Edmund G. Brown Jr., Governor
State of California
Health and Human Services Agency
DEPARTMENT OF MANAGED HEALTH CARE
320 West 4th Street, Suite 880
Los Angeles, CA 90013-2344
Telephone: 213-576-7633 | Fax: 213-576-7186

February 13, 2017

Via USPS Delivery and eFile

Kathryne McGowan
Chief Executive Officer and President
PREMIER HEALTH PLAN SERVICES, INC.
10833 Valley View Street, Suite 300
Cypress, CA 90630

FINAL REPORT OF ROUTINE EXAMINATION OF PREMIER HEALTH PLAN SERVICES, INC.

Dear Ms. McGowan:

Enclosed is the Final Report of a routine examination of the fiscal and administrative affairs of Premier Health Plan Services, Inc. (Plan), conducted by the Department of Managed Health Care (Department), pursuant to Section 1382(a) of the Knox-Keene Health Care Service Plan Act of 1975.[1] The Department issued a Preliminary Report to the Plan on September 22, 2016. The Department accepted the Plan's electronically filed response on November 4, 2016.

This Final Report includes a description of the compliance efforts included in the Plan's November 4, 2016 response, in accordance with Section 1382(c).

Section 1382(d) states, "If requested in writing by the plan, the director shall append the plan's response to the final report issued pursuant to subdivision (c). The plan may modify its response or statement at any time and provide modified copies to the department for public distribution not later than 10 days from the date of notification from the department that the final report will be made available to the public. The addendum to the response or statement shall also be made available to the public."

Please indicate within ten (10) days from the date of the Plan's receipt of this letter whether the Plan requests the Department to append its response to the Final Report. If so, please indicate which portions of the Plan's response shall be appended, and electronically file copies of those portions of the Plan's response excluding information held confidential pursuant to Section 1382(c). If the Plan requests the Department to

[1] References throughout this report to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, as codified in the California Health and Safety Code, Section 1340, et seq. References to "Rule" are to the regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act, found at Chapter 2 of Division 1, Title 28, of the California Code of Regulations, beginning with Section 1300.43.

append a brief statement summarizing the Plan's response to the Report or wishes to modify any information provided to the Department in its November 4, 2016 response, please provide the electronically filed documentation no later than ten (10) days from the date of the Plan's receipt of this letter through the eFiling web portal. Please file this addendum electronically via the Corrective Action Plan system (CAP system) within the Online Forms Section of the Department's eFiling web portal https://wpso.dmhc.ca.gov/secure/login/, as follows:

- From the main menu, select "eFiling".
- From the eFiling (Home) menu, select "Online Forms".
- From the Existing Online Forms menu, click on the "Details" for the DFO Corrective Action Plan **L16-R-473**.
- Go to the "Messages" tab
    - Select "Addendum to Final Report" (note this option will only be available for 10 days after the Final Report has been issued)
    - Select the deficiency(ies) that are applicable
    - Create a message for the Department
    - Attach and Upload all documents with the name "Addendum to Final Report"
    - Select "Send Message"

As noted in the attached Final Report, the Plan's response of November 4, 2016 did not fully respond to the deficiencies raised in the Preliminary Report issued by the Department on September 22, 2016. Pursuant to Rule 1300.82, the Plan is required to submit a response to the Department for any request for additional corrective action contained within the attached Final Report, within 30 days after receipt of the Report. If the Plan fails to fully respond and/or resolve the deficiencies addressed in the Final Report, then a referral will be made to the Office of Enforcement for appropriate administrative action for any remaining, unresolved deficiencies.

The Plan is hereby advised that any violations listed in this Final Report may be referred to the Office of Enforcement for appropriate administrative action upon the completion of all corrective actions required in response to this Report.

