BEFORE JAMES A. DODRILL, INSURANCE COMMISSIONER
OF THE STATE OF WEST VIRGINIA

In the Matter of:

THE HEALTH PLAN OF WEST VIRGINIA, INC. (NAIC#95677)

ADMINISTRATIVE PROCEEDING NO. 20-AP-FINCON-02014

AGREED ORDER ADOPTING REPORT OF FINANCIAL EXAMINATION AND DIRECTING ACTION

COMES NOW James A. Dodrill, Insurance Commissioner of the State of West Virginia, (hereinafter the "Insurance Commissioner") and issues this Order which adopts the REPORT OF FINANCIAL EXAMINATION as of December 31, 2018, of THE HEALTH PLAN OF WEST VIRGINIA, INC., (hereinafter referred to as "Company") based upon the following findings, to wit:

JURISDICTION & FINDINGS OF FACT

1. The Insurance Commissioner is charged with the duty of administering and enforcing the provisions of Chapter 33, of the *West Virginia Code* of 1931, as amended.

2. The Company is organized pursuant to provisions of Article 22, Chapter 33 of the *West Virginia Code*.

3. The Company is a non-profit, tax exempt health maintenance organization ("HMO") under the provision of the Internal Revenue Code 501c(4). The Company was organized on August 8, 1978 and began writing business in West Virginia on November 1, 1979. On March 3, 1980, the Company was authorized to transact business in Ohio and on July 9, 1980, the Company was federally qualified under the provisions of Title XIII of the Public Health Service Act. The Company was originally located in Wheeling, West Virginia. After receiving regulatory approval in 1985, the company relocated to St. Clairsville, Ohio. During 2017, the Company changed is name from the

Health Plan of the Upper Ohio Valley, Inc., to The Health Plan of West Virginia, Inc., and moved its statutory home office back to Wheeling, West Virginia.

4. In July 2003, the Company purchased Hometown Health Network, a Massillon, Ohio based managed care organization, from the Akron General Hospital. On April 1, 2006 (a non-profit HMO in Ohio, changed its name to "The Health Plan of Ohio, Inc." in 2017), Hometown Insurance Group, Hometown administrative Services, were transferred to the Company, completing the merger of Hometown into its parent company.

5. The Health Plan of West Virginia, Inc., writes Individual, Commercial, Medicare, and Medicaid line of business.

6. An examination of the financial condition and operational affairs of the Company for period beginning January 1, 2016 and ending December 31, 2018, was conducted in accordance with *Code* §33-2-9(c) by the Insurance Commissioner.

7. On May 17, 2020 the examiner filed a Report of Financial Examination with the Insurance Commissioner pursuant to W.Va. *Code* § 33-2-9(j)(2). A copy of the Report of Financial Examination is attached hereto as Exhibit A and incorporated herein as if set forth in full.

8. On or about May 27, 2020, a true and accurate copy of the Report of Financial Examination was sent and received via email to Jeff Knight. A copy of the Letter dated May 27, 2020, is attached hereto as Exhibit B.

9. Pursuant to W.Va. *Code* § 33-2-9(j)(2), the Company was notified and afforded a period of thirty (30) days, after receipt of the Report of Financial Examination, to make a submission, rebuttal, or objection concerning any matter contained in the Report.

10. By letter dated June 22, 2020, management of the Company acknowledged that they had reviewed the Report of Financial Examination and did not materially dispute the findings of the examination. A copy of the Company's letter of June 22, 2020, is attached hereto as Exhibit C.

CONCLUSIONS OF LAW

1. *Code* § 33-2-9(j)(2) provides that no later than sixty (60) days following completion of the examination, the examiner in charge shall file with the Insurance Commissioner a verified, written Report of Financial Examination under oath, and upon receipt of the verified report, the Insurance Commissioner shall transmit the Report of Financial Examination to the Company with a notice that shall afford the Company a reasonable opportunity of not more than thirty (30) days, to make a written submission or rebuttal.

2. *Code* § 33-2-9(j)(3) provides that within thirty (30) days of the end of the period allowed for the receipt of written submissions or rebuttals the Insurance Commissioner shall fully consider and review the Report of Financial Examination, together with any written submissions or rebuttal, and shall enter an ORDER adopting the Report of Financial Examination as filed or with modifications or corrections, enter an ORDER rejecting the Report of Financial Examination with directions to the examiners to reopen the examination or call for an investigatory hearing.

