community Health Plan" with reserves and unassigned funds totaling \$425,639. The Company received no premiums and paid no claims prior to January 1, 1996. On September 22, 1997, the Company changed its name to FirstCommunity Health Plan, Inc.

On February 13, 1998, the Alabama Department of Insurance issued a certificate of authority for FirstCommunity Healthcare, Inc. (an HMO) that was a wholly-owned subsidiary of the Company. In 1997, the Company invested \$1,000,000 in the stock of the HMO, which at December 31, 1997, was valued at \$1,015,930 using the equity method. On March 29, 1999, the Company voluntarily surrendered the certificate of authority for the HMO to the Alabama Department of Insurance and verified that all of the HMO's groups were converted into the Company starting on that date.

In September 1999, the Health Care Authority of Huntsville's Board of Directors resolved to downsize the Company. All insured member groups of the Company, except for the Medicare Select group, would be terminated or non-renewed by September 30, 2000.

The Company received approval on January 27, 2009 from the Alabama Department of Insurance Commissioner to repay Huntsville Hospital for the \$1.3 million restricted capital note. At 8.5% interest compounded since November 2000, the total repaid on March 31, 2009 was \$2,532,965. This placed the Company in Hazardous Financial Condition. The Company was ordered by the Alabama Department of Insurance to infuse \$500,000 into surplus. The Company obtained a surplus note from Huntsville Hospital for \$500,000. The Company made its first payment of \$25,000 during 2011. An additional payment of \$25,000 was made in 2012.

MANAGEMENT AND CONTROL

Board of Directors

The Company's Bylaws require that the Company have a minimum of fifteen members on the Board of Directors at all times. The Company was in compliance with the Bylaws with fifteen Directors throughout the examination period. The following members were serving on the Board of Directors as of December 31, 2011:

<u>Director/Residence</u>	<u>Principal Occupation</u>
Jack Edwin Batchelor, DMD Huntsville, Alabama	Retired Dentist
Tommie Lee Batts Huntsville, Alabama	Business Executive DP Associates, Inc.
Lee Roy Hoekenschnieder, Jr. Huntsville, Alabama	Huntsville President/Banking Executive Progress Bank
Carl August Grote, Jr., MD Huntsville, Alabama	Retired Physician
Joseph William Clark, Sr., MD Huntsville, Alabama	Orthopedic Surgeon The Orthopedic Center

Shirley Richardson Hale
Huntsville, Alabama

Retired President
Huntsville Botanical Gardens

Dorcus Sewell Harris
Huntsville, Alabama

Retired Business Owner

Nancy Palmer Rooks
Huntsville, Alabama

Retired Principal and Educator

Edward Earl Cobb
Huntsville, Alabama

Retired Engineer

Richard Aloysius Finch, MD
Huntsville, Alabama

Retired Nephrologist

Jesse Johnson, Jr.
Huntsville, Alabama

Retired Military US Army
Retired Civil Service USAMICOM

Jean Wessell Templeton
Huntsville, Alabama

Retired President
Wesfam, Inc.

Felicia Ann Wilson Lambert
Athens, Alabama

Director of Volunteer Services
Athens Limestone Hospital

Ashley Keir Burchfield, MD
Madison, Alabama

Physician
Huntsville Hospital Physician Care

Taron Keith Thorpe
Madison, Alabama

Market Executive
First Commercial Bank

Financial Affairs Committee

The members of the Financial Affairs Committee as of December 31, 2011 were as follows:

Lee Roy Hoekenschnieder, Jr., Chair

Jack Edwin Batchelor, DMD

Tommie Lee Batts

Richard Aloysius Finch, MD

Robert Willis Chappell, Jr., MD attends the Company's Financial Affairs Committee meetings; however, he is not a voting member of the Committee.

