

STATE OF ALABAMA  
DEPARTMENT OF INSURANCE  
MONTGOMERY, ALABAMA

REPORT OF EXAMINATION OF

**VIVA HEALTH, INC.**

BIRMINGHAM, ALABAMA

AS OF DECEMBER 31, 2010

TABLE OF CONTENTS

EXAMINER'S AFFIDAVIT ..... i

SALUTATION ..... 1

SCOPE OF EXAMINATION..... 2

ORGANIZATION AND HISTORY ..... 3

MANAGEMENT AND CONTROL..... 3

    Stockholder..... 3

    Board of Directors ..... 4

    Committees ..... 4

    Officers ..... 6

    Management and Service Agreements..... 6

    Conflict of Interest..... 7

CORPORATE RECORDS..... 7

HOLDING COMPANY AND AFFILIATE MATTERS..... 7

    Dividends to Stockholders ..... 7

    Organizational Chart..... 7

FIDELITY BONDS AND OTHER INSURANCE..... 9

EMPLOYEE AND AGENT WELFARE ..... 9

STATUTORY DEPOSITS ..... 10

FINANCIAL CONDITION/GROWTH OF COMPANY ..... 10

LOSS EXPERIENCE..... 10

MARKET CONDUCT ACTIVITIES..... 10

    Plan of Operation ..... 10

    Territory..... 11

    Policy Forms and Underwriting..... 11

    Marketing and Sales ..... 12

    Claims Payment Practices..... 12

    Policyholder Complaints ..... 12

    Compliance with Producer Licensing Requirements..... 13

    Privacy Standards ..... 13

REINSURANCE ..... 13

    Reinsurance Ceded ..... 13

    Reinsurance Assumed..... 15

ACCOUNTS AND RECORDS..... 15

FINANCIAL STATEMENTS ..... 16

NOTES TO FINANCIAL STATEMENTS .....	19
COMMENTS AND RECOMMENDATIONS .....	19
CONTINGENT LIABILITIES AND PENDING LITIGATION .....	20
COMPLIANCE WITH PREVIOUS RECOMMENDATIONS.....	20
SUBSEQUENT EVENTS .....	20
CONCLUSION .....	21

**EXAMINER'S AFFIDAVIT**

**STATE OF ALABAMA  
COUNTY OF JEFFERSON**

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

1. I have the authority to represent Alabama in the examination of VIVA Health, Inc.
2. Alabama 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 VIVA Health, Inc. was performed in a manner consistent with the standards and procedures required by the State of Alabama.

The affiant says nothing further.

*L. Brock*  
Examiner-in-charge

Subscribed and sworn before me by *Lori Brock* on this  
*2nd* day of *March*, 2012.

(SEAL)

*Marie S. Samble*  
(Signature of Notary Public)

My commission expires \_\_\_\_\_  
NOTARY PUBLIC STATE OF ALABAMA AT LARGE  
MY COMMISSION EXPIRES: Oct 25, 2012  
BONDED THRU NOTARY PUBLIC UNDERWRITERS



**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](http://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**

Birmingham, Alabama  
March 2, 2012

Jim L. Ridling, Commissioner  
Alabama Department of Insurance  
P.O. Box 303351  
Montgomery, Alabama 36130-3351

Dear Commissioner Ridling:

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

VIVA Health, Inc.  
Birmingham, Alabama

at its home office located at 1222 14<sup>th</sup> Avenue South, Birmingham, Alabama 35205 as of December 31, 2010. The report of examination is submitted herewith. Where the description "Company" appears herein without qualification, it will be understood to indicate VIVA Health, Inc.

## SCOPE OF EXAMINATION

The Company was last examined for the three year period ended December 31, 2007, by examiners representing the State of Alabama. Where deemed appropriate, transactions, activities and similar items subsequent to 2010 were reviewed.

The examination was conducted in accordance with applicable statutory requirements of the State of Alabama for Health Maintenance Organizations as provided for in Title 27, Chapter 21A 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, 2010, and to identify the Company's prospective risks by obtaining information about the Company including corporate governance, by identifying and assessing inherent risks within the Company and by evaluating 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 and management's compliance with statutory accounting principles and annual statement instructions.

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

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 examination included reviews of the Company's territory and plan of operation, management and operations, claims, complaint handling, marketing and sales, policyholder services, producer licensing, underwriting and rating, and privacy standards. See "MARKET CONDUCT ACTIVITIES" on page 10 for further discussion of the market conduct examination.

Pricewaterhouse Coopers, LLC (PwC) was the Company's certified public accountants (CPAs) for the years under examination. The examiners reviewed the CPAs' workpapers, copies of which were incorporated into the examination as deemed appropriate.

A signed certificate of representation was obtained during the course of 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, 2010.

## ORGANIZATION AND HISTORY

The Company was organized as a for-profit stock corporation on February 27, 1995, and commenced business on February 8, 1996. The Company was certified as a Health Maintenance Organization (HMO), as defined in ALA. CODE § 27-21A-1(7) (1975). The Company was originally incorporated as "HMO Inc." However, its Articles of Incorporation were amended on August 3, 1995, to change the name to current "VIVA Health, Inc."