ORDER

It is, therefore, **ORDERED** as follows:

1. The Report of Financial Examination of the Company, attached hereto as Exhibit A, is hereby ADOPTED and APPROVED by the Insurance Commissioner.

2. A copy of this Agreed Order Adopting Report of Financial Examination and Directing Action and the Report of Financial Examination shall be mailed to the Company via certified mail, return receipt requested, upon entry by the Insurance Commissioner.

3. The Company shall file with the Insurance Commissioner, within thirty (30) days of the issuance of this Agreed Order, affidavits executed by each of its directors stating under oath that they have received a copy of the Report of Financial Examination and a copy of this Agreed Order Adopting Report of Financial Examination and Directing Action in accordance with *Code* § 33-2-9(j)(4).

4. The Company shall take whatever actions are required to comply with the recommendations set forth in the Report of Financial Examination, if any, and shall demonstrate compliance to the satisfaction of the Insurance Commissioner, if necessary.

5. The Company, as indicated by its signature hereon, waives any right(s) to any notice, administrative hearing or appeal therefrom for the actions taken by the Insurance Commissioner herein this Agreed Order Adopting Report of Financial Examination and Directing Action. The Company reserves its rights to notice, administrative hearing or appeal for any future enforcement actions taken by the Commissioner that might result from this Agreed Order, if any.

6. This matter is dismissed from the administrative docket of the Insurance Commissioner.

ENTERED this 29th day of June, 2020.

James A. Dodrill
West Virginia Insurance Commissioner

THE PARTIES DO SO AGREE:

OFFICES OF THE INSURANCE COMMISSIONER
STATE OF WEST VIRGINIA

By: _____
Gregory A. Elam, Associate General Counsel

Date: 6/26/2020

THE HEALTH PLAN OF WEST VIRGINIA, INC.

BY: Jeffrey M. Knight
[Print Name]

Signed: _____

Its: Interim President/COO

Dated: 6.25.2020

REPORT OF EXAMINATION

OF

THE HEALTH PLAN OF WEST VIRGINIA, INC.

WHEELING, WV

NAIC #95677

AS OF DECEMBER 31, 2018

EXHIBIT

A

TABLE OF CONTENTS

SALUTATION 3
SCOPE OF EXAMINATION 4
SUMMARY OF SIGNIFICANT FINDINGS 5
HISTORY 5
MANAGEMENT AND CONTROL 7
- **BOARD OF DIRECTORS** 7
- **OFFICERS** 8
- **ORGANIZATIONAL CHART** 10
- **AGREEMENTS** 10

TERRITORY AND PLAN OF OPERATION 11
REINSURANCE 11
FINANCIAL STATEMENTS 12
- **STATEMENT OF ASSETS** 12
- **STATEMENT OF LIABILITIES, CAPITAL AND SURPLUS** 13
- **STATEMENT OF REVENUE AND EXPENSES** 14
- **RECONCILIATION OF SURPLUS** 15

SUMMARY OF EXAMINATION CHANGES 16
SUMMARY OF EXAMINATION RECOMMENDATIONS 18
ACKNOWLEDGEMENT AND SIGNATURE 19

SALUTATION

May 27, 2020
Charleston, West Virginia

The Honorable James A. Dodrill
West Virginia Insurance Commissioner
900 Pennsylvania Ave.
Charleston, West Virginia 25302

Pursuant to the authority vested in the West Virginia Offices of the Insurance Commissioner ("WVOIC"), as well as rules, regulations and procedures promulgated by the National Association of Insurance Commissioners ("NAIC"), an examination has been made of the administrative affairs, books, records, and financial condition of:

The Health Plan of West Virginia, Inc.
1110 Main Street
Wheeling, WV 26003

hereinafter referred to as the "Company". The following Report of Examination is respectfully submitted.

SCOPE OF EXAMINATION

The examiners have performed a multi-state financial examination of the Company. The last examination covered the three-year period from January 1, 2013 through December 31, 2015. The examination commenced on June 26, 2019 pursuant to W.Va. Code §33-2-9(a), as amended, and covers the three-year period from January 1, 2016 through December 31, 2018.