Officers

The Officers serving at December 31, 2011 were as follows:

<i><u>Officer</u></i>	<i><u>Position</u></i>
Lonnie Dean Younger	President
Jack Edwin Batchelor	DMD, Chair
Richare Alyosius Finch, MD	Vice Chair
Shirley Richardson Hale	Secretary
Lee Roy Hoekenschnieder, Jr.	Treasurer
Robert Willis Chappell, Jr. MD	Medical Director

The management and service agreement between the Company and the Health Care Authority of Huntsville empowers the Health Care Authority of Huntsville to recommend the President and Medical Director, which the Company's Board can either approve or reject. Lonnie Dean Younger was approved by the Board as President at the December 4, 2007 meeting of the Board of Directors. Robert Willis Chappell, Jr., MD was approved for his position as Medical Director at the August 22, 2000 meeting of the Board of Directors.

Conflict of Interest

Per the Company's Bylaws, Article III, Section 6. Disclosure of Interest:

“Each Director...shall submit in writing to the Chairperson...a list of all businesses, health care providers, or other organization of which he or she is an officer, director, trustee, member, owner..., shareholder with a five percent (5%) or greater interest...in which the Director would have conflicting interest, or which may compete with this Corporation. Each written statement will be resubmitted with any necessary changes each year.”

During this examination, all of the Company's Board members completed conflict of interest statements each year.

CORPORATE RECORDS

The Company filed a Certificate of Intention to become a Health Care Service Plan on February 25, 1995. The Certificate of Intention was amended on September 22, 1997. The Company's Bylaws were approved on July 23, 1996 and amended on February 7, 2002.

The documents were inspected during the course of the examination and appeared to provide for the operation of the Company in accordance with usual corporate practice and applicable statutes and regulations.

HOLDING COMPANY

The Company is organized as a nonprofit organization under ALA. CODE § 10A-20-6.01 and is not subject to the Alabama Insurance Holding Company Regulatory Act as defined in ALA. CODE § 27-29-1.

MANAGEMENT AND SERVICE AGREEMENTS

Management Agreement with the Health Care Authority

This agreement was revised in August 2004 and was approved by the Alabama Department of Insurance on December 17, 2004.

The management services agreement was entered into by and between The Health Care Authority of the City of Huntsville, Alabama ("Manager" with regards to managing the Plan. "Authority" with regards to being a Health Care Service Provider) and FirstCommunity Health Plan, Inc. (Plan).

General Duties of the Manager

The Manager is responsible for providing and maintaining office space, information systems and personnel. The Manager is also the attorney-in-fact for the purpose of negotiating and effectuating contractual issues for and on behalf of the Plan.

Duties and Responsibilities of the Plan

Neither the Plan nor its individual Board members will develop or promote any other competing health plan without the approval of 67% of the Plan Board. The

Plan also agrees not to develop or assist in the development of any other form of health plan without the Manager's approval.

Fees and Expenses

The plan agrees to pay its actual operating costs and expenses to the Manager on a monthly basis. In addition, the Plan is also responsible for normal business expenses including compensation and reimbursement to health care providers; Federal, State or local taxes; fines or penalties; legal judgments against the Plan; commissions and brokerage fees; extraordinary consultant or legal expenses not requested by the Plan Board or approved by the Manager; and any extraordinary expenses not identified in the published financial projections in the Business Plan and which were authorized by the Plan Board after the financial projections were published.

The Manager is responsible for billing and collecting premiums from subscribers. The Manager is also responsible for establishing a bank account in the Plan's name for the deposit of premiums collected. The Chief Executive Officer of the Manager designates individuals authorized on the Plan's bank account.

Assets of Plan

Any surplus or excess cash generated by the Plan above regulatory requirements are to be used to pay providers in the Plan, to reduce premiums paid by enrollees, to increase covered services and benefits available to enrollees or for other mutually agreed upon health-related community benefit.

Term and Termination

This agreement remains in force for ten years unless terminated by mutual agreement of the parties. The agreement will automatically renew for an additional five-year term unless the Manager or Board decides otherwise. Ninety days written notice must be provided in order to terminate the agreement.