The Company was formed as a wholly-owned subsidiary of Triton Enterprises, LLC (Triton). Triton was formed, simultaneously with the Company, by the University of Alabama at Birmingham (UAB) (75% owner) and JBL & Company (JBL) (25% owner). During 1996, JBL relinquished its ownership in Triton. Subsequently, the name of Triton was changed to Triton Health Systems, LLC; and, it has since been owned 99% by UAB and 1% by the UAB Educational Foundation.

The Company's principle lines of business are:

- Comprehensive (Hospital & Medical) which represented 19.38% of the net premium income in 2010; and
- Title XVIII - Medicare which represented 80.62% of the net premium income in 2010.

The Company was incorporated with \$100 in authorized capital, which consisted of 10,000 shares of common capital stock with par value of \$0.01 per share. On August 3, 1995, the Company increased its capitalization to \$100,000, which consisted of 10,000 shares of common capital stock with par value of \$10 per share.

At December 31, 2010, the Company's Annual Statement reflected outstanding capital stock of \$100,000. The Company also reported Gross paid in and contributed surplus of \$13,236,995 and Unassigned funds of \$20,282,887.

## MANAGEMENT AND CONTROL

### Stockholder

As of December 31, 2010, Triton Health System's, LLC was the sole owner of the Company. Triton is owned 99% by the University of Alabama at Birmingham and 1% by the University of Alabama Educational Foundation, both are not-for-profit entities.

## **Board of Directors**

Members elected to the Board of Directors of the Company by the sole shareholder and serving at December 31, 2010, were as follows:

<u>Director</u>	<u>Residence</u>	<u>Principal Occupation</u>
Arthur Brad Rollow	Birmingham, Alabama	President and CEO, VIVA Health, Inc.
Dr. Carol Zimmerman Garrison	Birmingham, Alabama	President, UAB
Richard Lee Margison	Birmingham, Alabama	Vice President, Financial Affairs & Administration, UAB
Dr. Isaac William Ferniany	Birmingham, Alabama	CEO, UAB Health System
Dr. Ray Lannom Watts	Birmingham, Alabama	Senior Vice President & Dean, UAB School of Medicine
William Watson Walker, III	Birmingham, Alabama	Retired
Nelson Straub Bean	Birmingham, Alabama	President & CEO, First Commercial Bank

## **Committees**

As of December 31, 2010, the Company had the following committees that reported to the Board of Directors:

- Utilization Management/Quality Improvement Committee
- Credentialing Committee
- Pharmacy & Therapeutics Committee
- Compliance Committee

### ***Utilization Management/Quality Improvement Committee (UM/QI)***

The UM/QI Committee was created as a standing committee of the Company by the Board of Directors. The Committee is responsible for implementing the UM/QI programs and serving as the coordinating and advisory body. The UM/QI Committee is composed of physicians representing the different kinds of specialties utilized by health plan members. The physicians are appointed for three-year terms and memberships are staggered in order to provide continuity of membership.

The following were members of the UM/QI Committee as of December 31, 2010:

Andrew Duxbury, MD  
James Bonner, MD  
Kenneth Elmer, MD  
Nathan Smith, MD

Henry Froshin, MD  
K. Randall Young, MD  
Leigh Copeland, MD  
Steve Kulback, MD

### ***Credentialing Committee***

The Credentialing Committee was created as a standing committee of the Company by Board of Directors and as a subcommittee of the UM/QI Committee. This Committee is responsible for making physician and facility credentialing and re-credentialing recommendations to the Board.

The following were members of the Credentialing Committee as of December 31, 2010:

Anthony Pitts, MD  
Elizabeth Stahl, MD  
John Gerwin, MD  
Sally Ebaugh, MD

Brian Wade, MD  
Jerry McLane, MD  
K. Randall Young, MD

### ***Pharmacy & Therapeutics Committee (P&T)***

The P&T Committee is an advisory group that serves as an advisor and liaison between the health plan and health care providers with regard to the drug evaluation, selection, use, and education matters. This Committee is a policy-recommending body for matters related to the therapeutic use of drugs. The Committee's minimum composition consists of three physicians, one pharmacist, one nurse and one administrator.

The following were members of the P&T Committee as of December 3, 2010:

Cheryl Mokry, PHD  
K. Randall Young, MD  
Staci Branham, RN  
Walter R. Ross, MD

J. Edward Alderson, MD  
Mark W. Todd, PHD  
W. Winn Chatham, MD

### ***Compliance Committee***

The Compliance Committee is responsible for creating and updating the annual compliance plan for compliance with state and federal authorities and regulations. This Committee educates the staff on compliance, investigations of compliance concerns, and conducts internal reviews and audits to determine adherence to the Compliance Plan. The members of the Compliance Committee are a cross-section of Company employees with various seniority and responsibility levels.

