

STATE OF ALABAMA  
DEPARTMENT OF INSURANCE  
MONTGOMERY, ALABAMA

REPORT OF  
EXAMINATION

OF

**FIRSTCOMMUNITY HEALTH PLAN, INC.**

---

**HUNTSVILLE, ALABAMA**

AS OF

DECEMBER 31, 2008

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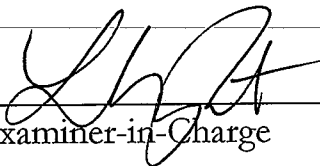
**EXAMINER'S AFFIDAVIT**

**STATE OF ALABAMA  
COUNTY OF MADISON**

Lori Wright, 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 Plans, 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 Plans, 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 Wright on this  
2 day of July, 2009.

(SEAL)

  
\_\_\_\_\_  
(Signature of Notary Public)

My Commission expires 3-27-2012.



BOB RILEY  
GOVERNOR

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COMMISSIONER  
ASSISTANT COMMISSIONER  
REN WHEELER  
DEPUTY COMMISSIONER  
D. DAVID PARSONS  
CHIEF EXAMINER  
RICHARD L. FORD  
STATE FIRE MARSHAL  
EDWARD S. PAULK  
GENERAL COUNSEL  
REYN NORMAN  
RECEIVER  
DENISE B. AZAR  
LICENSING MANAGER  
JIMMY W. GUNN

July 2, 2009

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, 2008. 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 four-year period ended December 31, 2003, by examiners representing the State of Alabama. The current examination covers the intervening period from the date of the last examination through December 31, 2008 and was conducted by examiners representing the State of Alabama. Where deemed appropriate, transactions, activities and similar items subsequent to December 31, 2008 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 § 10-4-100 (1975) through § 10-4-115 (1975), 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, 2008 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 Ernst & Young, LLP, certified public accountants (CPA's) from 2004 - 2007. Beason & Nalley performed the 2008 audit. 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, 2008.

## **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, 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 \$475,639. The Company received no premiums or paid any claims prior to January 1, 1996. On September 22, 1997, the Company changed its name to FirstCommunity Health Plan.

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 July 1999, the Company stopped marketing its

Medicare Supplement policies until such time as the claims processing with its outside vendor was cleaned up and running smoothly.

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.

On November 30, 2000, the Company received \$1.3 million from Huntsville Hospital in the form of a restricted capital note. As a result, the Alabama Department of Insurance approved the Company to begin marketing its Senior Select Medicare Supplement effective January 1, 2001.

There have been no other significant changes to the Company's structure or operations since January 1, 2001.

## 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 members of the Board of Directors serving at December 31, 2008 were as follows:

<i>Director/Residence</i>	<i>Principal Occupation</i>
Charles August Grote, Jr., MD Huntsville, Alabama	Retired Physician
Dorcas Sewell Harris Huntsville, Alabama	Retired Business Owner
Nancy Palmer Rooks Huntsville, Alabama	Retired Principal & Educator
Jack Edwin Batchelor, DMD Huntsville, Alabama	Retired Dentist

Ronald Michael Wyatt, MD, MHA Madison, Alabama	Physician Huntsville Hospital Madison Internal Medicine
Nicholas Leonard Shields, Jr. Huntsville, Alabama	Scientist The Boeing Company
Shirley Richardson Hale Huntsville, Alabama	Retired President Huntsville Botanical Gardens
Tommie Lee Batts Huntsville, Alabama	Business Executive DP Associates, Inc.
Lee Roy Hoekenschnieder, Jr. Huntsville, Alabama	Huntsville President/Banking Executive Progress Bank
Joseph William Clark, Sr., MD Huntsville, Alabama	Orthopedic Surgeon The Orthopedic Center
Edward Earl Cobb Huntsville, Alabama	Retired Engineer
Felicia Ann Wilson Lambert Athens, Alabama	Director of Volunteer Services Athens Limestone Hospital
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 Restaurants, Inc.