Service Agreement with DST Health Solutions (formerly Nichols TXEN)

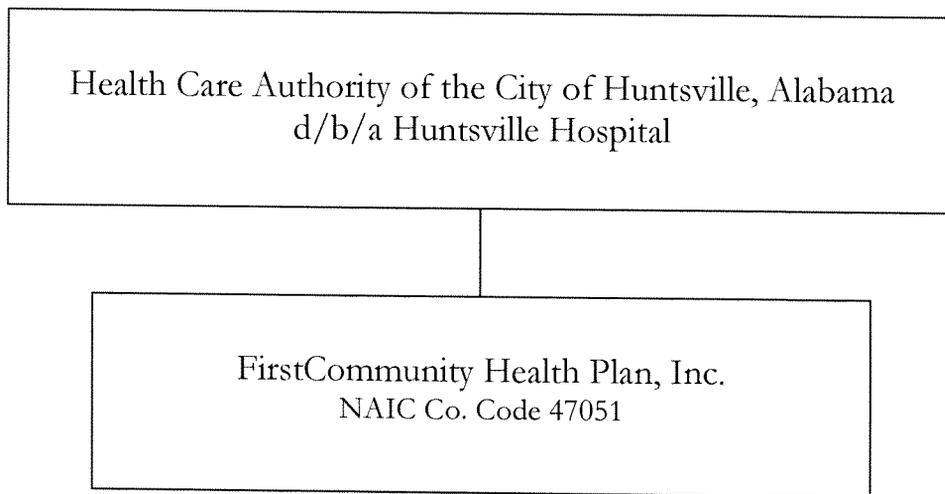
The original agreement between the Company and Nichols TXEN was dated August 26, 1998. In accordance with the agreement, DST Health Solutions (DST) processes and pays claims according to the fee schedule and benefit plan date provided by the Company. A listing of specific responsibilities for DST and the Company was included in the contract. A listing of reports available for the

Company to access as part of the Managed HealthCare System was included in the contract.

Applications and programs supplied under the agreement include: Membership, Providers, References, Claims, Authorization and Referral Management, Member Billing, Utilization Reporting, Accounts Payable and Accounts Receivable.

Within the service agreement, there is a Performance Standard section which describes the claims standards of processing and payment accuracy by DST. If these standards are not met, there can be reductions of fees paid by the Company.

ORGANIZATIONAL CHART



FIDELITY BONDS AND OTHER INSURANCE

The Company is a named insured on a Fidelity and Government Crime Policy issued to the Healthcare Authority of the City of Huntsville, Alabama d/b/a Huntsville Hospital. The bond is in excess of the NAIC mandated minimum for this Company.

In addition, the Company is a named insured on the following policies:

- Errors and Omissions Liability
- Directors and Officers Liability

EMPLOYEE WELFARE

The Company did not have any employees. All individuals who perform administrative and operational functions for the Company were employees of Huntsville Hospital (Hospital). The Hospital offered the following benefits:

Earned Time Off
Voluntary Sick Plan
Group Health Insurance and Dental Insurance
Retiree Health Insurance
Employee Badge Purchase
Flexible Spending Account
Health Care Authority 401(k) Plan
457(b) Deferred Compensation Plan
Group Life Insurance
Short-term and Long-term Disability
Education Reimbursement
Employee Assistance Program
Employee Pharmacy
Child Development Center

SCHEDULE OF SPECIAL DEPOSITS

The Company maintained the following deposits with the respective statutory authorities at December 31, 2011, as required or permitted by law.

States and Territories	Book Value		Fair Value	
Alabama	\$	30,000	\$	30,000
TOTAL	\$	30,000	\$	30,000

FINANCIAL CONDITION/GROWTH OF THE COMPANY

	Admitted Assets	Liabilities	Capital & Surplus	Premiums Earned
2011*	\$ 6,054,328	\$ 1,406,152	\$ 4,648,176	\$ 6,291,397
2010	5,600,496	1,324,110	4,276,386	6,303,658
2009	4,569,263	1,214,538	3,354,725	5,577,585
2008*	7,862,594	1,394,091	6,468,503	5,713,356

***Per Examination**

LOSS EXPERIENCE

The following are the percentages of combined losses and loss expenses incurred to premiums earned for each year under examination.

