

STATE OF ALABAMA
DEPARTMENT OF INSURANCE
MONTGOMERY, ALABAMA

REPORT OF EXAMINATION OF

VIVA HEALTH, INC.

BIRMINGHAM, ALABAMA

AS OF DECEMBER 31, 2013

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	8
Organizational Chart.....	9
FIDELITY BONDS AND OTHER INSURANCE.....	10
EMPLOYEE AND AGENT WELFARE	10
STATUTORY DEPOSITS	10
FINANCIAL CONDITION/GROWTH OF COMPANY	11
LOSS EXPERIENCE.....	11
MARKET CONDUCT ACTIVITIES	11
Plan of Operation	11
Territory.....	12
Policy Forms and Underwriting.....	12
Marketing and Sales	13
Claims Payment Practices.....	13
Policyholder Complaints	13
Compliance with Producer Licensing Requirements.....	13
Privacy Standards	14
REINSURANCE	14
Reinsurance Ceded	14
Reinsurance Assumed.....	15
ACCOUNTS AND RECORDS	15
FINANCIAL STATEMENTS	17

NOTES TO FINANCIAL STATEMENTS20
COMMENTS AND RECOMMENDATIONS20
CONTINGENT LIABILITIES AND PENDING LITIGATION20
COMPLIANCE WITH PREVIOUS RECOMMENDATIONS.....20
SUBSEQUENT EVENTS21
CONCLUSION22

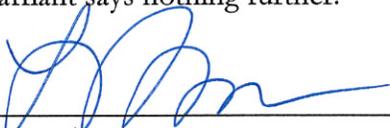
EXAMINER'S AFFIDAVIT

**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.

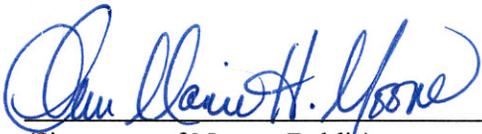
The affiant says nothing further.



Examiner-in-charge

Subscribed and sworn before me by Lori Brock on this
5th day of February, 2015.

(SEAL)



(Signature of Notary Public)

**NOTARY PUBLIC STATE OF ALABAMA AT LARGE
MY COMMISSION EXPIRES: Feb 6, 2015
BONDED THRU NOTARY PUBLIC UNDERWRITERS**

My commission expires _____.



ROBERT BENTLEY
GOVERNOR

JIM L. RIDLING
COMMISSIONER

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RICHARD L. FORD

STATE FIRE MARSHAL
EDWARD S. PAULK

GENERAL COUNSEL
REYN NORMAN

Birmingham, Alabama
February 5, 2015

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 417 20th Street North, Suite 1100, Birmingham, Alabama 35203 as of December 31, 2013. 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, 2010, by examiners representing the State of Alabama. Where deemed appropriate, transactions, activities and similar items subsequent to 2013 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, 2013, 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 11 for further discussion of the market conduct examination.

PricewaterhouseCoopers, 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, 2013.

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 17.1% of the net premium income in 2013; and
- Title XVIII – Medicare, which represented 82.9% of the net premium income in 2013.

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 a par value of \$10 per share.

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.

At December 31, 2013, 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 \$74,592,228.

MANAGEMENT AND CONTROL

Stockholder

As of December 31, 2013, Triton Health Systems, 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, 2013 were as follows:

<u>Director</u>	<u>Residence</u>	<u>Principal Occupation</u>
Arthur Brad Rollow	Birmingham, Alabama	President and CEO, VIVA Health, Inc.
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	President, UAB
Nelson Straub Bean	Birmingham, Alabama	President & CEO, First Commercial Bank
Dr. Selwyn Maurice Vickers	Birmingham, Alabama	Senior Vice President & Dean, UAB School of Medicine
James Louie Cartee, Jr.	Birmingham, Alabama	Retired Senior Account Manager, Corporate and Government Customers, Pfizer, Inc.
Vernon Leo Wells, II	Birmingham, Alabama	Partner, Jones Walker

Committees

As of December 31, 2013, 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
- VIVA Health Audit 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, 2013:

Deborah Leigh Copeland, MD	Nathan Smith, MD
Steve Kulback, MD	Henry Froshin, MD
Andrew Duxbury, MD	Kenneth Elmer, MD
Tara Bryant, 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, 2013:

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

Brian Wade, MD
Jerry McLane, MD
Tara Bryant, 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, 2013:

Mark W. Todd, PhD
Cheryl Mokry, PhD
Walter R. Ross, MD
Kimberly Ferguson, PhD

Tara Bryant, MD
W. Winn Chatham, MD
J. Edward Alderson, 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, 2013:

Bobby Moran
Angie LeBlanc
Linda Jenkins
Tom Pittman
Charlie Cutcliffe
Libba Yates

Wanda Crumel
Ethel Boston
Tony Ceasar
Teresa Evans
Cindy Holmes

VIVA Health Audit Committee

The VIVA Health Audit Committee is responsible for overseeing management's conduct of the Company's financial reporting process; the integrity of the financial statements and other financial information provided by the Company to regulatory authorities; the Company's internal accounting and financial controls; the Company's compliance with legal and regulatory requirements; the performance of the Company's internal audit function; the independent auditors' qualifications, performance and independence; and the annual independent audit of the Company's financial statements.

The following were members of the Audit Committee as of December 31, 2013:

Richard Margison
Nelson Bean

William Walker, III

Officers

Officers of the Company elected by the Board of Directors and serving at December 31, 2013 were as follows:

<u>Officer</u>	<u>Title</u>
Arthur Brad Rollow	President and Chief Executive Officer
Richard Lee Margison	Secretary/Treasurer*
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

*Resigned August 2014

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 and 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 adopted a policy that requires any interests of its employees, officers and directors that might conflict with any interests of the Company be disclosed. Conflict of interest disclosure statements are required to be signed and filed annually. During the review of the conflict of interest statements for each year under examination, there was one conflict of interest statement not provided for a director. According to the Company, this director was serving on an interim basis and did not complete a conflict of interest statement. Disclosures were made by some Company officers and directors; 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 regard to recording actions taken on matters before the respective bodies for deliberation and action.

HOLDING COMPANY AND AFFILIATE MATTERS

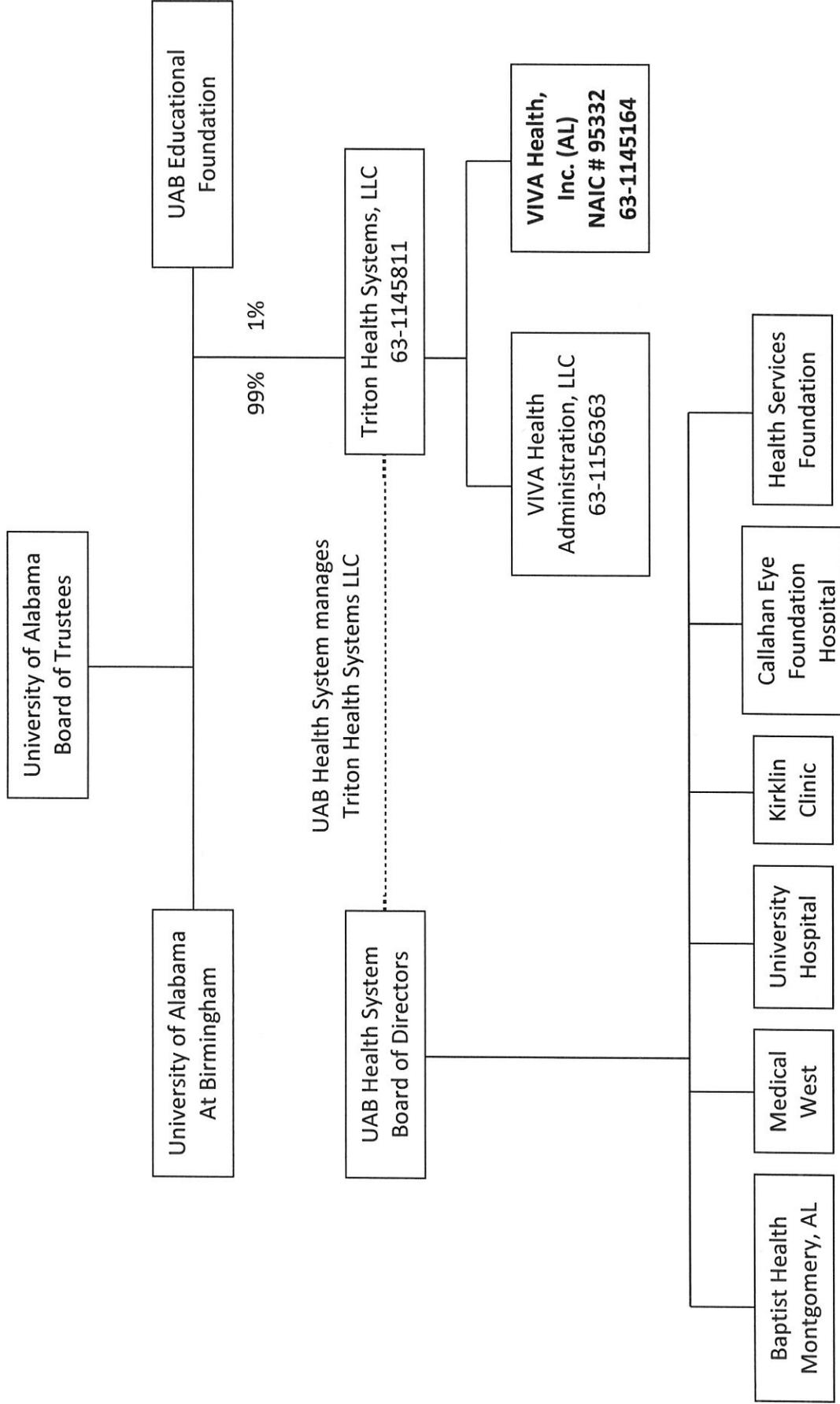
The Company was not subject to the Alabama Insurance Holding Company Regulatory Act, as defined in ALA. CODE § 27-29-1 (1975), except as expressly required by other statutes and regulations. Generally HMOs are subject to regulation in regard to changes in control, but are not subject to the holding company 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 at December 31, 2013.