The following were members of the Compliance Committee as of December 31, 2010:

Charlie Cutcliffe  
Cindy Ryland Holmes  
Angie LeBlanc  
Bobby Moran  
Kristy Bruce  
Tony Ceasar

Libba Yates  
Teresa Evans  
Belinda Smith  
Ethel Boston  
Linda Jenkins  
Wanda Crumel

## Officers

Officers of the Company elected by the Board of Directors and serving at December 31, 2010 were as follows:

<u>Officer</u>	<u>Title</u>
Arthur Brad Rollow	President and Chief Executive Officer
Richard Lee Margison	Secretary
Isaac William Ferniany	Chairman of the Board
Letitia Eubanks Watkins	Chief Financial Officer
Frank Cardwell Feagin, Jr.	Chief Operating Officer
Elizabeth Clayton Yates	Vice President of Corporate Development
William Doug Cannon	Vice President of Information Systems
Terry Dane Knight	Vice President of Provider Services

## Management and Service Agreements

The Company had no employees during the examination period. It operated under a Management Services Agreement with its parent, Triton Health Systems, LLC (Triton), which was approved by the Alabama Department of Insurance on November 20, 2006. The Agreement was amended during the examination period. The Amendment was approved by the Alabama Department of Insurance on February 5, 2010. The parties agreed to the following:

1. **Management Services:** Triton will perform management services for the Company including, but not limited to, general management, personnel management, human resources, facility management, purchasing, accounting, finance and legal services. The Company will be responsible for ensuring that its activities comply with all applicable statutes and regulations.
2. **Management Fee:** The Company will pay a fixed monthly management fee based on per member, per month. The management fee is intended to cover all direct and indirect expenses paid by Triton on behalf of the Company.
3. **Term and Termination:** The Amendment to the Agreement was effective January 1, 2010, and will continue until terminated by either party furnishing the other party with thirty days advance written notice.
4. **Access to Records:** Any requested annual reports on the financial operations and any other operational data requested by VIVA, the State Health officer or the Commissioner will be provided by Triton.
5. **Entire Agreement:** This Management Services Agreement, approved by the Commissioner, shall be the sole agreement between Triton and the Company for the purpose of management of the Company and payment to Triton for management services.
6. **Amendments:** Any amendments or revisions to this Management Services Agreement shall be effective only with the prior written consent of the Company, Triton and the Commissioner.

### **Conflict of Interest**

The Company has adopted a policy that requires that any interests of its officers and directors that might conflict with any interests of the Company be disclosed. The Company requires its officers and directors to sign and file conflict of interest disclosure statements annually. Conflict of interest statements were signed and filed by all of the Company's officers and directors for each year under examination. Disclosures were made by some officers and directors of the Company; however, it did not appear that the disclosures represented material conflicts.

### **CORPORATE RECORDS**

The Company's Articles of Incorporation, By-Laws, and amendments thereto were inspected and found to provide for the operation of the Company in accordance with Alabama statutes and regulations and with accepted corporate practices.

Minutes of the meetings and actions of the Board of Directors during the examination period were reviewed. The minutes appeared to be complete with regards to recording actions taken on matters before the respective bodies for deliberation and action.

### **HOLDING COMPANY AND AFFILIATE MATTERS**

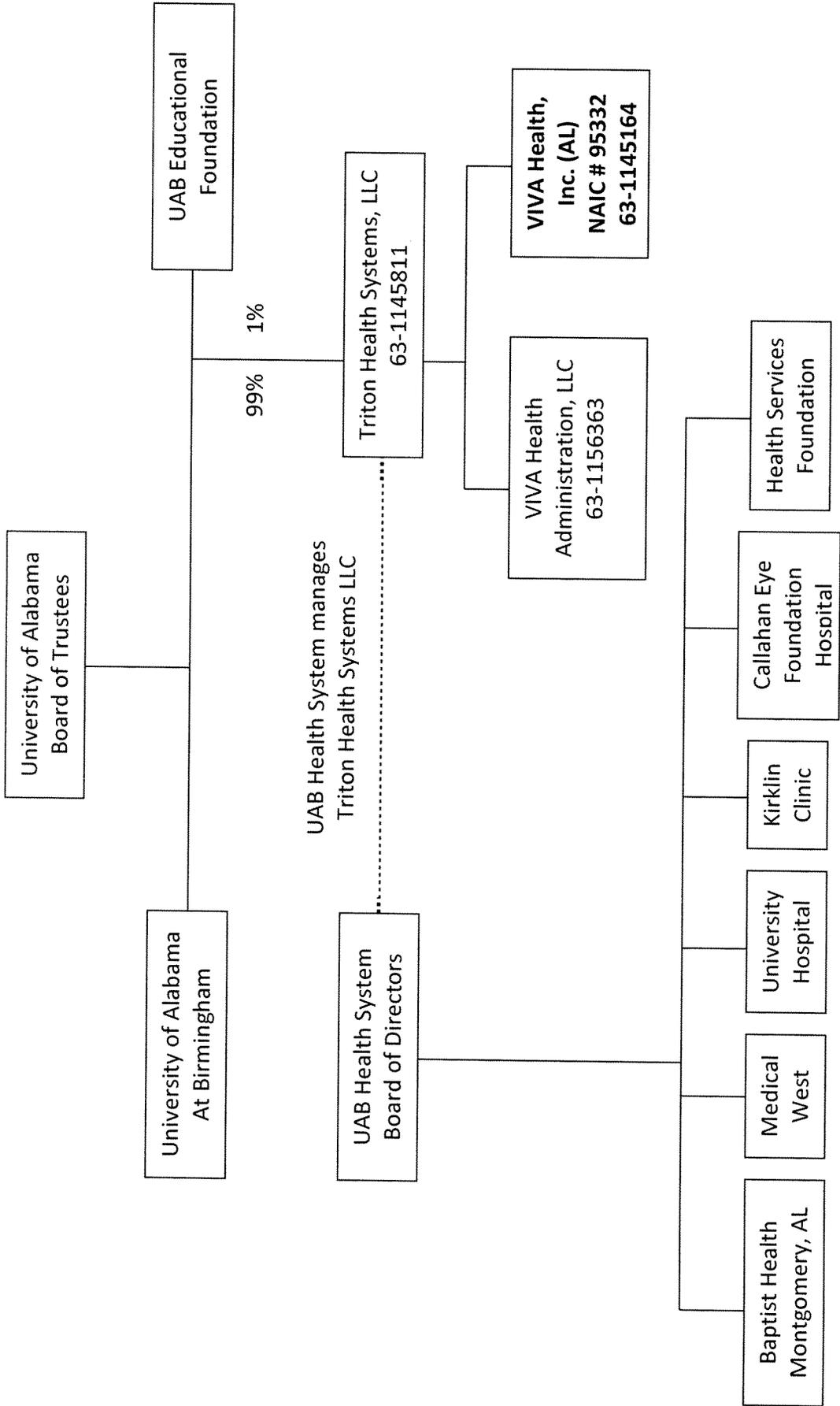
The Company was not subject to the Alabama Insurance Holding Company Regulatory Act, as defined in ALA. CODE § 27-29-1 (1975), except as expressly required by other statutes and regulations. Generally HMOs are subject to regulation in regard to changes in control, but are not subject to the holding company reporting requirements that apply to insurance companies.