<u>2009</u>	<u>2010</u>	<u>2011</u>
94.48%	77.51%	76.53%

MARKET CONDUCT AND RELATED ACTIVITIES

Plan of Operation

The Company is a non-stock, not-for-profit company that offers Medicare supplement policies (Senior Select Plan A, Senior Select Plan B and Senior Select Plan C). BakerWoodward Communications, Inc. handled the Company's marketing strategy. The Company used print ads, brochures, and television ads as well as their website (www.firstcomm.org) to promote their product.

Territory

The Company was authorized to do business in the state of Alabama. The Company's service area was Colbert, Franklin, Jackson, Lauderdale, Lawrence, Limestone, Madison, Marshall and Morgan counties.

Policy Forms and Underwriting

During the examination period, the Company utilized the rates filed and approved by the Alabama Department of Insurance. The Company submitted new filings with the DOI and did not implement the new rates until the proper approval was received.

The only underwriting that the Company performed was verification that the applicants had Medicare coverages Parts A and B, no Medicaid with the exception of SLMB (Specified Low-Income Medicare Beneficiary), be 65 years of age, and live in North Alabama. Also, the potential insured must not:

- Have had, or been advised to have any organ transplant;
- Be applying for or using dialysis for kidney disease; or
- Be hospitalized, confined to a skilled nursing facility, or have been advised that they will require confinement in a skilled nursing facility in the next 30 days.

Dividends to Policyholders

The Company is not a stock or a mutual corporation; therefore, no dividends were paid by the Company.

Advertising and Marketing

The examiner reviewed all television scripts, print ads and brochures as well as the Company's website (www.firstcomm.org). The ads disclosed the kind of plan and benefits offered by the Company. The materials also included the name and address of the Company and identified the policy (Medicare Supplement) being marketed. The ads were not misleading and did not guarantee benefits different than what the Certificate of Coverage outlined. Also, the examiner reviewed approvals from the Alabama Department of Insurance for all advertised materials. The Company's producers were not allowed to use their own advertising materials.

Claims Review

The Alabama Department of Insurance does not regulate the claims payment activities of this Company.

Policyholder Complaints

It was noted in the previous two examination reports that the Company was not responding to policyholder complaints within 45 days as required by the Problem Resolution Section of the Company's Certificate of Coverage. According to the previous examination report, the Company received a total of 115 complaints. There were 25 complaints whose response was provided after 45 calendar days. In the 2008 examination report it was again recommended that the Company issue a decision no later than 45 calendar days from the date an initial grievance is received as required by the Company's Certificate of Coverage.

The Company received a total of 77 complaints during the examination period 2009 - 2011. There were no complaints received by the Department of Insurance. The complaint files were reviewed to determine whether the Company maintained appropriate complaint procedures and responded to the members' issues in a timely manner. It was determined that 17 of the 77 complaints received were not responded to within the required 45 calendar days as stated in the Company's Certificate of Coverage. The Company did not comply with the previous examination's recommendation and did not follow its own guidelines as stated in the Certificate of Coverage. No other discrepancies were found.

Compliance with Producers' Licensing Requirements

As of December 31, 2011, the Company had a listing of 48 active producers. The examiners reviewed the Company's records and determined that the producers representing the Company were duly licensed and appointed by the State of Alabama. No discrepancies were found.

The examiners obtained a listing of new business applications that were written during the examination period. The sample selection reviewed included 114 new business policies. It was determined that the producers were properly licensed and appointed to transact business on the Company's behalf at the time the policies were written.

PRIVACY STANDARDS

The Company was not required to comply with ALA. ADMIN. CODE 482-1-122 based on ALA. CODE § 10A-20-6.16 (Applicability of Insurance Law). The Company's privacy procedures were reviewed and determined to be in compliance with HIPAA (Health Insurance Portability and Accountability Act). The Privacy Notice is provided to the member at enrollment and then mailed to each member annually. A copy of the Privacy Notice was available on the Company's website. The Privacy Notice disclosed that the Company had physical, electronic and procedural safeguards that complied with federal regulations to maintain the confidentiality and security of nonpublic personal information. The Privacy Notice also disclosed the categories of information that the Company collects and categories of parties to whom the Company may disclose information. The Company may disclose nonpublic personal information about an applicant to nonaffiliated third parties as permitted or required by law.