Please file the Plan's response electronically via the CAP system within the Online Forms Section of the Department's eFiling web portal https://wpso.dmhc.ca.gov/secure/login/, as follows:

- From the main menu, select "eFiling".
- From the eFiling (Home) menu, select "Online Forms".
- From the Existing Online Forms menu, click on the "Details" for the DFO Corrective Action Plan **L16-R-473**.
- Go to the "Data Requests" tab
    - Click on the "Details" for each data request that does not have a status of "Complete".

- Follow the Instructions and/or use the form shown to add the requested data (depending on the type of data requested: New Filing, Document Request, Claims Data, or Financial Statement refile).

The Department will also send the Plan an e-mail(s) requesting those items that are still outstanding. The e-mail(s) will contain a link to the CAP system for the Plan to file the response electronically.

Questions or problems related to the electronic transmission of the response should be directed to Vijon Morales at (916) 255-2447 or email at Vijon.Morales@dmhc.ca.gov. You may also email inquiries to wpso@dmhc.ca.gov.

The Department will make the attached Final Report available to the public in ten (10) days from the Plan's receipt of this letter through the eFiling system. The Report will be located at the Department's web site at View Financial Examination Reports.

If there are any questions regarding this Report, please contact me at 213-576-7633 or by email at Ned.Gennaoui@dmhc.ca.gov.

Sincerely,

ORIGINAL SIGNED BY

Ned Gennaoui
Supervising Examiner
Office of Financial Review
Division of Financial Oversight

cc: Michael Thornhill, Outside Counsel, Premier Health Plan Services, Inc.
Dana Neucere, Chief Financial Officer, Premier Health Plan Services, Inc.
Pritika Dutt, Deputy Director, Office of Financial Review
Neetu Bhangu, Examiner, Division of Financial Oversight
Joanna Giang, Counsel, Office of Plan Licensing
Laura Dooley Beile, Chief, Division of Plan Surveys
Paula Hood, Staff Services Manager I, Help Center

STATE OF CALIFORNIA
DEPARTMENT OF MANAGED HEALTH CARE

DIVISION OF FINANCIAL OVERSIGHT

FINAL REPORT OF ROUTINE EXAMINATION

OF

PREMIER HEALTH PLAN SERVICES, INC.

FILE NO. 933 0473

DATE OF FINAL REPORT: FEBRUARY 13, 2017

SUPERVISING EXAMINER: NED GENNAOUI

EXAMINER-IN-CHARGE: THOMAS ROEDL

FINANCIAL EXAMINERS:

EILEEN KIM
SUHAG PATEL

BACKGROUND INFORMATION FOR PREMIER HEALTH PLAN SERVICES, INC.

Date Plan Licensed:	June 25, 2009
Organizational Structure:	Premier Health Plan Services, Inc. (Plan) is a for-profit, wholly-owned subsidiary of Tenet California, Inc., which is an indirect, wholly-owned subsidiary of Tenet Healthcare Corporation (Tenet), a publicly traded company. The Plan owns and operates four independent physician associations (IPAs): Alamitos IPA, Brookshire IPA, Lakewood IPA, and St. Mary IPA. The Plan receives administrative and operational support services from Coast Healthcare Management, LLC, a Plan affiliate, and Tenet pursuant to administrative services agreements.
Type of Plan:	The Plan is authorized to engage in business as a restricted license, full service health care plan providing health care services to enrollees through contracts with other full service Knox-Keene licensed health care plans.
Provider Network:	The Plan contracts with medical groups, independent physicians, hospitals and ancillary providers, including affiliated entities, for the provision of medical services to its members. Providers are reimbursed on a capitated, per-diem, or fee-for-service basis.
Plan Enrollment:	The Plan reported 41,328 enrollees contracted from other Plans as of December 31, 2015.
Service Area:	The Plan operates in Los Angeles and Orange Counties.
Date of Prior Final Routine Examination Report:	December 20, 2013

FINAL REPORT OF A ROUTINE EXAMINATION OF PREMIER HEALTH PLAN SERVICES, INC.