### **Dividends to Stockholders**

No dividends to stockholders were paid during the examination period.

### **Organizational Chart**

The following chart presents the identities and interrelationships among all affiliated persons within the Insurance Holding Company System at December 31, 2010.



## FIDELITY BONDS AND OTHER INSURANCE

The Company is a named insured on a crime insurance policy issued to Triton Health Systems, LLC (Triton) by Federal Insurance Company, Indianapolis, Indiana. The single loss limit of the bond met the NAIC suggested minimum requirements for fidelity coverage, and ALA. CODE § 27-21A-6 (b) (1975), which states:

“A health maintenance organization shall maintain in force a fidelity bond on employees and officers in an amount not less than \$25,000 or such other sum as may be prescribed by the commissioner. All such bonds shall be written with at least a one-year discovery period and if written with less than a three-year discovery period shall contain a provision that no cancellation or termination of the bond, whether by or at the request of the insured or by the underwriter, shall take effect prior to the expiration of 90 days after written notice of such cancellation or termination has been filed with the commissioner unless an earlier date of such cancellation or termination is approved by the commissioner.”

The insurance policy included coverage for the following additional crimes: 1) Premises, 2) In Transit, 3) Forgery, 4) Computer Fraud, and 5) Funds Transfer Fraud. In addition to the crime insurance policy, the following policies or coverages were maintained by or on behalf of the Company at December 31, 2010.

1. Errors and Omissions Policy
2. Fiduciary Liability Policy
3. Property Insurance
  - Building and personal property
  - Business income with extra expense
  - Electronic data processing property
  - Extra expense
  - Account receivable, fine arts, money securities and valuable papers
  - Impairment of computer services – malicious programming
4. Liability Insurance
  - Liability coverage through a self-insured trust fund

## EMPLOYEE AND AGENT WELFARE

The Company does not have any employees. Its operations were conducted by personnel employed by Triton Health Systems, LLC, (Triton), the Company’s parent, under the terms of a Management Services Agreement. For further comment, see the caption Management Services Agreement under the heading HOLDING COMPANY AND AFFILIATE MATTERS.

## STATUTORY DEPOSITS

In order to comply with the statutory requirements for doing business in the State of Alabama, the Company had the following on deposit with the Alabama Department of Insurance as of December 31, 2010.

Description	Book/Adjusted Carrying Value	Fair Value
Certificate of Deposit	\$100,000	\$100,000

## FINANCIAL CONDITION/GROWTH OF COMPANY

The following information presents significant items that reflect the growth of the Company for the years indicated.

	Admitted Assets	Liabilities	Capital and Surplus	Net Premium Income
2010*	\$ 101,156,762	\$ 67,536,880	\$ 33,619,882	\$ 457,953,213
2009	77,198,488	45,993,754	31,204,734	380,914,375
2008	44,235,791	21,184,522	23,051,269	360,401,152
2007*	42,772,802	25,812,691	16,960,111	329,010,134

\*Per Examination

## LOSS EXPERIENCE

The loss experience as developed by the Company over the examination period is as follows:

	2008	2009	2010
Revenue	\$ 360,409,896	\$ 380,915,332	\$ 457,955,044
Underwriting Deductions	353,947,772	368,171,525	453,332,540
Underwriting Gain	6,462,124	12,743,807	4,622,504
Member Months	662,793	667,792	729,566
Cost Per Member Months	534.02	551.33	621.37

This table shows that the Company has made an underwriting profit each year over the examination period. It also shows that the underwriting cost per member per month is steadily increasing. The loss experience of the Company appears to be appropriate for the two lines of business they write.