REINSURANCE

Assumed Reinsurance

The Company did not assume any business for the period under examination.

Ceded Reinsurance

The Company did not cede any business during the period under examination.

ACCOUNTS AND RECORDS

Schedule Y – Part 1

The Company incorrectly completed Schedule Y - Part 1 in its Annual Statement. Schedule Y - Part 1 should be completed in accordance with the NAIC Annual Statement Instructions which state to include "a chart or listing presenting the identities of and interrelationships between the parent, all affiliated insurers and reporting entities; and other affiliates, identifying all insurers and reporting entities as such and listing the Federal Employer's Identification Number for each. The NAIC company code and two-character state abbreviation of the state of domicile should be included for all domestic insurers."

Underwriting and Investment Exhibit

It was noted in the previous examination that the Company was including gains/losses on investments in the Underwriting and Investment Exhibit - Part 3 - Analysis of Expenses. It was again noted that the Company inappropriately included realized gains/losses on its enhanced cash investments during this exam period. The amount reported in the 2011 Annual Statement for investment expenses was \$37,059. Due to immateriality, no change was made to the Annual Statement.

Information Systems

During an examination of the Company's Information Systems, the controls governing disaster recovery/business contingencies were reviewed. It was determined the Company has not developed a disaster recovery plan or established any type of pre-planned contingency response. Should a disaster occur, the lack of a disaster recovery plan significantly increases the risk the Company will not be able to efficiently recover.

The Company should develop and maintain a disaster recovery plan that:

- a. Is based on a business impact analysis.
- b. Is tested periodically.
- c. Is developed to address all significant business activities, including financial functions, telecommunication services, data processing and network services.
- d. Clearly describes senior management's roles and responsibilities associated with the declaration of an emergency and implementation of the disaster recovery/business continuity and disaster recovery plan.
- e. Clearly identifies the general process by which threats will be assessed and the specific individuals who are authorized to declare an emergency.
- f. Addresses communication of the disaster event and provides for alternative points of contact (if necessary) to customers, vendors and state and other regulatory officials.
- g. Contains a list of critical computer application programs, operating systems and data files.
- h. Contains a list of the supplies that would be needed in the event of a disaster, together with names and phone numbers of the suppliers.
- i. Assigns a restoration priority to all significant business activities.
- j. Contains manual processing procedures for use until electronic data processing functions are restored.
- k. Is kept at relevant off-site locations.

FINANCIAL STATEMENT INDEX

The Financial Statements included in this report were prepared on the basis of the Company's records and the valuations and determinations made during the course of the examination for the year 2011. Amounts shown in the comparative statements for the years 2009, 2010 and 2011 were compiled from Company copies of filed Annual Statements. The statements are presented in the following order:

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**THE NOTES TO THE FINANCIAL STATEMENTS ARE AN
INTEGRAL PART THEROF.**

FirstCommunity Health Plan, Inc.
Statement of Assets, Liabilities, Capital and Surplus
For the Year Ended December 31, 2011

	<u>Assets</u>	<u>Nonadmitted</u> <u>Assets</u>	<u>Net Admitted</u> <u>Assets</u>
Bonds	\$ 3,308,875	\$ -	\$ 3,308,875
Cash, cash equivalents and short-term investments	<u>2,728,231</u>	<u>-</u>	<u>2,728,231</u>
Subtotal, cash and invested assets	\$ 6,037,106	\$ -	\$ 6,037,106
Investment income due and accrued	21,682	-	21,682
Premium considerations:			
Uncollected premiums and agents' balances in the course of collection	5,938		5,938
Net deferred tax asset	6,017,263	6,027,661	(10,398)
Aggregate write-ins for other than invested assets:			
Prepaid Administrative Insurance	<u>19,890</u>	<u>19,890</u>	<u>-</u>
TOTAL	<u><u>\$ 12,101,879</u></u>	<u><u>\$ 6,047,551</u></u>	<u><u>\$ 6,054,328</u></u>