**Financial Affairs Committee**

The members of the Financial Affairs Committee as of December 31, 2008 were as follows:

Lee Roy Hoekenschnieder, Jr.  
Jack Edwin Batchelor, DMD

Tommie Lee Batts  
Ronald Michael Wyatt, MD, MHA

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, 2008 were as follows:

<i><u>Officer</u></i>	<i><u>Position</u></i>
Lonnie Dean Younger	President
Jack Edwin Batchelor, DMD	Chair
Nicholas Leonard Shields, Jr.	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 § 10-4-100 (1975) and is not subject to the Alabama Insurance Holding Company Regulatory Act as defined in ALA. CODE § 27-29-1 (1975).

## **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)**

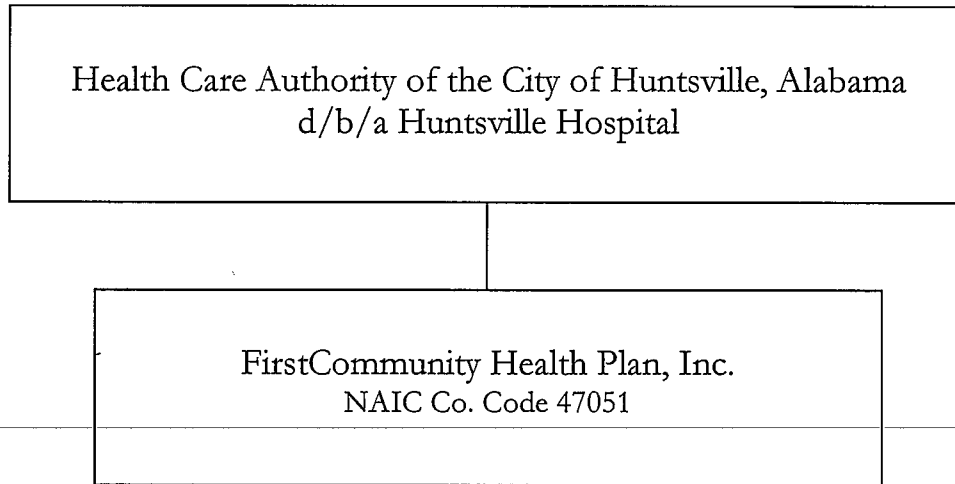
The original agreement between the Company and Nichols TXEN was dated August 26, 1998. In accordance with the agreement, DST Health Solutions (DST) processes and pays claims according to the fee schedule and benefit plan date provided by the Company. A listing of specific responsibilities for DST and 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 performed 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  
Group Dental Insurance  
Employee Badge Purchase Program  
Flexible Spending Account  
Health Care Authority 401(k) Plan  
Group Life Insurance  
Long Term Disability  
Educational Assistance  
Employee Assistance Program  
Prescription Drug Benefits

As a result of a recommendation made in the previous examination, the Company added the following statement to its Affirmation Statement: "I further affirm that I am not prohibited or limited in any manner from engaging in the business of insurance." Affirmation Statements were not signed in 2004. Affirmation Statements were signed by the officers and directors for 2005 - 2008. The other employees of Huntsville Hospital who are responsible for the administrative and operational functions on a daily basis did not sign Affirmation Statements in 2008.

## SCHEDULE OF SPECIAL DEPOSITS

The Company maintained the following deposits with the respective statutory authorities at December 31, 2008, as required or permitted by law.