## MARKET CONDUCT ACTIVITIES

### Plan of Operation

The Company has been in both the large and small group commercial markets since its inception in 1996. In the late nineties, the Company's membership growth objective was scaled back and more emphasis was placed on ensuring the efficiency and accuracy of operations and customer service. The Company's focus continues to be conservative, managed growth in both

the large and small group markets. As of December 31, 2010, the Company was licensed to sell its commercial products in 38 counties in Alabama.

VIVA Health began its Medicare contract with the Centers for Medicare & Medicaid Services (CMS) in October 1998. As of December 31, 2010, the Company was approved by CMS in eighteen counties and administered six Medicare plan designs: two premium plans including Part D, \$0 premium plan including Part D, \$0 premium plan excluding Part D, special needs plan for overweight/obese Medicare beneficiaries, and a special needs plan for Medicare beneficiaries also receiving Medicaid.

The Company's agency operations were under the direction of a Sales Director. As of December 31, 2010, the Company had 160 producers. The Company utilized both independent and captive (in-house) agents to market and solicit its business. The independent agents, contracted by the Company, were not employed by VIVA Health, Inc. The Company's captive agents were employees of Triton and only sold VIVA Health products.

**Territory**

As of December 31, 2010, the Company was licensed to transact business in the State of Alabama. The Certificate of Authority was inspected for the period under review and found to be in order. The Company was licensed to write its products in the following counties:

Autauga*	Chilton*	Elmore*	Madison	St. Clair*
Baldwin	Clarke	Etowah*	Marion	Talladega
Bibb	Conecuh	Fayette	Mobile	Tuscaloosa
Blount*	Crenshaw*	Hale	Monroe	Walker
Bullock*	Cullman*	Jefferson*	Montgomery*	Washington
Butler	Dale	Lawrence	Perry	Winston
Calhoun*	Dallas	Lowndes*	Pike*	
Cherokee*	DeKalb*	Macon*	Shelby*	

\*Medicare licensed county.

**Policy Forms and Underwriting**

At December 31, 2010, the Company was issuing Commercial Health and Medicare policies. The Company filed rate increases during the examination period which were approved by the Alabama Department of Insurance.

According to the Company's underwriting for large groups, the rates are based on a blend of experience and model rates. The blending ratio is dependent on claims experience and the model rates utilize age/sex/tiered demographics along with industry and market factors. Initial rates are trended for one year from the effective date and are guaranteed for that time period. The Small Group Rating Model utilized age/sex tiered demographics, along with market and group size factors. The rating model for the small groups varies according to health characteristics of the whole group.

The examiners recalculated the policy premiums to determine that the members were charged the applicable rate for policy coverage selected based on the Company's rating plan. The Company's rating factors are based upon the Group as a whole and each member of the group is rated according to their age, sex and family status. There were no exceptions noted during the review.

The review of the cancellation/nonrenewed files determined the Company maintained proper documentation of the Company initiated and insured initiated cancellations. The Company provided all the cancellation/nonrenewed policies requested which complied with Ala. Code § 27-21A-16 (f) which states, "All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the commissioner."

### **Marketing and Sales**

The Company's advertising and marketing strategy focused on the basics of healthcare along with service, quality and value. The Company utilized both independent and captive (in-house) agents to market and solicit its business. Advertising materials for all years under examination were reviewed. The Company's advertising file contained specimen copies of all the Company's advertisements that were printed, published or prepared. The Company's advertising materials included the Company's name and address and identified the policy being advertised. The advertising material did not misrepresent policy benefits, forms or conditions, make unfair or incomplete comparisons with other policies, or make false, deceptive or misleading statements or representations.

Communication with the producers primarily consisted of verbal communications, e-mail, telephone and fax. The Company allowed its producers to create their own personal websites; however, producers were not permitted to use the Company's logo (name) on their website. Producers were required to use Company-approved advertising materials.

### **Claims Payment Practices**

A sample of paid claims for the examination period was reviewed. The paid claims sample was reviewed for compliance with Alabama Laws and Regulations, and compliance with policy provisions, timeliness of payments, and adequacy of documentation. No discrepancies were found.

### **Policyholder Complaints**

During the examination period, there was a total of 395 complaints. The examiner reviewed a sample of 84 complaints. It was determined that the Company recorded all complaints and other required information in the complaints register. The Company had adequate complaint procedures in place for the distribution of complaints, and obtaining and recording responses to the complaints. The Company provided its complaint handling process, telephone number and address to the policyholders for consumer inquiries and/or complaints.

## **Compliance with Producer Licensing Requirements**

The examiners made an inspection of the Company's records in order to determine that the 160 producers representing the Company were duly licensed and appointed by the State of Alabama.