LIABILITIES

	<u>2011</u>
Claims unpaid	\$ 766,000
Unpaid claims adjustment expenses	198,698
Premiums received in advance	105,107
General expenses due or accrued	282,720
Amounts due to parent, subsidiaries and affiliates	<u>53,627</u>
TOTAL LIABILITIES	\$ 1,406,152

CAPITAL AND SURPLUS

Gross paid in and contributed surplus (Note 1)	25,975,245
Surplus notes	500,000
Aggregate write-ins for other than special surplus funds (Note 2)	-
Unassigned funds (surplus) (Note 3)	<u>(21,827,069)</u>
TOTAL LIABILITIES, CAPITAL AND SURPLUS	\$ <u><u>6,054,328</u></u>

**THE NOTES TO THE FINANCIAL STATEMENTS ARE AN
INTEGRAL PART THEROF.**

FirstCommunity Health Plan, Inc.
Statement of Revenue and Expenses
For the Years Ended December 31, 2011, 2010, and 2009

	2011	2010	2009
Net premium income	\$ 6,291,397	\$ 6,303,658	\$ 5,577,585
Total revenues	<u>\$ 6,291,397</u>	<u>\$ 6,303,658</u>	<u>\$ 5,577,585</u>
Hospital and Medical:			
Hospital/medical benefits	<u>\$ 4,147,201</u>	<u>\$ 4,232,063</u>	<u>\$ 4,620,092</u>
Less:			
Total hospital and medical	4,147,201	4,232,063	4,620,092
Claim adjustment expenses	665,804	651,687	647,513
General administrative expenses	<u>1,153,976</u>	<u>1,102,019</u>	<u>2,240,251</u>
Total underwriting deductions	\$ 5,966,981	\$ 5,985,769	\$ 7,507,856
Net underwriting gain or (loss)	324,416	317,889	(1,930,271)
Net investment income earned	74,423	124,891	113,569
Net investment gains (losses)	74,423	124,891	113,569
Net gain or (loss) from agents' or premium balances charged off	-	-	2,923
Net income or (loss) after capital gains tax and before other federal income taxes	<u>398,839</u>	<u>442,780</u>	<u>(1,813,779)</u>
Net income (loss)	<u>\$ 398,839</u>	<u>\$ 442,780</u>	<u>\$ (1,813,779)</u>
<u>Capital and Surplus Account</u>			
Capital and surplus prior reporting period	\$ 4,276,386	\$ 3,364,424	\$ 6,468,503
Net income	398,839	442,780	(1,813,779)
Change in net deferred income tax	(175,885)	1,011,018	-
Change in nonadmitted assets	148,836	(1,041,836)	-
Change in surplus notes	-	500,000	(1,300,000)
Net change in capital & surplus	<u>\$ 371,790</u>	<u>\$ 911,962</u>	<u>\$ (3,113,779)</u>
Capital and surplus end of reporting period	<u>\$ 4,648,176</u>	<u>\$ 4,276,386</u>	<u>\$ 3,354,724</u>

**THE NOTES TO THE FINANCIAL STATEMENTS ARE AN
INTEGRAL PART THEREOF.**

NOTES TO FINANCIAL STATEMENTS

Note 1 – Gross paid in and contributed surplus

\$25,975,245

The above captioned amount is \$25,975,245 more than the \$-0- reported by the Company in its 2011 Annual Statement. \$25,975,245 less than the \$25,975,245 reported for Aggregate write-ins for other than special surplus funds as reported by the Company in its 2011 Annual Statement.

It was noted in the previous examination that the Company was reporting Contributed Capital in Aggregate write-ins for other than special surplus funds. According to the NAIC Annual Statement Instructions and SSAP No. 72, the Company should report its contributed capital as Gross paid-in and contributed surplus. A review of the 2011 Annual Statement indicated that the Company is still incorrectly reporting contributed capital as a write-in.

Note 2 – Aggregate write-ins for other than special surplus funds

\$-0-

The above captioned amount is \$25,975,245 less than the \$25,975,245 reported by the Company in its 2011 Annual Statement.