This is the Final Report of a routine examination of the fiscal and administrative affairs of Premier Health Plan Services, Inc. (Plan), conducted by the Department of Managed Health Care (Department) pursuant to Section 1382(a) of the Knox-Keene Health Care Service Plan Act of 1975.[1] The Department issued a Preliminary Report to the Plan on September 22, 2016. The Department accepted the Plan's electronically filed response on November 4, 2016.

This Final Report includes a description of the compliance efforts included in the Plan's November 4, 2016 response to the Preliminary Report, in accordance with Section 1382(c). The Plan's response is noted in *italics*.

The Plan is hereby advised that any violations listed in this Final Report may be referred to the Office of Enforcement for appropriate administrative action upon the completion of all corrective actions required in response to this Report.

The Department examined the Plan's financial report filed with the Department for the quarter ended December 31, 2015, as well as other selected accounting records and controls related to the Plan's various fiscal and administrative transactions. The Department's findings are presented in this Report as follows:

Section I.	Financial Report
Section II.	Calculation of Tangible Net Equity
Section III.	Compliance Issues

Pursuant to Rule 1300.82, the Plan is required to submit a response to the Department for any requests for additional corrective action contained within this report, within 30 days after receipt of this Report.

[1] References throughout this report to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, as codified in the California Health and Safety Code, Section 1340, et seq. References to "Rule" are to the regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act, found at Chapter 2 of Division 1, Title 28, of the California Code of Regulations, beginning with Section 1300.43.

SECTION I. FINANCIAL REPORT

A. BALANCE SHEET AT QUARTER ENDED DECEMBER 31, 2015

ASSETS Account	Bal. per F/S @ 12/31/15	AJE or RJE	Exam Adjustments Dr.	 Cr.	Bal. per Exam @ 12/31/15
Cash and Cash Equivalents	18,644,305				18,644,305
Short-Term Investments	3,352,173				3,352,173
Premiums Receivable – Net					
Interest Receivable					
Shared Risk Receivables – Net					
Other Health Care Receivables – Net					
Prepaid Expenses	42,135				42,135
Secured Affiliate Receivables – Current					
Unsecured Affiliate Receivables – Current					
Aggregate Write-ins for Current Assets	548,806				548,806
TOTAL CURRENT ASSETS	**22,587,419**				**22,587,419**
Restricted Assets	300,985				300,985
Long-Term Investments					
Intangible Assets & Goodwill – Net					
Secured Affiliate Receivables – Long Term					
Unsecured Affiliate Receivables – Past Due	3,669,026	RJE-1 RJE-2	12,119,492 798,054		16,586,572
Aggregate Write-ins for Other Assets	71,423				71,423
TOTAL OTHER ASSETS	**4,041,434**		**12,917,546**		**16,958,980**
Land, Building and Improvements					
Furniture and Equipment – Net					
Computer Equipment – Net					
Leasehold Improvements – Net					
Construction in Progress					
Software Development Costs					
Aggregate Write-ins for Other Equipment					
TOTAL PROPERTY & EQUIPMENT					
TOTAL ASSETS	**26,628,853**		**12,917,546**		**39,546,399**

BALANCE SHEET (Continued)