<b>States and Territories</b>	<b>Book Value</b>		<b>Fair Value</b>	
Alabama	\$	30,000	\$	30,000
<b>TOTAL</b>	<b>\$</b>	<b>30,000</b>	<b>\$</b>	<b>30,000</b>

## FINANCIAL CONDITION/GROWTH OF THE COMPANY

	Admitted Assets	Liabilities	Capital & Surplus	Premiums Earned
2008*	\$ 7,862,594	\$ 1,394,091	\$ 6,468,503	\$ 5,713,356
2007	7,691,818	1,519,315	6,172,503	5,815,049
2006	6,915,247	1,435,471	5,479,776	5,625,893
2005	6,431,602	1,389,414	5,042,189	5,561,671
2004	5,849,269	1,376,381	4,472,888	4,953,523
2003*	5,650,529	1,466,012	4,184,517	4,952,042

\*Per Examination

## SCHEDULE T – PREMIUMS AND OTHER CONSIDERATIONS

States	Accident & Health Premiums	Total
Alabama	\$ 5,713,356	\$ 5,713,356
TOTAL	\$ 5,713,356	\$ 5,713,356

## LOSS EXPERIENCE

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

<u>2004</u>	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>
80.4%	76.41%	79.87%	78.72%	80.52%

## 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). BakerWoodard Communications, Inc. handled the Company's marketing

strategy. The Company used print ads, brochures, television and radio ads as well as their website ([www.FirstComm.org](http://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 coverage 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 or applied for/using dialysis for kidney disease.

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### **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, radio scripts, print ads and brochures as well as the Company's website ([www.firstcomm.org](http://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 stamp 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**

According to the previous examination report, the Company received a total of 129 complaints. There were 32 complaints whose response was provided after 45 calendar days. "Within the Company's Certificate of Coverage, the Problem Resolution Section stated that the Initial Grievance Committee is to issue a decision no later than 45 calendar days from the date an initial grievance is received." It was 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 115 complaints during the examination period 2004 - 2008. There were no complaints received by 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 23 of the 115 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, 2008, the Company had a listing of 52 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 NAIC Privacy Model Regulation or ALA. ADMIN. CODE 482-1-122 based on ALA. CODE §10-4-115 (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 customer 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**

### **Information Systems**

During an examination of the Company's Information System Controls, the procedures governing inventory control of checks were reviewed. It was determined that management was not ensuring check number continuity. By not checking to make sure the check numbers are continuous, it is feasible an unauthorized check could be released for payment. Unauthorized checks increase the risk of fraud and theft.

During a meeting with the Company CEO, it was determined the Company does not conduct strategic planning. The lack of a strategic plan increases the risks associated with the Company's ability to effectively deal with its external

environment. Additionally, the ability to measure tactical/business plan effectiveness is impossible because senior management has not set strategic goals.

The Company's 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 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 managements' 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.

While reviewing the controls governing premiums, it was determined the accountant creating monthly general ledger entries was making an adjusting entry to balance the account. Neither the accountant nor the cost accounting representative could provide a reason or documentation for the entry. Adjusting general ledger accounts without recognition of a valid reason for the adjustment increases the risk of fraud and incorrect financial reporting and is not in keeping with general or statutory accounting principles.

Approximately 500 personnel have authorized access to the Company's building; a facility that routinely requires less than 25 personnel. The large number of individuals negates the purpose of electronic access; which is to restrict access to personnel that require access for legitimate business and support purposes. The large number of personnel authorized access to the Company's resources increases the risk of theft and unauthorized use/release of sensitive information.

The Company's system level passwords did not meet length requirements of at least eight characters. Also, the passwords did not require the use of a special character. Current best industry standards require a password length of at least eight characters and at least one of the characters should be other than alphanumeric. The lack of strong passwords increases the risk of unauthorized access to the Company's information.

The Company has no contingency plan in place to make sure essential services are provided to policyholders in the event of a pandemic or major disaster.

### **Underwriting and Investment Exhibit**

The Company did not complete the Underwriting and Investment Exhibit - Part 2C - Development of Paid and Incurred Health Claims - Medicare Supplement correctly.

The Company inappropriately included Realized gains/losses on its enhanced cash investments and Unclaimed Property remitted to the State Treasurer totaling \$3,318 as expenses on the Underwriting and Investment Exhibit – Part 3, Analysis of Expenses. Due to immateriality, no change was made to the Annual Statement. The Company also had numerous write-ins listed on this exhibit which were incorrectly categorized.