The purpose of this examination is to assess the financial condition of the Company and set forth findings of fact (together with citations of pertinent laws, regulations and rules) with regard to any material adverse findings disclosed by the examination.

The general procedures of the examination followed rules and standards as set forth in the NAIC Financial Condition Examiners Handbook ("Handbook") and West Virginia Laws, Regulations, and Directives of the WVOIC. The examination was conducted to evaluate the financial condition and identify prospective risks of the Company by obtaining information about the Company including corporate governance, identifying and assessing inherent risk within the Company and evaluating system controls and procedures used to mitigate those risks. In addition, the principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation, management's compliance with Statements of Statutory Accounting Principles ("SSAP") and annual statement instructions were assessed.

All accounts and activities of the Company were considered in accordance with the risk-focused examination process. Accordingly, planning materiality and tolerable error thresholds were based on professional judgment after considering the nature of the business written by the Company, operating results, and the Company's financial position as of December 31, 2018.

The report is presented on an exception basis. It is designed to set forth the facts with regard to any material adverse findings disclosed during the examination. If necessary, comments and recommendations have been made in those areas in need of correction or improvement. In such cases, these matters were discussed with responsible Company officials during the course of the examination.

SUMMARY OF SIGNIFICANT FINDINGS

As a result of the current examination, the following recommendations are being made:

1. The Company's Administrative Services Agreement was not in compliance with SSAP 70, in that the allocation of expenses does not yield the most accurate results.

2. The Company did not record its other than temporary impairment, if any, in accordance with SSAP 26R and 30 on a quarterly basis.

3. The Company's methodology and assumptions to calculate its premium deficiency reserve ("PDR") were found to be deficient for Medicaid and Medicare lines of business.

4. The 2018 Actuarial Opinion and 2018 Actuarial Memorandum did not meet the NAIC Annual Statement Instruction requirements in several regards.

5. Appointed Actuary did not opine on the Medicare Risk Adjustment Receivable.

HISTORY

The Company is a non-profit, tax exempt health maintenance organization ("HMO") under the provision of the Internal Revenue Code 501c(4). The Company was organized on August 8, 1978 and began writing business in West Virginia on November 1, 1979. On March 3, 1980, the Company was authorized to transact business in Ohio and on July 9, 1980, the Company was federally qualified under the provisions of Title XIII of the Public Health Service Act. The Company was originally located in Wheeling, West Virginia. After receiving regulatory approval in 1985, the Company relocated to St. Clairsville, Ohio. During 2017, the Company changed its name from The Health Plan of the Upper Ohio Valley, Inc. to The Health Plan of West Virginia, Inc. and moved its statutory home office back to Wheeling, West Virginia.

In July 2003, the Company purchased Hometown Health Network, a Massillon, Ohio based managed care organization, from the Akron General Hospital. On April 1, 2006, Hometown's membership and that of its divisions, which included Hometown Health Plan (a non-profit HMO in Ohio, changed its name to "The Health Plan of Ohio, Inc." in 2017), Hometown Insurance

Group, Hometown Administrative Services, were transferred to the Company, completing the merger of Hometown into its parent company.

The Health Plan of West Virginia, Inc. writes Individual, Commercial, Medicare, and Medicaid lines of business.

Capitalization

At December 31, 2018, the Company's reported total capitalization was $125,973,518, consisting of $500,000 of aggregate write-ins for other-than-special surplus funds and $125,473,518 of unassigned funds (surplus).

According to W. Va. Code §33-25A-4(c)ii (B) & (C), the Company must maintain a minimum of $1,000,000 in capital and $1,000,000 in surplus to engage in the business for which they are licensed. The Company has met this requirement throughout the examination period.

Dividends to Policyholders

The Company did not pay any dividends to policyholders during the examination period.

Mergers and Acquisitions

There were no mergers or acqusitions during the examination period.