LIABILITIES AND NET WORTH Account	Bal. per F/S @ 12/31/15	AJE or RJE	Exam Adjustments Dr.	 Cr.	Bal. per Exam @ 12/31/15
LIABILITIES					
Trade Accounts Payable					
Capitation Payable	111,436				111,436
Claims Payable (Reported)	5,541,577				5,541,577
Incurred But Not Reported Claims	7,538,626				7,538,626
POS Claims Payable (Reported)					
POS Incurred But Not Reported Claims					
Other Medical Liability					
Unearned Premiums	195,194				195,194
Loans & Notes Payable					
Amounts Due to Affiliates – Current	(62)				(62)
Aggregate Write-ins for Current Liabilities	292,152				292,152
TOTAL CURRENT LIABILITIES	**13,678,923**				**13,678,923**
Loans and Notes Payable (Not Subordinated)					
Loans and Notes Payable (Subordinated)					
Accrued Subordinated Interest Payable					
Amounts Due To Affiliates – Long Term		RJE-1		12,119,492	12,917,546
		RJE-2		798,054	
Aggregate Write-Ins for Other Liabilities	4,264,771				4,264,771
TOTAL OTHER LIABILITIES	**4,264,771**			**12,917,546**	**17,182,317**
TOTAL LIABILITIES	**17,943,694**			**12,917,546**	**30,861,240**
NET WORTH					
Common Stock					
Preferred Stock					
Paid in Surplus	220,999				220,999
Contributed Capital					
Retained Earnings (Deficit)/Fund Balance	8,507,361				8,507,361
Aggregate Write-ins for Other Net Worth Items	(43,201)				(43,201)
EXAMINATION ADJUSTMENTS (from Income Statement)					
TOTAL NET WORTH	**8,685,159**				**8,685,159**
TOTAL LIABILITIES & NET WORTH	**26,628,853**			**12,917,546**	**39,546,399**

B. STATEMENT OF INCOME AND EXPENSES FOR THE QUARTER ENDED DECEMBER 31, 2015

REVENUE AND EXPENSES Account	Bal. Per F/S @ 12/31/15	AJE or RJE	Exam Adjustments Dr.	Exam Adjustments Cr.	Bal. per Exam @ 12/31/15
REVENUE					
Premiums (Commercial)					
Capitation	23,443,707				23,443,707
Co-payments, COB, Subrogation					
Title XVIII – Medicare					
Medicaid, Healthy Families					
Fee-For-Service					
Point-Of-Service (POS)					
Interest					
Risk Pool Revenue	(235)				(235)
Aggregate Write-Ins for Other Revenues	83,984				83,984
TOTAL REVENUE	**23,527,456**				**23,527,456**
EXPENSES					
Medical and Hospital					
Inpatient Services – Capitated					
Inpatient Services – Per Diem/Managed Hospital	10,498,349				10,498,349
Inpatient Services – Fee-For-Service/Case Rate					
Primary Professional Services – Capitated	8,230,656				8,230,656
Primary Professional Services – Non-Capitated	301,360				301,360
Other Medical Professional Services – Capitated	2,465,645				2,465,645
Other Medical Professional Services – Non-Capitated	2,286,090				2,286,090
Non-Contracted Emergency Room and Out-of-Area	573,497				573,497
Expense, not including POS					
POS Out-Of-Network Expense					
Pharmacy Expense – Capitated					
Pharmacy Expense – Fee-for-Service					
Aggregate Write-Ins for Other Medical and Hospital Expenses	720,287				720,287
TOTAL MEDICAL AND HOSPITAL EXPENSES	**25,075,884**				**25,075,884**
Administration					
Compensation	313,111				313,111
Interest Expense					
Occupancy, Depreciation and Amortization					
Management fees	1,938,360				1,938,360
Marketing	76,157				76,157
Affiliate Administration Services					
Aggregate Write-Ins for Other Administration	2,637,799				2,637,799
TOTAL ADMINISTRATION EXPENSES	**4,965,427**				**4,965,427**
TOTAL EXPENSES	**30,041,311**				**30,041,311**
INCOME (LOSS)	**(6,513,855)**				**(6,513,855)**
Provision for Taxes	(2,746,741)				(2,746,741)
NET INCOME (LOSS)	**(3,767,114)**				**(3,767,114)**

C. EXPLANATION OF EXAMINATION ADJUSTMENTS

RECLASSIFYING JOURNAL ENTRIES (RJEs)

RJE No.	ACCOUNT NAME	DR.	CR.
1	Unsecured Affiliate Receivables – Past Due Amounts Due to Affiliates – Long Term *To properly report amounts receivable from and payable to Tenet Healthcare Corporation, Plan's ultimate parent.*	$ 12,119,492	$ 12,119,492
2	Unsecured Affiliate Receivables – Past Due Amounts Due to Affiliates – Long Term *To properly report amounts receivable from and payable to Coast Healthcare Management, LLC, a Plan's affiliate.*	$ 798,054	$ 798,054

The Preliminary Report required the Plan to provide written assurance to the Department that the above reclassifying journal entries were posted to the books. In addition, the Plan was required to refile the DMHC Reporting Forms for the quarter and year ended December 31, 2015 to include the required reclassifications noted above. The Plan was to state the date the DMHC Reporting Forms were refiled with the Department.