The examiners obtained the 2008 - 2010 commercial commissions paid listing from the Company. A sample of individuals who received commission payments during 2008 - 2010 was selected and verified with the licensed producers' register obtained from the Alabama Department of Insurance. The examiners compared the dates of the commission payments to the producers' appointment dates. There were no discrepancies found. It was determined that the producers were appropriately licensed at the time the commissions were paid.

## **Privacy Standards**

*Compliance with ALA. ADMIN. CODE 482-1-122*

The Company does not disclose any nonpublic personal financial or health information to nonaffiliated third parties. The Company detailed in Section 11 of its Privacy/Security Policies and Procedures, the steps taken to safeguard confidential member information, such as: safeguarding conversations, documents, faxes, emails, voicemails/messages, computers and internet communications. However, the Company indicated in its privacy policy that it may disclose the member's medical information for treatment and treatment alternatives, for payment, for health care operations, to individuals involved in the member's care or payment for the member's care, business associates, employers, as required by law, and for certain marketing activities.

The Company is also required to comply with the Health Insurance Portability and Accountability Act (HIPAA) privacy rule as promulgated by the U.S. Department of Health and Human Services.

## **REINSURANCE**

### **Reinsurance Ceded**

As of the examination date, the Company maintained two reinsurance treaties designed to protect the Company from large single-risk losses and losses from human organ and bone marrow transplant services. The treaty with HCC Life Insurance Company, Kennesaw, Georgia, was structured as a Specific Excess of Loss reinsurance treaty whereby the Company retained a predetermined dollar amount of loss per person, per year, and was indemnified by the reinsurer for eligible services at the percentage of coinsurance over and above the retention up to the limit of the agreement. The treaty with ARCH Insurance Company, Hunt Valley, Maryland, was structured as a Specific Excess of Loss reinsurance treaty, whereby the Company was indemnified by the reinsurer for losses over and above the Company's retention of \$25,000 per transplant.

Schedule S - Part 3 - Section 2 of the Company's 2010 Annual Statement reported \$1,758,400 in ceded premiums. No reserve credit was taken at year-end 2010 for ceded reinsurance.

The reinsurance contracts in-force as of December 31, 2010, are summarized below:

*HCC Life Insurance Company:*

Type of contract	Per risk excess of loss
Policy effective date	January 1, 2010, through December 31, 2010
Line of business insured	<ul style="list-style-type: none"> <li>• Commercial</li> <li>• Medicare</li> </ul>
Annual deductible	\$225,000 per member per year
Maximum lifetime reimbursement	\$2,000,000 per member
Maximum aggregate reimbursement	\$5,000,000
Percentage payable	Reinsurers liability is 90%
Eligible expenses reimbursement	<p><b><u>Charges are segregated</u></b></p> <ul style="list-style-type: none"> <li>• Commercial HMO - (UAB)</li> <li>• Commercial HMO - All other members</li> <li>• Medicare HMO</li> <li>• Covered Acute Care</li> <li>• Sub-Acute Care</li> </ul>

*ARCH Insurance Company:*

Type of contract:	Human Organ and Bone Marrow Transplant Excess of Loss
Policy effective date	October 1, 2010 through September 30, 2011
Line of Business insured	<ul style="list-style-type: none"> <li>• Commercial</li> <li>• Medicare</li> </ul>
Deductible per transplant	\$25,000 per transplant
Maximum life time benefit	\$2,000,000 for each covered transplant procedure
Maximum reimbursement per covered transplant procedure	<p><b><u>In-Network Services:</u></b> 100% of covered charges subject to all applicable limits, terms and conditions of the contract.</p> <p><b><u>Travel expenses:</u></b></p> <ul style="list-style-type: none"> <li>• \$200 per day</li> <li>• \$10,000 per covered transplant procedure</li> </ul> <p><b><u>Air Ambulance Services:</u></b></p> <ul style="list-style-type: none"> <li>• \$10,000 per covered transplant procedure</li> </ul> <p><b><u>Nursing services:</u></b></p> <ul style="list-style-type: none"> <li>• \$10,000 per covered transplant procedure</li> </ul> <p><b><u>Out-of-Network services:</u></b></p> <ul style="list-style-type: none"> <li>• 60% of covered charges subject to all applicable limits, terms and conditions of the contract.</li> <li>• Other maximum limits apply</li> </ul>

### Reinsurance Ceded Claims Recoveries

The Company had reinsurance ceded claims recoveries during 2009 of \$173,111 and during 2008 of \$415,310. Those amounts were not recorded in the Underwriting and Investment Exhibit, Part 2 - Claims Incurred During the Year or Part 2A - Claims Liability End of Current Year as they should have been. The Annual Statement Instructions include the following language for Part 2: "Line 1.3 should include only those reinsurance recoveries received during the year; Line 3.3 should include the reinsurance ceded amounts booked but not yet billed; Lines 7 and 11 These amounts should include reinsurance recoveries on paid losses but not yet received." The reinsurance recoveries for Reported in Process of Adjustment, Incurred and Unreported and Amounts Withheld from Paid Claims and Capitations in Part 2A are carried forward to Part 2, for both current year and prior year.

### Reinsurance Assumed

The Company did not assume any business during the period covered by this examination.