It was noted in the previous examination that the Company was reporting Contributed Capital in Aggregate write-ins for other than special surplus funds. According to the NAIC Annual Statement Instructions and SSAP No. 72, the Company should report its contributed capital as Gross paid-in and contributed surplus. A review of the 2011 Annual Statement indicated that the Company is still incorrectly reporting contributed capital as a write-in.

Note 3 – Unassigned funds (surplus)

(\$21,827,069)

Unassigned funds (surplus) per Company		(\$21,827,069)
Examination increase/(decrease) to assets:	0	
Total increase/(decrease) to assets	<u>0</u>	0
Examination (increase)/decrease to liabilities:	0	
Total (increase)/decrease to liabilities	<u>0</u>	0
Unassigned funds (surplus) per Examination		<u>(\$21,827,069)</u>

The immaterial items noted during this examination were not determined to be material in the aggregate.

COMPLIANCE WITH PREVIOUS RECOMMENDATIONS

A review was conducted to determine if the Company complied with the recommendations made in the preceding Report of Examination. This review determined that the Company had complied, with the exception of the items noted below:

Policy Holder Complaints

It was noted in the previous two examination reports that the Company was not responding to policyholder complaints within 45 days as required by the Problem Resolution Section of the Company's Certificate of Coverage. According to the previous examination report, the Company received a total of 115 complaints. There were 25 complaints whose response was provided after 45 calendar days. In the 2008 examination report it was again recommended that the Company issue a decision no later than 45 calendar days from the date an initial grievance is received as required by the Company's Certificate of Coverage.

The Company received a total of 77 complaints during the examination period 2009 - 2011. There were no complaints received by the Department of Insurance. The complaint files were reviewed to determine whether the Company maintained appropriate complaint procedures and responded to the members' issues in a timely manner. It was determined that 17 of the 77 complaints received were not responded to within the required 45 calendar days as stated in the Company's Certificate of Coverage. The Company did not comply with the previous examination's recommendation and did not follow its own guidelines as stated in the Certificate of Coverage. No other discrepancies were found.

Accounts and Records – Underwriting and Investment Exhibit

It was noted in the previous examination that the Company was including gains/losses on investments in the Underwriting and Investment Exhibit - Part 3 - Analysis of Expenses. It was again noted that the Company inappropriately included realized gains/losses on its enhanced cash investments during this exam period. The amount reported in the 2011 Annual Statement for investment expenses was \$37,059. Due to immateriality, no change was made to the Annual Statement.

Accounts and Records – Information Systems

During an examination of the Company's Information Systems, the controls governing disaster recovery/business contingencies were reviewed. It was determined the Company has not developed a disaster recovery plan or established any type of pre-planned contingency response. Should a disaster occur, the lack of a disaster recovery plan significantly increases the risk the Company will not be able to efficiently recover.

The Company should develop and maintain a disaster recovery plan that:

- a. Is based on a business impact analysis.
- b. Is tested periodically.
- c. Is developed to address all significant business activities, including financial functions, telecommunication services, data processing and network services.
- d. Clearly describes senior management's roles and responsibilities associated with the declaration of an emergency and implementation of the disaster recovery/business continuity and disaster recovery plan.
- e. Clearly identifies the general process by which threats will be assessed and the specific individuals who are authorized to declare an emergency.
- f. Addresses communication of the disaster event and provides for alternative points of contact (if necessary) to customers, vendors and state and other regulatory officials.
- g. Contains a list of critical computer application programs, operating systems and data files.
- h. Contains a list of the supplies that would be needed in the event of a disaster, together with names and phone numbers of the suppliers.
- i. Assigns a restoration priority to all significant business activities.
- j. Contains manual processing procedures for use until electronic data processing functions are restored.
- k. Is kept at relevant off-site locations.

Notes to Financial Statements

It was noted in the previous examination that the Company was reporting Contributed Capital in Aggregate write-ins for other than special surplus funds. According to the NAIC Annual Statement Instructions and SSAP No. 72, the Company should report its contributed capital as Gross paid-in and contributed surplus. A review of the 2011 Annual Statement indicated that the Company is still incorrectly reporting contributed capital as a write-in.