The Plan responded that it refiled on November 4, 2016 the DMHC Reporting Forms for the quarter and year ended December 31, 2015 that included the required reclassifying journal entries noted above. [The revised DMHC Reporting Form for the quarter ended December 31, 2015 filed with the Department does not agree with the financial statements in this Report (with immaterial differences) due to independent auditors' adjustments for the year ended December 31, 2015, which were recorded after the examination date.]

The Department finds that the Plan's compliance effort is responsive to the deficiency cited and the corrective action required. Therefore, no further response is required.

SECTION II. CALCULATION OF TANGIBLE NET EQUITY (TNE)

Net Worth per Examination as of the Quarter Ended December 31, 2015	$ 8,685,159
Less: Unsecured Affiliate Receivables - Past Due	16,586,572
Tangible Net Equity	$ (7,901,413)
Required TNE	3,864,505
TNE Deficiency per Examination	$(11,765,918)

The Plan was not in compliance with the TNE requirements of Section 1376 and Rule 1300.76 as of December 31, 2015. The TNE deficiency per examination of $11,765,918 was the result of the reclassifying journal entries. These entries were needed because the Plan was offsetting amounts due to affiliates against amounts due from affiliates without a written right of offset agreement as described below in Section III.B. of this Report.

The Preliminary Report required the Plan to state how it corrected the TNE deficiency in its response to the Preliminary Report. In addition, the Plan was required to provide the policy and procedures implemented, the date of implementation, and identify the management position(s) responsible for ensuring continued compliance with Section 1376 and Rule 1300.76.

The Plan responded that it corrected the TNE deficiency by entering into a written Offset Agreement with its affiliates, as described below in Sections III.A. and B. of this Report.

The Plan also submitted the policy and procedures implemented on June 1, 2016 to ensure compliance with the TNE requirements of Section 1376 and Rule 1300.76. The Plan represented that the Chief Financial Officer is responsible for ensuring continued compliance.

The Department finds that the Plan's compliance effort is responsive to the deficiency cited and the corrective action required. Therefore, no further response is required.

SECTION III. COMPLIANCE ISSUES

A. AMENDMENTS TO PLAN APPLICATION – Repeat deficiency

Section 1352(a) and Rule 1300.52 require all plans to file an amendment with the director within thirty (30) days after any changes in the information contained in its application, other than financial or statistical information. Rule 1300.52.4 sets forth standards for amendment filings.

The Department's examination disclosed that the Plan failed to comply with the filing requirements of the above Section and Rules, as it did not file nor enter into a written agreement to support the various administrative services it receives from Tenet Healthcare Corporation, the Plan's ultimate parent (Tenet), on a routine, recurring basis, including trade payables, payroll, property insurance, and information technology services.

The Plan's failure to file changes to the plan's operations was a repeat deficiency, as this deficiency was previously noted in the Department's Final Report of examination dated December 20, 2013, for the quarter ended March 31, 2013. This examination disclosed that the Plan's compliance efforts in response to the previous examination did not achieve the necessary levels of compliance with the above Section and Rules.

The Preliminary Report required the Plan to provide an explanation of why the corrective actions implemented by the Plan to resolve this deficiency in the previous examination were not effective in ensuring continued compliance.

The Plan was also required to electronically file with the Department a written administrative services agreement that clearly described the services performed by Tenet, and disclosed the reimbursement and settlement arrangements for those services, in accordance with the Section and Rules stated above. The administrative services agreement should require regular performance reports from Tenet, timeframes for the Plan's monitoring of Tenet's performance under the contract, and provisions for onsite monitoring by the Plan.