## **ACCOUNTS AND RECORDS**

### Actuarial Opinion and Memorandum

The Instructions to the Annual Statement require the following: "The Appointed Actuary must report to the Board of Directors or the Audit Committee each year on the items within the scope of the Actuarial Opinion. The Actuarial Opinion and the Actuarial Memorandum must be made available to the Board of Directors. The minutes of the Board of Directors should indicate that the Appointed Actuary has presented such information to the Board of Directors or the Audit Committee and that the Actuarial Opinion and the Actuarial Memorandum were made available. A separate Actuarial Opinion is required for each company filing an Annual Statement." The Company did not provide evidence that such presentation was made to the Board of Directors (or Audit Committee) of the Company.

### Actuarial Appointment

The Company appointed PricewaterhouseCoopers, LLP as the opining (appointed) actuary. However, the opining actuary must be an individual; the opining actuary cannot be a firm such as PricewaterhouseCoopers. In addition, the Company did not notify the Commissioner of Insurance of the appointment.

## FINANCIAL STATEMENTS

The financial statements included in this report reflect the financial condition of the Company as of December 31, 2010, and its operations for the years under examination. The statements were presented in the following order.

Statement of Assets, Liabilities, Surplus and Other Funds	Page 17
Summary of Operations	Page 18
Capital and Surplus Account	Page 18

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

**VIVA Health, Inc.**  
**Statement of Assets, Liabilities, Surplus and Other Funds**  
**for the Year Ended December 31, 2010**

Assets

	Assets	Non- admitted Assets	Admitted Assets
Bonds	\$ 10,101,717	\$ -	\$ 10,101,717
Cash and short-term investments	82,682,873	-	82,682,873
Investment income due and accrued	116,952	-	116,952
Premiums and considerations: Uncollected premiums agents' balances in the course of collection	374,566	13,728	360,838
Accounts receivable relating to uninsured plans ( <b>Note 1</b> )	2,500,000	-	2,500,000
Current federal and foreign income tax recoverable and interest thereon	606,801	-	606,801
Net deferred tax asset	264,356	-	264,356
Guaranty funds receivable or on deposit	41,000	-	41,000
Receivable from parent, subsidiaries or affiliates	1,831,944	-	1,831,944
Health care and other amounts receivable	4,845,493	2,195,212	2,650,281
<b>Total Assets</b>	<u>\$ 103,365,702</u>	<u>\$ 2,208,940</u>	<u>\$ 101,156,762</u>

Liabilities, Surplus and Other Funds

	Covered	Uncovered	Total
Claims Unpaid	\$ 24,322,390	\$ 752,239	\$ 25,074,629
Unpaid claim adjustment expenses	631,159	-	631,159
Premiums received in advance	1,355,310	-	1,355,310
General expenses due or accrued	235,437	-	235,437
Amounts due to parent, subsidiaries and affiliates	37,439	-	37,439
Medicare risk adjustment reserve	39,558,936	-	39,558,936
Risk share	643,970	-	643,970
Total Liabilities	<u>\$ 66,784,641</u>	<u>\$ 752,239</u>	<u>\$ 67,536,880</u>
Common capital stock			\$ 100,000
Gross paid in and contributed surplus			13,236,995
Unassigned funds (surplus) ( <b>Note 2</b> )			20,282,887
Surplus as regards policyholders			<u>\$ 33,619,882</u>
Totals			<u>\$ 101,156,762</u>

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

**VIVA Health, Inc.**  
**Statement of Revenue and Expenses**  
**for the Years Ended December 31, 2010, 2009 and 2008**

	2010	2009	2008
Net premium income	\$ 457,953,213	\$ 380,914,375	\$ 360,401,152
Other services	\$ 1,831	\$ 957	\$ 8,744
Total revenues	<u>\$ 457,955,044</u>	<u>\$ 380,915,332</u>	<u>\$ 360,409,896</u>
<b>Hospital and Medical:</b>			
Hospital/medical benefits	\$ 329,661,069	\$ 274,169,076	\$ 263,636,445
Other professional services	8,446,503	5,987,121	4,275,166
Emergency room and out-of-area	8,818,513	6,578,352	5,360,719
Prescription drugs	38,182,981	29,023,836	32,441,547
Home health/DME	17,556,366	12,819,557	9,643,043
Incentive pool, withhold adjustments and bonus amounts	13,652	-	-
Subtotal	<u>\$ 402,679,084</u>	<u>\$ 328,577,942</u>	<u>\$ 315,356,920</u>
<b>Less:</b>			
Net reinsurance recoveries	\$ -	\$ 173,111	\$ 415,310
Total hospital and medical	402,679,084	328,404,831	314,941,610
Claim adjustment expenses	10,130,691	7,953,339	2,730,432
General administrative expenses	40,522,765	31,813,355	36,275,730
Total underwriting deductions	<u>\$ 453,332,540</u>	<u>\$ 368,171,525</u>	<u>\$ 353,947,772</u>
Net underwriting gain or (loss)	4,622,504	12,743,807	6,462,124
Net investment income earned	205,685	200,379	1,153,164
Net realized capital gains (losses)	2,034	5,520	11,561
Net investment gains (losses)	207,719	205,899	1,164,725
Net income or (loss) after capital gains tax and before other federal income taxes	4,830,223	12,949,706	7,626,849
Federal and foreign income taxes incurred	1,720,521	4,453,694	2,649,852
<b>Net income (loss)</b>	<u><b>\$ 3,109,702</b></u>	<u><b>\$ 8,496,012</b></u>	<u><b>\$ 4,976,997</b></u>
<b><u>Capital and Surplus Account</u></b>			
Capital and surplus prior reporting period	\$ 31,204,734	\$ 23,051,269	\$ 18,355,320
Net income	3,109,702	8,496,012	4,976,997
Change in net deferred income tax	43,849	40,688	3,495
Change in nonadmitted assets	(738,403)	(383,214)	(284,544)
Net change in capital & surplus	<u>\$ 2,415,148</u>	<u>\$ 8,153,486</u>	<u>\$ 4,695,948</u>
Capital and surplus end of reporting period	<u><b>\$ 33,619,882</b></u>	<u><b>\$ 31,204,755</b></u>	<u><b>\$ 23,051,268</b></u>