Significant changes in key trends

Direct premium written by line of business is outlined below:

	DIRECT PREMIUM WRITTEN		
	2018	**2017**	**2016**
Medicaid	$ 285,990,422	$ 335,421,921	$ 297,372,031
Medicare	$ 179,792,894	$ 152,531,700	$ 144,743,211
Comprehensive	$ 110,414,758	$ 121,916,441	$ 125,919,008
TOTAL	$ 576,198,074	$ 609,870,062	$ 568,034,250

MANAGEMENT AND CONTROL

BOARD OF DIRECTORS

The corporate powers of the Company are vested in the Board of Directors consisting of not less than nine nor more than thirteen directors, and is in compliance with Article II, Section 1(a) of the Company's Bylaws and in compliance with W. Va. Code §33-25A-3(5). The individuals serving as members of the Board of Directors on December 31, 2018 were as follows:

Name and Address	Business Affiliation	Board Member Since
John E. Wright, IV Wheeling, WV	American Plate Glass	1993
John T. McDonald, CPA. Jr. Wheeling, WV	Strauss Industries	2015
Jill L Hall Scott Depot, WV	Jackson Kelly PLLC	2014
John D. Holloway, MD Wheeling, WV	Sole Proprietor	1998
James M Pennington Wheeling, WV	President of the Company	2014
Susan L Buchanan, CPA St. Clairsville, OH	Lee & Associates, CPA	2015
John Gianola Charleston, WV	Summit Financial Group; WVV Foundation; Evidence Action	2016
Edward P Polack, MD Wheeling, WV	Wheeling Hospital	1998
Mark D Lancellotti, CLU Pittsburgh, PA	Consultant	2015

OFFICERS

The annual meeting of the Board of Directors shall be held in the month of November, unless otherwise specified by resolution of the Board. Bylaws require that "the officers of the Company shall be Chairperson of the Board, a Vice-Chairperson of the Board, a President, a Secretary, and a Treasurer/Chief Financial Officer (CFO), and such other officers and assistant offices as the Board of Directors may deem necessary". Officers elected by the Board of Directors, and serving as of December 31, 2018, were as follows:

Name	Title
John E. Wright, IV	Chairman of the Board
Jill E. Hall	Vice-Chairman of the Board
James M. Pennington	President, CEO
Jeffrey M. Knight	Treasurer, CFO
John T. McDonald	Secretary

COMMITTEES

At December 31, 2018, the Company was in compliance with its Bylaws concerning committees. The composition of the Audit Committee meets the independence requirements of W. Va. Code §33-33-12. Following are the committee members for the Audit and Corporate Compliance Committee, Finance Committee, Executive Committee, By-Laws Committee and Nominating/Personnel/Executive Compensation Committee.

Audit and Corporate Compliance Committee
Susan Buchanan, CPA, Chair
John E. Wright
Mark Lancellotti
John Gianola
James M. Pennington
Jeffrey M. Knight

Jeffrey M. Knight, Company's Treasurer, is a non-voting member of the Audit Committee.

Finance Committee
John T. McDonald, Chair
John E. Wright, IV
Mark Lancellotti
James M. Pennington
Jeffrey M. Knight

Executive Committee
John E. Wright, IV
John D. Holloway, MD
Jill E. Hall
James M. Pennington

By-Laws Committee
Edward P. Polack, MD, Chair
John E. Wright, IV
Jill E. Hall
John D. Holloway, MD
James M. Pennington

Nominating/Personnel/Executive Compensation Committee
Jill E. Hall, Chair
John E. Wright, IV
John D. Holloway, MD
John T. McDonald
Edward P. Polack, MD
James M. Pennington

Articles of Incorporation

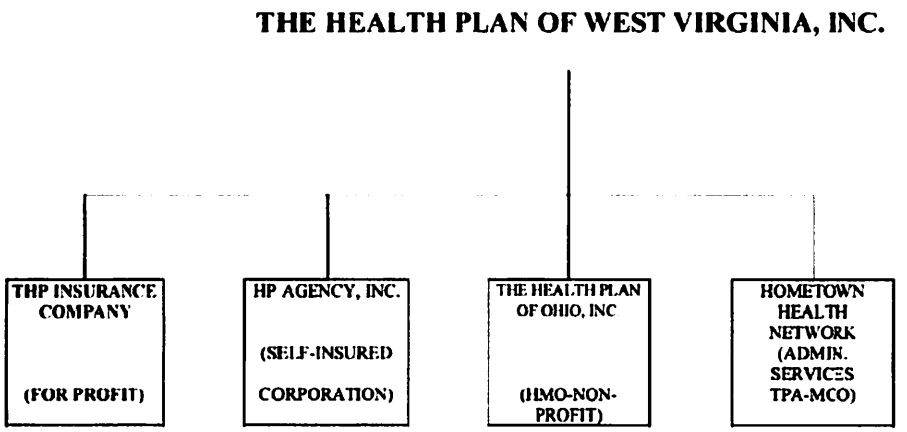
Company's Articles of Incorporation were amended on December 31, 2016 to change the name of Company from The Health Plan of the Upper Ohio Valley, Inc. to The Health Plan of West Virginia, Inc.