In addition, the Plan was required to provide evidence (eFile number) in its response to the Preliminary Report that the requested filing was submitted to the Department. The cover page for this filing was to state that it was filed as a result of the recent financial examination.

Furthermore, the Plan was required to provide the policy and procedures implemented, the date of implementation, and identify the management position(s) responsible for ensuring continued compliance with the Section and Rules cited above.

The Plan responded that it filed with the Department the following three executed agreements with affiliates:

- *An Amended and Restated Administrative Services Agreement with Coast Healthcare Management, LLC (Coast), a Plan's affiliate, (Coast Agreement);*
- *An Administrative Services Agreement with Tenet (Tenet Agreement); and*
- *An Offset Agreement among Coast, Tenet and the Plan (Offset Agreement).*

The Coast Agreement amends and restates the 2008 Coast Agreement, which was filed as part of the Plan's original licensure. The Coast and Tenet Agreements reflect that the payroll and accounts payable services formerly performed by Coast are currently performed by Tenet.

The Plan added that the Agreements also confirm the parties' intentions to offset affiliate balances with the Plan's prior written approval. The Agreements elaborate upon the duties of Coast, and those delegated to Tenet, but do not change the essential administrative services functions that are performed on behalf of the Plan by its affiliates.

The Agreements were filed with the Department under eFile number 20162984 on November 4, 2016, and are currently under review.

The Plan also submitted the policy and procedures implemented on November 2, 2016 to ensure compliance with the requirements of the Section and Rules stated above. The Plan represented that the Chief Executive Officer (President), Chief Operating Officer, and Compliance Officer are responsible for ensuring continued compliance.

The Department finds that the Plan's compliance effort is not fully responsive to the corrective action required since the Plan did not provide an explanation of why the corrective actions implemented by the Plan to resolve this deficiency in the previous examination were not effective in ensuring continued compliance for this examination.

B. RIGHT OF OFFSET FOR AFFILIATE TRANSACTIONS

Section 1384, 1345(s) and Rule 1300.45(q) include requirements for filing financial statements in accordance with generally accepted accounting principles (GAAP) and other authoritative pronouncements of the accounting profession.

Accounting Standards Codification (ASC) 210-20-45-1 states a right of setoff (offset) exists when all of the following conditions are met:

a. Each of two parties owes the other determinable amounts.
b. The reporting party has the right to set off the amount owed with the amount owed by the other party.
c. The reporting party intends to set off.
d. The right of setoff is enforceable at law.

A right of offset is a debtor's legal right, by contract or otherwise, to discharge all or a portion of the debt owed to another party by applying against the debt an amount that the other party owes to the debtor.

While ASC 210-20-45-1 does not require a written right of offset, it does require that this right of offset be enforceable at law. The Department has consistently required a Plan to execute a written right of offset, where offsetting occurs, as a means of strengthening and clarifying the relationship. This written right of offset provides evidence that all parties have agreed to the offset, and identifies the amounts and accounts to be offset. In the absence of a written right of offset, intercompany receivables and payables must not be offset in preparing financial statements filed with the Department.

The Department's examination disclosed that amounts due from Tenet were offset against amounts owed to Tenet without a written right of offset agreement. In addition, amounts due from Coast were offset against amounts owed to Coast without a written right of offset agreement. As a result, the Department's examination required reclassifying journal entries 1 and 2, respectively, as described above in Section I of this Report.

The Preliminary Report required the Plan to electronically file with the Department a written right of offset agreement with Tenet and Coast that allows for the offsetting of affiliate accounts, and describe the settlement arrangement of the outstanding balance resulting from the offsetting.

In addition, the Plan was required to provide evidence (eFile number) in its response to the Preliminary Report that the requested filing was submitted to the Department. The cover page for this filing was to state that it was filed as a result of the recent financial examination.