### **Operations/Management**

The Company has never filed or certified the claims payments on the Medicare supplement insurance experience reporting form which is not in compliance with ALA. ADMIN. CODE 482-1-071-.13 B which states, "Compliance with the requirements set forth in Subsection A above shall be certified on the Medicare supplement insurance experience reporting form."

### **CPA Adjusting Entries**

The CPA adjusting entries were reviewed. The only adjustment made by the CPA to the financial statements was an increase to unearned premiums totaling \$33,274. Due to immateriality, no changes were made to the Annual Statement. For further discussion, see Note 3 - Premiums received in advance under Notes to Financial Statements.

## 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 2008. Amounts shown in the comparative statements for the years 2004, 2005, 2006, 2007 and 2008 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  
INTERGRAL PART THEROF.**

**FirstCommunity Health Plan, Inc.**  
**Statement of Assets, Liabilities, Capital and Surplus**  
**For the Year Ended December 31, 2008**

	<u>Assets</u>	<u>Nonadmitted</u> <u>Assets</u>	<u>Net Admitted</u> <u>Assets</u>
Bonds	\$ 4,036,734	\$ -	\$ 4,036,734
Cash, cash equivalents and short-term investments (Note 1)	<u>3,706,837</u>	<u>-</u>	<u>3,706,837</u>
Subtotal, cash and invested assets	\$ 7,743,571	\$ -	\$ 7,743,571
Investment income due and accrued	65,145	-	65,145
Premium considerations:			
Uncollected premiums and agents' balances in the course of collection (Note 2)	2,516		2,516
Net deferred tax asset	5,722,805	5,671,443	51,362
Aggregate write-ins for other than invested assets:			
Prepaid Administrative Insurance	<u>19,700</u>	<u>19,700</u>	<u>-</u>
<b>TOTAL</b>	<b><u>\$ 13,553,737</u></b>	<b><u>\$ 5,691,143</u></b>	<b><u>\$ 7,862,594</u></b>

**LIABILITIES**

	<u>2008</u>
Claims unpaid	\$ 986,749
Unpaid claims adjustment expenses	198,698
Premiums received in advance (Note 3)	9,346
General expenses due or accrued (Note 4)	167,973
Amounts due to parent, subsidiaries and affiliates	<u>31,325</u>
<b>TOTAL LIABILITIES</b>	<b>\$ 1,394,091</b>

**CAPITAL AND SURPLUS**

Gross paid in and contributed surplus (Note 5)	25,975,245
Surplus notes (Note 6)	1,300,000
Aggregate write-ins for other than special surplus funds (Note 7)	-
Unassigned funds (surplus) (Note 8)	<u>(20,806,742)</u>
<b>TOTAL LIABILITIES, CAPITAL AND SURPLUS</b>	<b><u>\$ 7,862,594</u></b>

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

**FirstCommunity Health Plan, Inc.**  
**Statement of Revenue and Expenses**  
**For the Years Ended December 31, 2008, 2007, 2006, 2005 and 2004**