Bylaws

The Company's Bylaws were amended in September of 2018 to extend the term of any currently serving officer and board member.

ORGANIZATIONAL CHART

At December 31, 2018, an abbreviated organization chart for the Company and its subsidiaries is shown below:



AGREEMENTS

Administrative Services Agreement ("ASA")

The Company provides administrative services to THP Insurance Company under an administrative services contract that was effective January 1, 2014. Under the terms of the contract, Company provides executive management, administration, marketing, accounting and claims management services in return for a monthly fee. The monthly fee is computed at 3% of the premiums received by THP for its products and such fee is paid monthly and is determined based upon the premiums paid in the preceding month. THP makes the monthly payment on or before the 15th day of the following month. Effective January 1, 2019, the ASA was amended to require THP to pay 5.5% of its total revenue to the Company in return for executive management, administration, marketing, accounting and claims administration services. **The ASA was found to be not in compliance with SSAP 70 in that the expense allocation between the Company and THP Insurance Company does not yield the most accurate results.**

TERRITORY AND PLAN OF OPERATION

The Company is licensed in all 55 counties in West Virginia and in 36 counties in Ohio. The Company also has an additional license to provide Administrative Services Only/Third-party Administrator services in the regular service area and the State of Kentucky.

REINSURANCE

Assumed

The Company did not assume any reinsurance during the period under examination.

Ceded

The Company purchased reinsurance with American National Insurance Company which provides coverage for catastrophic impatient hospital claims. The specific deductible is $600,000 of allowable expenses subject to 20% coinsurance up to and including $2,000,000 per member per agreement period and 0% thereafter with an unlimited lifetime reinsurance indemnity for each member. In addition to the specific deductible, there are also specific aggregation deductibles for each line of business ranging from $5,000 to $800,000. Company and THP Insurance Company share a combined reinsurance risk with the reinsurance carrier through a layered risk arrangement.

FINANCIAL STATEMENTS

The following financial statements are based on the statutory financial statements filed by the Company with the WVOIC and present the financial condition of the Company for the period ending December 31, 2018. The accompanying comments on financial statements reflect any examination adjustments to the amounts reported in the annual statement and should be considered an integral part of the financial statements.

STATEMENT OF ASSETS
DECEMBER 31, 2018

	Assets	Non-Admitted	Admitted Assets
Bonds	$90,458,614		$90,458,614
Common Stocks	71,696,227	4,288,562	67,407,665
Properties Occupied by the Company	3,538,965		3,538,965
Cash and Equivalents	33,477,998		33,477,998
Receivables for Securities	24,665		24,665
Subtotals	**$199,196,469**	**$4,288,562**	**$194,907,907**
Investment Income Due and Accrued	487,318		487,318
Uncollected Premium	8,106,776		8,106,776
Accrued Retro Premiums	20,469,425		20,469,425
Amounts Receivable relating to uninsured plans	430,178		430,178
EDP and Software	521,361	258,405	262,956
Furniture and Equipment	1,871,440	1,871,440	
Receivable from affiliates	3,326,295		3,326,295
Health Care	4,668,547	451,044	4,217,503
Aggregate write-in for other than invested assets	2,839,011	2,668,105	170,906
Total Assets	**$241,916,820**	**$9,537,556**	**$232,379,264**