The Plan was also required to provide the policy and procedures implemented, the date of implementation, and identify the management position(s) responsible for ensuring compliance with the corrective action and proper financial statement reporting of these affiliate transactions.

The Plan responded that the Offset Agreement was filed with the Department under eFile number 20162984 on November 4, 2016, and is currently under review as described above in Section III.A. of this Report.

The Plan also submitted the policy and procedures implemented on June 1, 2016 to ensure compliance with the Offset Agreement. In addition, the Plan added that Tenet and Coast acknowledge that the specific offset must be approved in advance by the Plan's Chief Financial Officer. The Plan represented that the Chief Financial Officer is responsible for ensuring continued compliance.

The Department finds that the Plan's compliance effort is responsive to the deficiency cited and the corrective action required. Therefore, no further response is required.

C. FIDELITY BOND

Rule 1300.76.3 requires each plan to maintain at all times a fidelity bond covering each officer, director, trustee, partner, and employee of the plan, whether or not they are compensated. The fidelity bond shall provide for 30 days' notice to the Director prior to cancellation, and it shall provide for the Plan at least the minimum coverage of $2 million with a deductible amount not in excess of $100,000.

The Department's examination disclosed that the Plan's fidelity bond had the following deficiencies:

- It named Tenet as the insured party, and it did not provide exclusive minimum coverage of $2 million for the Plan;
- It had a deductible of $2.5 million, which significantly exceeded the maximum allowed deductible of $100,000;
- It did not cover each officer, director, trustee, partner, and employee of the plan, whether or not they were compensated; and
- It did not provide for 30 days' notice to the Director prior to cancellation.

The Preliminary Report required the Plan to file evidence of a fidelity bond that corrected the above noted deficiencies.

The Plan was also required to provide the policy and procedures implemented to ensure that the fidelity bond complies with all of the requirements of Rule 1300.76.3, the date of implementation, and identify the management position(s) responsible for ensuring continued compliance.

The Plan responded by filing an Endorsement to its fidelity bond that provides for an exclusive coverage of $2 million, and a deductible of $100,000, for the Plan.

The Plan also submitted the policy and procedures implemented on June 1, 2016 to ensure compliance with the requirements of Rule 1300.76.3. The Plan represented that the Chief Financial Officer is responsible for ensuring continued compliance.

The Department finds that the Plan's compliance effort is not fully responsive to the corrective action required since the Plan did not file evidence that the fidelity bond:

- **covers each officer, director, trustee, partner, and employee of the Plan, whether or not they are compensated; and**
- **provides for 30 days' notice to the Director prior to cancellation.**

The Plan is again required to file evidence of compliance with Rule 1300.76.3.

D. INSURANCE COVERAGE

Section 1351(o) requires each health care service plan to have evidence of adequate coverage or self-insurance to respond to claims for damages arising out of the furnishing of health care services (malpractice insurance).

Section 1351(p) requires each health care service plan to have evidence of adequate insurance coverage or self-insurance to protect against losses of facilities (property insurance).

Section 1351(r) requires each health care service plan to have evidence of adequate insurance coverage to protect against claims arising out of work-related injuries that

might be brought by the employees and staff of a plan against the plan (workers' compensation insurance).

Rule 1300.51(d)(HH)(6)(b) requires each health care service plan to have evidence of adequate insurance coverage or self-insurance to respond to claims for tort claims, other than with respect to claims for damages arising out of furnishing health care services (liability insurance).

The Department's examination disclosed that the malpractice and liability insurance policies maintained by the Plan were in the name of Coast. In addition, the property and workers' compensation insurance policies were in the name of Tenet. The Plan was not specifically identified by name as an insured on these insurance policies.

The Preliminary Report required the Plan to file evidence of insurance in the form of an endorsement or rider that specifically identifies the Plan as a named insured on the malpractice, property, workers' compensation and liability insurance policies to demonstrate compliance with the Sections and Rule stated above.