FIDELITY BONDS AND OTHER INSURANCE

As of December 31, 2013, the Company was a named insured under a crime policy issued by Federal Insurance Company to University of Alabama Health Services Foundation, P.C. The single loss limit exceeded 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) Client Coverage. In addition to this coverage, the following policies or coverages were maintained by or on behalf of the Company to protect it from hazards to which it may be exposed:

1. Legal Liability Policy
2. Managed Care Errors and Omissions Policy
3. Fiduciary Liability Policy
4. Property Insurance
5. Worker's Compensation

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, 2013.

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
2013*	\$ 147,170,476	\$ 59,241,253	\$ 87,929,223	\$ 554,835,869
2012	132,508,993	54,274,887	78,234,106	559,846,713
2011	131,666,383	64,904,813	66,761,570	571,700,467
2010*	\$ 101,156,762	\$ 67,536,880	\$ 33,619,882	\$ 457,953,213

*Per Examination

LOSS EXPERIENCE

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

	2011	2012	2013
Revenue	\$ 571,702,014	\$ 559,847,713	\$ 554,836,449
Underwriting Deductions	520,808,632	543,532,212	534,510,393
Underwriting Gain	50,893,382	16,315,501	20,326,056
Member Months	792,282	803,027	806,566
Cost Per Member Months	657.35	676.85	662.70

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 strategic 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 growth focus continues to be conservative, managed growth in both the large and small group markets. As of December 31, 2013, the Company was licensed to sell its commercial products throughout Alabama.

VIVA Health began its Medicare contract with the Centers for Medicare & Medicaid Services (CMS) in October 1998. As of December 31, 2013, 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 need 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, 2013, the Company had an adequate number of insurance 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, 2013, 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*	Clarke	Elmore*	Madison	Shelby*
Baldwin	Conecuh	Etowah*	Marion	St. Clair*
Bibb	Coosa	Fayette	Mobile	Talladega
Blount*	Crenshaw*	Hale	Monroe	Tallapoosa
Bullock*	Cullman*	Jefferson*	Montgomery*	Tuscaloosa
Butler	Dale	Lawrence	Morgan	Walker
Calhoun*	Dallas	Lowndes*	Perry	Washington
Cherokee*	DeKalb*	Macon*	Pike*	Winston
Chilton*				

*Medicare licensed county.

Policy Forms and Underwriting

At December 31, 2013, 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 commercial 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

Claims paid for the examination period were 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, the number of complaints was not excessive for the Company's size and complexity. The Company recorded all complaints other required information in its 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 producers representing the Company were duly licensed and appointed by the State of Alabama.

The examiners obtained the 2011 - 2013 commercial commissions paid listing from the Company. A sample of individuals who received commission payments during 2011 - 2013 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 American National Insurance Company, Galveston, Texas, 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 2013 Annual Statement reported \$2,317,686 in ceded premiums. No reserve credit was taken at year-end 2013 for ceded reinsurance.