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

## NOTES TO FINANCIAL STATEMENTS

Note 1 – Amounts receivable related to uninsured plans \$2,500,000

The amount reported above is the same as reported by the Company in its 2010 Annual Statement.

The Company included \$891,239 for its Part D Risk Sharing Receivable under Amounts receivable related to uninsured plans. This amount should have been reported as Accrued retrospective premiums. Since this is a classification error which did not affect the overall reported assets, no changes were made to the Annual Statement.

Note 2 – Unassigned funds (surplus) \$20,282,887

The above captioned amount is the same as reported by the Company in its 2010 Annual Statement.

The following schedule presents a reconciliation of the unassigned funds per the Company's filed statement to this examination's findings:

Unassigned funds (surplus) per Company	\$20,282,887
Examination increase/(decrease) to assets:	0
Total increase/(decrease) to assets	<u>0</u>
Examination (increase)/decrease to liabilities:	0
Total (increase)/decrease to liabilities	<u>0</u>
Unassigned funds (surplus) per Examination	<u>\$20,282,887</u>

## COMMENTS AND RECOMMENDATIONS

### Reinsurance Ceded Claims Recoveries

**It is recommended** that the Company record reinsurance ceded recoveries each year in the Underwriting and Investment Exhibit, Part 2 - Claims Incurred During the Year and Part 2A - Claims Liability End of Current Year in accordance with Annual Statement Instructions.

### ***Accounts and Records***

### Actuarial Opinion and Memorandum

**It is recommended** that the appointed actuary make a presentation each year, in accordance with the Instructions to the Annual Statement, to the Board of Directors (or Audit Committee) of the Company, of those items within the scope of the Actuarial Opinion and that the minutes of the Board of Directors (or Audit Committee) reflect that such presentation was made.

### Actuarial Appointment

**It is recommended** that the Company appoint a specific qualified actuary (instead of a firm) as the opining (appointed) actuary of the Company and also notify the Commissioner of Insurance of the appointment of such qualified actuary.

### Note 1 – Amounts receivable related to uninsured plans

**It is recommended** that the Company report its Part D Risk Sharing Receivable under Accrued retrospective premiums in accordance with NAIC Annual Statement Instructions.

## **CONTINGENT LIABILITIES AND PENDING LITIGATION**

The review of the contingent liabilities and pending litigation included an inspection of representation made by the Company's managers and a review of the Company's records and files for the period under examination as well as the review of the records subsequent to the examination date. The reviews performed did not identify any items that would have a material effect on the Company's financial condition in the event of an adverse outcome.

## **COMPLIANCE WITH PREVIOUS RECOMMENDATIONS**

A review was conducted during the current examination with regard to the Company's compliance with the recommendations made in the previous examination report. This review indicated that the Company had complied with the prior recommendations.

## **SUBSEQUENT EVENTS**

Subsequent to the examination period, the Company sought authorization and received approval to add three additional Alabama counties to its commercial service area. The three counties included Coosa, Morgan and Tallapoosa.

The Company received approval from the Alabama Department of Insurance on December 20, 2011 to convert to an Alabama non-profit corporation, effective January 1, 2012.

As of December 31, 2010, the Company had \$39,558,936 reserved for negative payment adjustments resulting from CMS Risk Adjustment Data Validation Audits ("RADV Audits"). The Company was selected by CMS for a RADV Audit of its 2006 risk adjustment data used to determine VIVA Health's 2007 premium rates. On February 24, 2012, CMS notified the Company that payment year 2011 is the first year for which payment recovery based on extrapolated estimates will be conducted for Medicare Advantage plans. The impact of this notice on the Company's financial statement has not yet been determined but management expects it to result in a significant improvement to the Company's capital and surplus.

## CONCLUSION

Acknowledgement is hereby made of the courtesy and cooperation extended by all persons representing VIVA Health, Inc. during the examination.

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

In addition to the undersigned, Charles Turner, CISA, Examiner; and Harland A. Dyer, FSA, MAAA, actuarial examiner; all representing the Alabama Department of Insurance, participated in the examination of VIVA Health, Inc.

Respectfully submitted,



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