	2008	2007	2006	2005	2004
Net premium income	\$ 5,713,356	\$ 5,815,049	\$ 5,625,893	\$ 5,561,671	\$ 4,953,523
Total revenues	<u>\$ 5,713,356</u>	<u>\$ 5,815,049</u>	<u>\$ 5,625,893</u>	<u>\$ 5,561,671</u>	<u>\$ 4,953,523</u>
<b>Hospital and Medical:</b>					
Hospital/medical benefits	<u>\$ 3,991,534</u>	<u>\$ 4,002,177</u>	<u>\$ 3,929,003</u>	<u>\$ 3,714,366</u>	<u>\$ 3,447,047</u>
<b>Less:</b>					
Total hospital and medical	3,991,534	4,002,177	3,929,003	3,714,366	3,447,047
Claim adjustment expenses	606,567	587,852	562,516	533,325	503,609
General administrative expenses	<u>1,017,680</u>	<u>913,557</u>	<u>904,641</u>	<u>837,349</u>	<u>966,372</u>
Total underwriting deductions	\$ 5,615,781	\$ 5,503,586	\$ 5,396,160	\$ 5,085,040	\$ 4,917,028
Net underwriting gain or (loss)	97,575	311,463	229,733	476,631	36,495
Net investment income earned	296,866	315,171	187,857	100,383	23,913
Net realized capital gains (losses)	(2,496)	-	-	-	-
Net investment gains (losses)	294,370	315,171	187,857	100,383	23,913
Net income or (loss) after capital gains tax and before other federal income taxes	<u>391,945</u>	<u>626,634</u>	<u>417,590</u>	<u>577,014</u>	<u>60,408</u>
<b>Net income (loss)</b>	<b><u>\$ 391,945</u></b>	<b><u>\$ 626,634</u></b>	<b><u>\$ 417,590</u></b>	<b><u>\$ 577,014</u></b>	<b><u>\$ 60,408</u></b>
<b>Capital and Surplus Account</b>					
Capital and surplus prior reporting period	\$ 6,172,503	\$ 5,479,776	\$ 5,042,188	\$ 4,434,903	\$ 4,391,903
Net income	391,945	626,634	417,590	577,014	60,408
Change in net deferred income tax	(202,192)	(201,128)	(139,757)	(183,334)	(20,581)
Change in nonadmitted assets	<u>106,247</u>	<u>267,221</u>	<u>159,755</u>	<u>213,605</u>	<u>3,173</u>
Net change in capital & surplus	<u>\$ 296,000</u>	<u>\$ 692,727</u>	<u>\$ 437,588</u>	<u>\$ 607,285</u>	<u>\$ 43,000</u>
Capital and surplus end of reporting period	<b><u>\$ 6,468,503</u></b>	<b><u>\$ 6,172,503</u></b>	<b><u>\$ 5,479,776</u></b>	<b><u>\$ 5,042,188</u></b>	<b><u>\$ 4,434,903</u></b>

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

## NOTES TO FINANCIAL STATEMENTS

**Note 1 - Cash and short-term investments** **\$3,706,837**

The above captioned amount is the same as reported by the Company in its 2008 Annual Statement.

The Company included \$3,150 accrued interest on Schedule E - Part 1 - Cash in Column 6: Balance. Accrued interest is to be reported in Column 5 - Amount of Interest Accrued December 31 of Current Year. This error did not change the total amount reported for Cash and short-term investments.

**Note 2 – Uncollected premiums and agents’ balances  
in the course of collection** **\$2,516**

The above captioned amount is the same as reported by the Company in its 2008 Annual Statement.

The Company did not complete Exhibit 2 - Accident and Health Premiums Due and Unpaid in its 2007 or 2008 Annual Statements. According to the NAIC Annual Statement Instructions, this exhibit should reconcile to page 2, line 13.1 Uncollected premiums and agents’ balances in the course of collection.

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**Note 3 – Premiums received in advance** **\$9,346**

The above captioned amount is the same as reported by the Company in its 2008 Annual Statement.

The Company's CPAs reviewed Premiums received in advance. It was determined that the Company lists unearned premiums from the "Aged Trial Balance" report. The only amount listed as unearned is the amount of the outstanding credit which relates to the month immediately subsequent to the month/year-end. Upon further investigation, it was noted that many individuals' accounts carried credits in excess of the one month liability being recognized. The CPA performed further testing and determined that this liability was understated by \$33,274. Since this amount is immaterial to this examination, no adjustments were made to the Annual Statement.

**Note 4 – General expenses due or accrued**

**\$167,973**

The above captioned amount is the same as reported by the Company in its 2008 Annual Statement.

The Company's CPA reviewed a sample of checks written in 2009 in order to determine if the Company had properly accrued for expenses related to 2008. The CPA workpapers indicated that the Company had not included \$8,678 in expenses related to 2008 in General expenses due and accrued at year-end 2008. Based on the errors found in the sample, the CPA determined that it is reasonable that another \$6,052 in errors could be expected. Since the total errors noted were immaterial, no changes were made to the financial statements. However, it was determined that the Company has not complied with the recommendation made in the previous examination report.