STATEMENT OF LIABILITIES, CAPITAL AND SURPLUS
DECEMBER 31, 2018

Claims Unpaid	$81,247,451
Unpaid Claims Adjustment Expenses	2,476,485
Aggregate Health Policy Reserves	1,086,305
Premiums received in advance	2,012,099
General Expenses Due or Accrued	6,112,273
Amounts Withheld for Account of Others	129,136
Amounts Due to Affiliates	9,854,461
Liability Under Uninsured Plans	2,105,532
Aggregate write-ins for other Liabilities	1,382,004
Total Liabilities	**$106,405,746**
Aggregate write-ins for other than special Surplus Funds	500,000
Unassigned Funds (Surplus)	125,473,518
Total Capital and Surplus	125,973,518
TOTAL	**$232,379,264**

STATEMENT OF REVENUE AND EXPENSES
DECEMBER 31, 2018

Member Months	1,427,405
Net Premium Income	$574,821,025
Aggregate Write-Ins for other Non-Health Revenues	263,150
Total Revenues	575,084,175
Hospital and Medical:	
Hospital/medical benefits	410,017,945
Other Professional Services	55,224,587
Emergency Room and Out-of-Area	42,752,014
Prescription drugs	30,715,459
Subtotal	538,710,005
Less:	
Net Reinsurance Recoveries	94,666
Total Hospital and Medical	538,615,339
Claims Adjustment Expenses	20,599,035
General Administrative Expenses	35,490,155
Increase in Reserves for L&H Contracts	463,495
Total Underwriting Deductions	595,168,024
Net Underwriting Gain (Loss)	(20,083,849)
Net Investment Income Earned	5,019,302
Net Realized Capital Gains	166,366
Net Investment Gains	5,185,668
Net Income Before Taxes	(14,898,181)
Federal and Foreign Income Tax	0
Net Income (Loss)	**($14,898,181)**

RECONCILIATION OF SURPLUS
DECEMBER 31, 2018

Surplus as of Prior Examination – 12/31/2015	$171,022,585
Net Income (Loss)	(18,017,441)
Change in net unrealized capital gains	3,354,079
Change in non-admitted assets	(3,505,683)
Aggregate write-ins for gains in surplus	(3,113,486)
Net change in capital and surplus	(21,282,531)
Surplus at December 31, 2016	$149,740,054
Net Income (Loss)	(4,213,507)
Change in net unrealized capital gains	12,419,498
Change in non-admitted assets	3,423,315
Net change in capital and surplus	11,629,306
Surplus at December 31, 2017	$161,369,359
Net Income (Loss)	(14,898,181)
Change in net unrealized capital gains	(18,082,487)
Change in nonadmitted assets	(2,415,174)
Net change in capital and surplus	(35,395,842)
Surplus at December 31, 2018	$125,973,518

SUMMARY OF EXAMINATION CHANGES

The following is a reconciliation of Surplus as regards policyholders between the reported by the Company and as determined by the examination.

Surplus as Regards Policyholders Per December 31, 2018, Annual Statement			$125,973,518
	PER COMPANY	PER EXAM	INCREASE (DECREASE) IN SURPLUS
ASSETS:			
Accrued Retrospective Premiums	$20,469,425	$18,216,081	$(2,253,344)
LIABILITIES:			
Aggregate Health Policy Reserve	$1,086,305	$12,822,810	$(11,736,505)
Net Change in Surplus:			($13,989,849)
Surplus as Regards Policyholders December 31, 2018, Per Examination			$111,983,669

COMMENTS ON FINANCIAL STATEMENT ITEMS

Accrued Retrospective Premiums $18,216,081

The amount of $18,216,081 represents an adjusted balance as a result of this examination, which was decreased by $2,253,344 from the original balance of $20,469,425 reported on the filed 2018 Annual Statement. The adjusted amount is based on actual settlements with CMS in subsequent period, and included two components:

1. Risk sharing balance which was originally estimated to be a receivable of $1,295,579. However, the Company paid $73,707 to CMS in 2019 related to risk sharing component. This resulted in reduction of Accrued Retrospective Premiums by $1,369,287.
2. The Company estimated its risk adjustment amount to be $19,173,846. However, it collected $18,289,808 from CMS in 2019. This resulted in a reduction of Accrued Retrospective Premiums by $884,057.