The reinsurance contracts in-force as of December 31, 2013 are summarized below:

American National Insurance Company:

Type of contract	Per risk excess of loss
Policy effective date	January 1, 2013, through December 31, 2013
Line of business insured	• Commercial
Annual deductible	\$2,000,000 per Member per Agreement Period
Maximum lifetime reimbursement	\$2,000,000 per Member per Agreement Period
Maximum aggregate reimbursement	\$2,000,000

Percentage payable	Reinsurers liability is 90%
Eligible expenses reimbursement	<p><u>Charges are segregated</u></p> <ul style="list-style-type: none"> • Commercial HMO - (UAB) • Commercial HMO - All other members • Home Health Care Services • Inpatient Hospital Services • Long Term Acute Care Facility Services • Outpatient Health Services – Dialysis only • Rehabilitation Services • Skilled Nursing Facility Services

ARCH Insurance Company:

Type of contract:	Human Organ and Bone Marrow Transplant Excess of Loss
Policy effective date	October 1, 2013 through September 30, 2014
Line of Business insured	<ul style="list-style-type: none"> • Commercial • Medicare
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><u>In-Network Services:</u> 100% of covered charges subject to all applicable limits, terms and conditions of the contract.</p> <p><u>Travel expenses:</u></p> <ul style="list-style-type: none"> • \$200 per day • \$10,000 per covered transplant procedure <p><u>Air Ambulance Services:</u></p> <ul style="list-style-type: none"> • \$10,000 per covered transplant procedure <p><u>Nursing services:</u></p> <ul style="list-style-type: none"> • \$10,000 per covered transplant procedure <p><u>Out-of-Network services:</u></p> <ul style="list-style-type: none"> • 60% of covered charges subject to all applicable limits, terms and conditions of the contract. • Other maximum limits apply

Reinsurance Assumed

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

ACCOUNTS AND RECORDS

Actuarial Opinion and Memorandum

The NAIC Annual Statement Instructions required 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. This issue was also noted in the previous examination.

FINANCIAL STATEMENTS

The financial statements included in this report reflect the financial condition of the Company as of December 31, 2013, 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 18
Summary of Operations	Page 19
Capital and Surplus Account	Page 19

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, 2013

<u>Assets</u>	<u>Assets</u>	<u>Non- admitted</u>	<u>Admitted Assets</u>
Bonds	\$ 15,765,273	\$ -	\$ 15,765,273
Common stocks	62,383,619	-	62,383,619
Cash and short-term investments	56,317,995	-	56,317,995
Investment income due and accrued	132,803	-	132,803
Premiums and considerations: Uncollected premiums agents' balances in the course of collection	3,508,990	2,848	3,506,142
Accounts receivable relating to uninsured plans	625,836	-	625,836
Current federal and foreign income tax recoverable and interest thereon	0	-	-
Net deferred tax asset	303,972	-	303,972
Guaranty funds receivable or on deposit	74,000	-	74,000
Receivable from parent, subsidiaries or affiliates	1,817,530	-	1,817,530
Health care and other amounts receivable	13,231,059	6,987,752	6,243,307
Total Assets	<u>\$ 154,161,077</u>	<u>\$ 6,990,600</u>	<u>\$ 147,170,477</u>

<u>Liabilities, Surplus and Other Funds</u>	<u>Covered</u>	<u>Uncovered</u>	<u>Total</u>
Claims Unpaid	\$ 36,550,612	\$ 1,130,431	\$ 37,681,043
Accrued medical incentive pool and bonus amounts	693,650	-	693,650
Unpaid claim adjustment expenses	1,244,210	-	1,244,210
Aggregate health policy reserves	3,566,666	-	3,566,666
Premiums received in advance	983,322	-	983,322
General expenses due or accrued	356,182	-	356,182
Current federal and foreign income tax payable	1,752,652	-	1,752,652
Amounts due to parent, subsidiaries and affiliates	63,528	-	63,528
Medicare risk adjustment reserve	12,900,000	-	12,900,000
Total Liabilities	<u>\$ 58,110,822</u>	<u>\$ 1,130,431</u>	<u>\$ 59,241,253</u>
Common capital stock			\$ 100,000
Gross paid in and contributed surplus			13,236,995
Unassigned funds (surplus)			74,592,228
Surplus as regards policyholders			<u>\$ 87,929,223</u>
Totals			<u>\$ 147,170,476</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, 2013, 2012 and 2011