**Note 5 – 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 2008 Annual Statement.

The Company included contributed capital totaling \$25,975,245 in Aggregate write-ins for other than special surplus funds. According to the NAIC Annual Statement Instructions and SSAP No. 72, paragraphs 7 – 10, the Company should report its contributed capital as Gross paid-in and contributed surplus.

**Note 6 – Surplus notes**

**\$1,300,000**

The above captioned amount is \$1,300,000 more than the \$-0- reported by the Company in its 2008 Annual Statement.

The Company included its restricted capital note in Aggregate write-ins for other than special surplus funds. According to the NAIC Annual Statement Instructions and SSAP No. 72, paragraph 11, the Company should report its \$1.3 million restricted capital note as Surplus notes.

**Note 7 – Aggregate write-ins for other than special surplus funds**

**\$-0-**

The above captioned amount is \$27,255,545 less than the \$27,255,545 reported by the Company in its 2008 Annual Statement.

The Company included contributed capital of \$25,975,245, a \$1,300,000 restricted capital note and (\$19,700) in non-admitted assets 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. The \$1.3 million restricted capital note should be reported as Surplus notes. According to SSAP No. 72, paragraph 12. d., non-admitted assets are a reduction of unassigned funds.

**Note 8 – Unassigned funds (surplus)** **(\$20,806,742)**

The above captioned amount is \$19,700 less than the (\$20,787,042) reported by the Company in its 2008 Annual Statement.

The Company included contributed capital of \$25,975,245, a \$1,300,000 restricted capital note and \$19,700 in non-admitted assets in Aggregate write-ins for other than special surplus funds. According to SSAP No. 72, paragraph 12. d., non-admitted assets are a reduction of unassigned funds.

**Unassigned funds per Company's 2008**

**Annual Statement** **\$ (20,787,042)**

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Decrease due to reclassification of  
non-admitted assets from Aggregate  
write-ins for other than special surplus funds (19,700)

Total increase (decrease) to surplus (19,700)

**Unassigned funds (surplus) per examination** **\$ (20,806,742)**

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:

### Employee Welfare

Within the previous examination report, it was recommended that the Company maintain documentation to provide evidence that its employees, officers and directors are not in conflict with Section 1033 of Title 18 of the US Code and ALA. ADMIN CODE 482-1-121 (2003), which prohibits certain persons from participating in the business of insurance. As a result of this recommendation, the Company added the following statement to the Company's Affirmation Statement: "I further affirm that I am not prohibited or limited in any manner from engaging in the business of insurance." However, Affirmation Statements were not signed in 2004. Affirmation Statements were signed by the officers and directors for 2005 - 2008. However, the other employees of Huntsville Hospital who are responsible for the administrative and operational functions on a daily basis did not sign Affirmation Statements in 2008.

### Policyholder Complaints

According to the previous examination report, the Company received a total of 129 complaints. There were 32 complaints whose response was provided after 45 calendar days. "Within the Company's Certificate of Coverage, the Problem Resolution Section stated that the Initial Grievance Committee is to issue a decision no later than 45 calendar days from the date an initial grievance is received." It was 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 115 complaints during the examination period 2004 - 2008. 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 23 of the 115 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.

### General Expenses Due or Accrued

The previous recommendation report recommended that the Company include an accrual for expenses in order to match all expenses to their related periods of income/claims. The Company's CPA reviewed a sample of checks written in 2009 in order to determine if the Company had properly accrued for expenses related to 2008. The CPA workpapers indicated that the Company had not included \$8,678 in expenses related to 2008 in General expenses due and accrued at year-end 2008. Based on the errors found in the sample, the CPA determined that it is reasonable that another \$6,052 in errors could be expected. Since the total errors noted were immaterial, no changes were made to the financial statements.