In addition, the Plan was required to provide the policy and procedures implemented, the date of implementation, and identify the management position(s) responsible for ensuring continued compliance with the above Sections and Rule.

The Plan responded by filing a copy of Certificates of Insurance for malpractice, property, workers' compensation and liability coverage identifying the Plan as the insured entity.

The Plan also submitted the policy and procedures implemented on June 1, 2016 to ensure compliance with the above Sections and Rule. The Plan represented that the Chief Financial Officer is responsible for ensuring continued compliance.

The Department finds that the Plan's compliance effort is responsive to the deficiency cited and the corrective action required. Therefore, no further response is required.

E. RESTRICTED DEPOSITS

Rule 1300.76.1(a) requires each full service health care plan to deposit with the Director or at the discretion of the Director with any bank authorized to do business in this state and insured by the Federal Deposit Insurance Corporation an amount which at all times shall have a value of not less than $300,000. The deposit must be assigned to the Director of the Department until released by the Director.

The Department's examination disclosed that the Plan failed to execute a new assignment form for the U.S. Treasury Bill purchased in 2013. The CUSIP number on the assignment form on file with the Department did not match with the CUSIP number on the bank statement reviewed during the examination.

On May 18, 2016, the Plan filed a new assignment form that reflects the current information for the U.S. Treasury Bill assigned to the Department (eFile number 20161432).

The Preliminary Report required the Plan to provide the policy and procedures implemented, the date of implementation, and identify the management position(s) responsible for ensuring continued compliance with the above Rule.

The Plan responded by submitting the policy and procedures implemented on June 1, 2016 to ensure compliance with the above Rule. The Plan represented that the Chief Financial Officer is responsible for ensuring continued compliance.

The Department finds that the Plan's compliance effort is responsive to the deficiency cited and the corrective action required. Therefore, no further response is required.

F. ADMINISTRATIVE CAPACITY

Section 1367(g) and Rule 1300.67.3 require every plan to have the organizational and administrative capacity to provide services to subscribers and enrollees. This includes sufficient staffing in administrative services and written procedures for effective controls that result in the effective conduct of the plan's business.

The Department's examination disclosed that the Plan lacked sufficient staffing in administrative services and written procedures for effective controls as demonstrated by the following:

- The Plan's repeated failure to file with the Department changes in the information contained in its application;

- The Plan's failure to file a written right of offset agreement with Tenet and Coast, resulting in a TNE deficiency at December 31, 2015;

- The Plan's failure to comply with the fidelity bond requirements of Rule 1300.76.3;

- The Plan's failure to comply with the insurance requirements of Sections 1351(o), 1351(p), 1351(r) and Rule 1300.51(d)(HH)(6)(b); and

- The Plan's failure to have the Board of Directors exercise adequate oversight of the Plan's operations and to document this oversight in the Board minutes. The minutes did not reflect appropriate approval and review of operational decisions, as follows:

    - The minutes failed to disclose whether the Board of Directors discussed and approved the 2014 and 2015 annual independent auditors' reports.
    - The minutes failed to disclose whether the Board of Directors approved the

      Plan's investments in 2014 and 2015.

- The minutes failed to disclose whether the Board of Directors approved the Plan's officers for 2015.

The Preliminary Report required the Plan to demonstrate adequate administrative capacity by correcting the above stated deficiencies. In addition, the Plan was required to document the Board of Directors' oversight and approval of significant operational decisions in the Board minutes. In addition, the Plan was required to provide the policy and procedures implemented, the date of implementation, and identify the management position(s) responsible for ensuring continued compliance with the above Section and Rule.

The Plan responded by providing a copy of the minutes for the Plan's Board of Directors meeting on November 2, 2016. The minutes demonstrated the Board of Directors' oversight and approval of significant operational decisions.

The Department finds that the Plan's compliance effort is not fully responsive to the corrective action required. The Plan is required to provide the policy and procedures implemented, the date of implementation, and identify the management position(s) responsible for ensuring continued compliance.