CONTINGENT LIABILITIES AND PENDING LITIGATION

Examination of these items included: a review of the Company's Annual Statement disclosures, a general review of the Company's records and files for unrecorded items; and obtaining letters of representation from management.

As of December 31, 2011, there was no pending litigation against the Company. No material unreported contingencies were identified.

SUBSEQUENT EVENTS

The examiners reviewed general ledger and cash transactions occurring subsequent to the balance sheet date. In addition, the examiners inquired of management regarding any significant subsequent events. No significant subsequent events were noted.

COMMENTS AND RECOMMENDATIONS

Policyholder Complaints – Page 12

It is again recommended that the Company issue a decision no later than 45 calendar days from the date an initial complaint is received as required by the Company's Certificate of Coverage.

Accounts and Records – Page 14

It is recommended that the Company complete Schedule Y - Part 1 in accordance with the *NAIC Annual Statement Instructions* which state to include "a chart or listing presenting the identities of and interrelationships between the parent, all affiliated insurers and reporting entities; and other affiliates, identifying all insurers and reporting entities as such and listing the Federal Employer's Identification Number for each. The NAIC company code and two-character state abbreviation of the state of domicile should be included for all domestic insurers."

It is again recommended that the Company not include gains/losses on investments on the Underwriting and Investment Exhibit - Part 3 - Analysis of Expenses.

It is again recommended that the Company develop contingency plans to provide essential services to policyholders such as payment of claims in the event of a pandemic or major disaster. Such contingency plans should include the isolation of certain employees, back-up power generators, etc. Since the Company is owned by a major hospital, the contingency plan could utilize the facilities of that hospital, since the hospital would have back-up generators, isolation rooms, etc.

Note 1 – Gross paid in and contributed capital – Page 17

It is again recommended that the Company report contributed capital as Gross paid in and contributed surplus as required by SSAP No. 72, paragraphs 7 - 10 and the NAIC Annual Statement Instructions.

Note 2 – Aggregate write-ins for other than special surplus funds – Page 17

It is again recommended that the Company not report contributed surplus, surplus notes or non-admitted assets as Aggregate write-ins for other than special surplus funds. These items should be report on the appropriate lines as required by the NAIC Annual Statement Instructions.

Compliance with previous recommendations – Page 20

Policyholder Complaints

It is again recommended that the Company issue a decision no later than 45 calendar days from the date an initial complaint is received as required by the Company's Certificate of Coverage.

Accounts and Records

It is again recommended that the Company not include gains/losses on investments on the Underwriting and Investment Exhibit - Part 3 - Analysis of Expenses.

It is again recommended that the Company develop contingency plans to provide essential services to policyholders such as payment of claims in the event of a pandemic or major disaster. Such contingency plans should include the isolation of certain employees, back-up power generators, etc. Since the Company is owned by a major hospital, the contingency plan could utilize the facilities of

that hospital, since the hospital would have back-up generators, isolation rooms, etc.

Notes to Financial Statements

It is again recommended that the Company report contributed capital as Gross paid in and contributed surplus as required by SSAP No. 72, paragraphs 7 - 10 and the NAIC Annual Statement Instructions.

It is again recommended that the Company not report contributed surplus, surplus notes or non-admitted assets as Aggregate write-ins for other than special surplus funds. These items should be report on the appropriate lines as required by the NAIC Annual Statement Instructions.

CONCLUSION

Acknowledgement is hereby made of the courteous cooperation extended by all persons representing FirstCommunity Health Plan, Inc. during the course of this examination.

The customary insurance examination procedures, as recommended by the National Association of Insurance Commissioners, have been followed to the extent deemed appropriate in connection with the verification and valuation of assets and determination of liabilities set forth in this report.

In addition to the undersigned, Charles Turner, CISA, examiner for the State of Alabama Department of Insurance; and Harland A. Dyer, ASA, MAAA, actuarial examiner, participated in this examination of FirstCommunity Health Plan, Inc.

Respectfully submitted,



Lori Brock, CFE
Examiner-charge
State of Alabama
Department of Insurance