Aggregate Health Policy Reserve $12,822,810

The amount of $12,822,810 is an adjusted balance as a result of examination, which increased by $11,0736,505 from $1,086,305, as originally reported in the Company's 2018 Annual Statement. Part of the originally reported balance was $463,495 reserve attributed to premium deficiency reserve ("PDR"). Exam adjustment was due to the appointed actuary's review of methodology and assumptions used in calculation of PDR. The adjusted amount was attributed to the following factors:

1. Due to anticipated overall gains for the Medicare Advantage blocks based on the 2019 bid pricing, the Company's actuary did not perform a detailed Gross Premium Valuation ("GPV") for the Medicare segment. However, historically, the Company reported underwriting losses for this line of business, and the Company should have performed a full GPV analysis. Based on exam actuary's review of the losses and investment gains, the 2018 reported PDR was understated by an estimated $1,200,000.
2. For Medicaid block of business, the Company's PDR analysis estimated the reserve at $463,496. However, based on review of the factors and methodology used in estimation of PDR for this line, the exam actuary concluded that the Company did not use appropriate administrative expense factor, nor did the actuary use claims assumptions based on historical performance of the Medicaid contract. Based on the actual January to June 2019 Medicaid results, the exam actuary concluded that the Company should have reserved approximately $11,000,000 for this line of business.

The exam actuary's estimate of PDR was $12,200,000. Considering the initial PDR reserve of $463,495, the Company understated its PDR by $11,736,505.

SUBSEQUENT EVENTS

Beginning in December 2019 in China and progressing to the United States in March 2020, the coronavirus (SARS-CoV-2), also known as COVID-19, reached pandemic status on March 11, 2020 per the World Health Organization. In efforts to slow the spread of COVID-19, the Federal Government along with various state governments and local municipalities have strongly encouraged and/or mandated work, school and travel restrictions along with mass "non-essential"

business shutdowns. These actions have brought the US economy to at or near a grinding halt. As a result, the entire US economy, including the US stock market, has experienced significant deterioration. At the exam report date, the extent of short and long-term detrimental impact upon insurers, particularly workers' compensation insurers, as well as the US and global economy as a whole, remains unknown.

SUMMARY OF EXAMINATION RECOMMENDATIONS

1. It is recommended that the Company amends its Agreement and adopts a method that yields the most accurate results, as required by SSAP 70.

2. It is recommended that the Company comply with the SSAP 26R and SSAP 30, and record its investment for OTTI on a quarterly basis.

3. It is recommended that the Company's actuary perform a full PDR analysis for Medicare block of business. Additionally, for Medicaid line, it is recommended that the actuary use administrative expenses that are consistent with the current administrative services agreement in place, and appropriate claims adjustment expenses reflecting projections consistent with recent results.

4. It is recommended that the actuary include the following information in the Actuarial Opinion: reliance statements for data and/or calculations provided by other employees or outside Company vendors; indicate when only a portion of an Annual Statement line is being opined on. Additionally, it is recommended that the actuary include the following information in the Actuarial Memorandum: both narrative and technical components for all reserves and assets upon which he is opining; provide a reconciliation of the data used for the analysis to the U&I Exhibit Part 2B for all lines of business.

5. It is recommended that the Appointed Actuary include the Medicare Risk Adjustment Receivable in future opinions.

ACKNOWLEDGEMENT AND SIGNATURE

This is to certify that the undersigned is a duly qualified Examiner appointed by the West Virginia Offices of the Insurance Commissioner. In addition to the undersigned, Mario Ascic, CFE, consulting examiner of Lewis & Ellis, Inc., Karen Elsom, FCAS, MAAA, consulting actuary of Lewis & Ellis, Inc. and Lindsey Pittman, CPA, CFE, CISA, IT Specialist of Lewis & Ellis, Inc. participated in the examination.

The examination was performed in accordance with those procedures authorized by the NAIC Financial Condition Examiner's Handbook and other procedures appropriate for this examination. The attached report of examination is a true and complete report of financial condition of The Health Plan of West Virginia, Inc. as of December 31, 2018 as determined by this examination.