	2013	2012	2011
Net premium income	\$ 554,835,869	\$ 559,846,713	\$ 571,700,467
Other services	580	1,000	1,540
Miscellaneous income	-	-	7
Total revenues	<u>\$ 554,836,449</u>	<u>\$ 559,847,713</u>	<u>\$ 571,702,014</u>
Hospital and Medical:			
Hospital/medical benefits	\$ 377,768,566	\$ 391,017,672	\$ 379,868,151
Other professional services	15,251,584	15,069,373	11,522,614
Emergency room and out-of-area	12,313,891	11,307,242	10,783,906
Prescription drugs	38,350,138	40,984,661	42,157,047
Home health/DME	28,457,353	25,078,435	21,008,349
Incentive pool, withhold adjustments and bonus amounts	861,901	738,320	54,833
Subtotal	<u>\$ 473,003,433</u>	<u>\$ 484,195,703</u>	<u>\$ 465,394,900</u>
Less:			
Net reinsurance recoveries	\$ (1,800)	\$ 400,500	\$ -
Total hospital and medical	473,005,233	483,795,203	465,394,900
Claim adjustment expenses	15,376,290	14,934,252	11,105,755
General administrative expenses	46,128,870	44,802,757	44,307,977
Total underwriting deductions	<u>\$ 534,510,393</u>	<u>\$ 543,532,212</u>	<u>\$ 520,808,632</u>
Net underwriting gain or (loss)	20,326,056	16,315,501	50,893,382
Net investment income earned	389,223	311,724	539,713
Net realized capital gains (losses)	127,526	54,566	(799)
Net investment gains (losses)	516,749	366,290	538,914
Net gain or (loss) from agents' or premium balances charged off	(28,086)	-	-
Net income or (loss) after capital gains tax and before other federal income taxes	20,814,719	16,681,791	51,432,296
Federal and foreign income taxes incurred	7,121,318	5,727,458	18,224,884
Net income (loss)	<u>\$ 13,693,401</u>	<u>\$ 10,954,333</u>	<u>\$ 33,207,412</u>
Capital and Surplus Account			
Capital and surplus prior reporting period	\$ 78,234,106	\$ 66,761,570	\$ 33,619,882
Net income	13,693,401	10,954,333	33,207,412
Change in net unrealized capital gains (losses) less capital gains tax	(789,599)	-	-
Change in net deferred income tax	(72,562)	(75,885)	100,297
Change in nonadmitted assets	(3,136,124)	(1,479,515)	(166,021)
Adjustment for 2011 CMS Financial Risk Audit	-	2,073,603	-
Net change in capital & surplus	<u>\$ 9,695,116</u>	<u>\$ 11,472,536</u>	<u>\$ 33,141,688</u>
Capital and surplus end of reporting period	<u>\$ 87,929,222</u>	<u>\$ 78,234,106</u>	<u>\$ 66,761,570</u>

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

NOTES TO FINANCIAL STATEMENTS

Note 1 – Unassigned funds (surplus)

\$74,592,228

The above captioned amount is the same as reported by the Company in its 2013 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		<u>\$74,592,228</u>
Examination increase/(decrease) to assets:	<u>0</u>	
Total increase/(decrease) to assets		<u>0</u>
Examination (increase)/decrease to liabilities:	<u>0</u>	
Total (increase)/decrease to liabilities		<u>0</u>
Unassigned funds (surplus) per Examination		<u><u>\$74,592,228</u></u>

COMMENTS AND RECOMMENDATIONS

Conflict of Interest- Page 7

It is recommended that the Company require all of its employees, officers and directors to complete a conflict of interest statement on an annual basis in accordance with its conflict of interest policy.

Accounts and Records – Page 15

Actuarial Opinion and Memorandum

It is again recommended that the appointed actuary make a presentation each year, in accordance with the NAIC Annual Statement Instructions, 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.

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 with the exception of the following:

Accounts and Records

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.

For further commentary see the “ACCOUNTS AND RECORDS” section of this report.

SUBSEQUENT EVENTS

A review of events subsequent to the December 31, 2013 examination date was done. The following was noted during this review:

Richard Margison, Board member and Audit Committee Chair (Secretary/Treasurer) resigned in August 2014. Allen Bolton replaced Mr. Margison on the Board and as the Audit Committee Chair in October 2014.

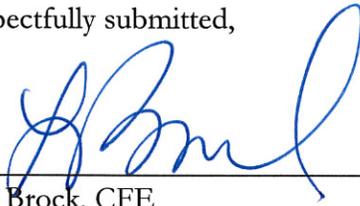
CONCLUSION

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, Rhonda Ball, CFE; Charles Turner, CISA, Examiner; and Harland A. Dyer, ASA, MAAA, actuarial examiner; all representing the Alabama Department of Insurance, participated in the examination of VIVA Health, Inc.

Respectfully submitted,



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