### **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, 2008, 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.

The Company entered into a lease agreement with its parent, Huntsville Hospital, effective January 1, 2009. The Company agreed to lease office space at its current location for a term of five years.

On January 27, 2009, the Company received approval from the Alabama Department of Insurance to repay its \$1.3 million restricted capital note to Huntsville Hospital. The note and interest totaling \$2,532,965 was repaid on March 31, 2009.

## COMMENTS AND RECOMMENDATIONS

### Employee Welfare – Page 7

**It is again recommended** that the Company maintain documentation to provide evidence that it is in compliance with Section 1033 of Title 18 of the US Code and ALA. ADMIN. CODE 482-1-121 (2003), which prohibits certain persons from participating in the business of insurance.

### Policyholder Complaints – Page 13

**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 management review all checks for check number continuity.

**It is recommended** that the Company develop and implement a strategic plan.

**It is recommended** that the Company develop and maintain a disaster recovery plan.

**It is recommended** that the Company maintain documentation for adjusting entries.

**It is recommended** that the Company restrict electronic access to its building to personnel who have a need for routine access.

**It is recommended** that the Company implement strong passwords.

**It is 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 plans could utilize the facilities of that hospital, since the hospital would have back-up generators, isolation rooms, etc.

**It is recommended** that the Company complete the Underwriting and Investment Exhibit - Part 2C - Development of Paid and Incurred Health Claims - Medicare Supplement in accordance with the NAIC Annual Statement Instructions.

**It is recommended** that the Company not include gains/losses on investments or unclaimed property remitted to the State Treasurer as expenses on the Underwriting and Investment Exhibit - Part 3 - Analysis of Expenses.

**It is recommended** that the Company classify expenses in the appropriate categories on the Underwriting and Investment Exhibit - Part 3 - Analysis of Expenses in accordance with the NAIC Annual Statement Instructions.

**It is recommended** that the Company certify the claims payments on the Medicare supplement insurance experience reporting form as required by ALA. ADMIN. CODE 482-1-071-.13 B.

Cash and short-term investments – Page 21

**It is recommended** that the Company report accrued interest for cash and short-term investments at year-end in Column 5 of Schedule E - Part 1 - Cash.

Uncollected premiums and agents' balances in  
the course of collection – Page 21

**It is recommended** that the Company complete Exhibit 2 - Accident and Health Premiums Due and Unpaid in accordance with the NAIC Annual Statement Instructions.

Premiums received in advance – Page 21

**It is recommended** that the Company include all unearned premiums in Premiums received in advance.

General Expenses Due or Accrued – Page 22

**It is again recommended** that the Company include an accrual for expenses in order to match all expenses to their related periods of income/claims.

Gross paid in and contributed surplus – Page 22

**It is 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.

Surplus notes – Page 22

**It is recommended** that the Company report its restricted capital note as Surplus notes as required by SSAP No. 72, paragraph 11 and the NAIC Annual Statement Instructions.

Aggregate write-ins for other than special surplus funds – Page 22

**It is 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.

Unassigned funds (surplus) – Page 23

**It is recommended** that the Company report non-admitted assets as a reduction to Unassigned funds (surplus) as required by the NAIC Annual Statement Instructions and SSAP No. 72, paragraph 12. d.

Compliance with Previous Recommendations – Page 23

*Employee Welfare*

**It is again recommended** that the Company maintain documentation to provide evidence that it is in compliance with Section 1033 of Title 18 of the US Code and ALA. ADMIN CODE 482-1-121 (2003), which prohibits certain persons from participating in the business of insurance.

*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.

*General Expenses Due or Accrued*

**It is again recommended** that the Company include an accrual for expenses in order to match all expenses to their related periods of income/claims.


## 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 and Mora Perkins, MCM, examiners for the State of Alabama Department of Insurance; and Harland A. Dyer, FSA, MAAA, actuarial examiner, participated in this examination of FirstCommunity Health Plan, Inc.

Respectfully submitted,



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