Respectfully Submitted,

Katerina Bolbas, CFE, CIA, MCM
Examiner-in-Charge
Lewis & Ellis, Inc.
Representing the WV Offices of the Insurance Commissioner

Jamie Taylor, CFE, PIR
Chief Financial Examiner
Company Analysis and Examination Division
Financial Conditions
WV Offices of the Insurance Commissioner

STATE OF WEST VIRGINIA
Offices *of the* Insurance Commissioner

James A. Dodrill
Insurance Commissioner

May 27, 2020

Mr. Jeff Knight, Interim President
The Health Plan of West Virginia, Inc.
THP Insurance Company
1110 Main Street
Wheeling, WV 26003

RE: Reports of Examination as of December 31, 2018
Health Plan of West Virginia, Inc. – NAIC #59575
THP Insurance Company – NAIC #60016

Dear Mr. Knight:

Please find enclosed a copy of the ***Reports of Examination*** of Health Plan of West Virginia, Inc. and THP Insurance Company (collectively "Health Plan Group"). This examination was performed in accordance with the provisions of Chapter 33, Article 2, Section 9 of the *West Virginia Code* of 1931, as amended. The ***Reports of Examination*** reflect the financial affairs and condition of the Health Plan Group as of December 31, 2018.

You are hereby notified that you have thirty (30) days from receipt of this letter to make written submission or rebuttals with respect to any matter contained in the ***Reports of Examination***. If an exception is taken, it must be filed with this agency during the statutory time period. If no exception is taken, please respond accordingly by the end of the thirty (30) day comment period.

Very truly yours,

James A. Dodrill
Insurance Commissioner

JAD/jot

Enclosure: Copies of Reports of Financial Examination

EXHIBIT
B

June 22, 2020

James A. Dodrill
Insurance Commissioner
West Virginia Offices of the Insurance Commissioner
900 Pennsylvania Avenue, 7th Floor
Charleston, West Virginia 25302

Dear Mr. Dodrill:

Regarding the significant findings identified in The Health Plan of West Virginia, Inc. (the Company) Report of Examination as of December 31, 2018, the following are Management's responses:

Significant Findings and Management's Response

1. The Company's Administrative Services Agreement was not in compliance with SSAP 70, in that the allocation of expenses does not yield the most accurate results.

   Management's Response
   The Company agrees that the Administrative Services Agreement (ASA) in place during the examination period did not contemplate the growth and additional administrative expenses associated with THP Insurance Company's third party administration (TPA) business. In 2020, the Company will revisit and amend the ASA to ensure that the administrative expenses associated with each individual line of business (fully-insured and TPA) are appropriately allocated and cross-charged between legal entities in accordance with SSAP 70. The Company notes, however, that for all years under examination, the financial statements filed with the West Virginia Offices of the Insurance Commissioner (WVOIC) reflected the terms of the ASA in place and on file with the WVOIC.

2. The Company did not record its other than temporary impairment, if any, in accordance with SSAP 26R and 30 on a quarterly basis.

   Management's Response
   While the Company has historically evaluated its investments for other than temporary impairment on a quarterly basis, it has not recorded any impairment due to immateriality. Going forward, the Company will evaluate and record any other than temporary impairment on a quarterly basis in accordance with its accounting policy.

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3. The Company's methodology and assumptions to calculate its premium deficiency reserve ("PDR") were found to be deficient for Medicaid and Medicare lines of business.

   Management's Response
   While the Company considers the methodology and assumptions used in developing its December 31, 2018 premium deficiency reserve to be reasonable, appropriate, and in accordance with actuarial and accounting standards, the Company will evaluate all assumptions used in future premium deficiency reserve calculations for appropriateness, including the seasonality of results, as it has done historically and will complete a gross premium valuation for its Medicare Advantage line of business, if necessary, based on financial performance.

4. The 2018 Actuarial Opinion and 2018 Actuarial Memorandum did not meet the NAIC Annual Statement instruction requirements in several regards.

   Management's Response
   The Company agrees and as a result, completed its 2019 Actuarial Opinion and Memorandum in accordance with the NAIC Annual Statement instructions.

5. The Appointed Actuary did not opine on the Medicare Risk Adjustment Receivable.

   Management's Response
   The Company agrees and as a result, the Appointed Actuary opined on the Medicare Risk Adjustment Receivable in its 2019 Annual Statement.

We appreciate the opportunity to work with the WVOIC on these matters. If there are any questions or concerns about our responses, please feel free to contact me.

Sincerely,

Jeffrey M. Knight, Interim President and Chief Operating Officer