

**REPORT ON EXAMINATION**

**of the**

**CARITEN HEALTH PLAN INC.  
1420 CENTERPOINT BLVD.  
KNOXVILLE, TENNESSEE**

**as of**

**DECEMBER 31, 2009**

**DEPARTMENT OF COMMERCE AND INSURANCE**

**STATE OF TENNESSEE**

**NASHVILLE, TENNESSEE**



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Nashville, Tennessee  
June 24, 2011

Honorable Julie Mix McPeak  
Commissioner  
State of Tennessee  
Department of Commerce and Insurance  
Nashville, Tennessee 37243

Dear Commissioner:

Pursuant to your instructions and in accordance with Tennessee insurance laws, regulations, and resolutions adopted by the National Association of Insurance Commissioners ("NAIC"), a financial examination and market conduct review was made of the condition and affairs of the

**CARITEN HEALTH PLAN INC.**  
1420 CENTERPOINT BOULEVARD  
KNOXVILLE, TENNESSEE

hereinafter and generally referred to as the "HMO", and a report thereon is submitted as follows:

#### **INTRODUCTION**

This examination was called by the Commissioner of Commerce and Insurance, State of Tennessee ("Commissioner") and commenced on February 4, 2011. The examination was conducted under the association plan of the NAIC by duly authorized representatives of the Department of Commerce and Insurance, State of Tennessee ("Department").

#### **SCOPE OF EXAMINATION**

This examination report covers the period from December 31, 2005, the date of the previous examination, to the close of business on December 31, 2009, and includes any material transactions and/or events occurring subsequent to the examination date and noted during the course of the examination.

The examination of the financial condition was conducted in accordance with guidelines and procedures contained in the NAIC Examiners Handbook. During the course of

examination, assets were verified and valued and liabilities were determined and estimated as of December 31, 2009. The financial condition of the HMO and its amount of solvency were thereby established. Test checks were made of income and disbursement items for selected periods, and a general review was made of the HMO's operations, practices, and compliance with applicable statutes and regulations. All asset and liability items contained in the financial statement of this report were examined and verified with relative emphasis according to their amount and potential impact on capital and surplus.

In addition, the following topics were reviewed:

- HMO History
- Charter and Bylaws
- Management and Control
- Corporate Records
- Fidelity Bonds and Other Insurance
- Territory
- Plan of Operation (includes inforce/premium by state)
- Market Conduct Activities (includes privacy statement)
- Retirement Plan and Other Employee Benefits
- Loss Experience
- Accounts and Records
- Statutory Deposits
- Agreements with Parent, Subsidiaries and Affiliates
- Pecuniary Interest - Tenn. Code Ann. § 56-3-103
- Dividends or Distributions
- Litigation
- Subsequent Events
- Financial Statement

These are discussed in detail as follows:

### **PREVIOUS EXAMINATION COMMENTS AND RECOMMENDATIONS**

The previous full scope examination of the Company was conducted as of December 31, 2005, by examiners of the Tennessee Department of Commerce and Insurance. The previous examination produced several adverse findings. These findings and their resolutions are as follows:

- The HMO's bylaws remained in a previous entity's name. This was also noted in the December 31, 2001 examination.

*Amended and Restated Bylaws were adopted on December 12, 2007. The*

*bylaws now reflect the correct name of the HMO.*

- The HMO should implement a consistent system for responding to all grievances, including Department inquiries. This system should comply with Tenn. Code Ann. § 56-32-210(c)(5) which stipulates that review of each grievance by a grievance committee, "shall be held within ten (10) working days, such extension not to exceed an additional ten (10) working days." (It is noted that Tenn. Code Ann. §§ 56-32-201 through 56-32-238, former part 2, was redesignated as part 1, §§ 56-32-101-through 56-32-138 by the code commission in 2008).

*It appears that the HMO has updated its grievance procedures to comply with the statute.*

- An inquiry made by the Department noted the HMO's Physicians' manual and the provider contracts need to be updated as required by Tenn. Code Ann. § 56-32-203(b)(4) and (c)(1).

*It appears that the Physicians' Manual and provider contracts have been updated to comply with the statute.*

- No approval was given for the HMO's financial transactions and events in the Board of Directors' minutes as required by Tenn. Code Ann. § 56-3-408(b)(1).

*Board of Directors minutes were reviewed for the current examination period and show approval of the HMO's financial and investment transactions.*

### **HMO HISTORY**

The HMO was incorporated on September 13, 1994, as a for-profit corporation under the provisions of the Tennessee General Corporation Act, with the name "PHP Health Plans Inc." The HMO recorded the charter with the Secretary of State, State of Tennessee but did not record the charter with the Register of Deeds of Knox County. The HMO's original principal place of business was 280 Fort Sanders West Boulevard, Suite 205, Knoxville, Tennessee. The HMO was certified on December 31, 1995, and commenced business on January 1, 1996.

On November 20, 1996, the HMO amended its charter to change its name to "Cariten Health Plan Inc." The Department approved the amendment on November 27, 1996. The amendment was recorded with the Secretary of State, State of Tennessee on December 4, 1996. The amendment was recorded with the Register of Deeds of Knox County on December 9, 1996. A new Certificate of Authority was issued to the HMO on January 7, 1997.

The charter of the HMO authorized the issuance of 100,000 shares of common stock with a par value of \$1.00 per share. Effective September 13, 1994, the HMO became a wholly-owned subsidiary of PHP Companies, Inc. (PHP), a Tennessee for-profit corporation. On October 30, 2008, PHP was acquired by Humana Inc., making the HMO a subsidiary of Humana Inc.

At December 31, 2009, the HMO had \$100,000 of common stock, \$31,214,528 of contributed capital, and \$47,667,676 in unassigned funds.

### GROWTH OF HMO

The following exhibit depicts certain aspects of the growth and financial history of the HMO since the previous examination, according to annual statements filed with the department:

<u>Date</u>	<u>Total Revenues</u>	<u>Net Investment Gain</u>	<u>Medical &amp; Hospital Expenses</u>	<u>Claims &amp; Administrative Expenses</u>	<u>Net Income/ (Loss)</u>	<u>Admitted Assets</u>	<u>Total Capital and Surplus</u>
12/31/05	\$226,213,381	\$3,151,283	\$201,232,361	\$13,515,640	\$ 7,930,081	\$ 76,637,149	\$ 27,697,784
12/31/06	412,734,828	6,206,229	380,238,446	19,713,914	9,809,844	125,610,088	33,085,839
12/31/07	463,652,844	6,171,822	426,939,366	23,115,170	16,361,440	123,653,793	33,588,535
12/31/08	549,813,156	1,392,907	465,296,815	24,862,874	66,054,197	167,155,212	108,321,487
12/31/09	588,966,805	4,237,774	511,759,591	45,370,085	22,867,802	125,247,778	78,982,204

### CHARTER AND BYLAWS

#### Charter:

The original undated charter of PHP Health Plans, Inc., was filed and recorded with the Secretary of State, State of Tennessee on September 13, 1994, after having been approved by the Department on September 9, 1994. The objectives and purposes for which the said HMO is organized, and the natures of its powers and of the business to be carried on by it, are as follows:

To conduct business as a health maintenance organization and to carry on all activities ancillary thereto; and to engage in any lawful act or activity for which corporations for profit may be organized under the laws of the State of Tennessee; and the corporation shall have all powers necessary to conduct such businesses and engage in such activities, including, but not limited to, the powers enumerated in the Tennessee Business Corporation Act or any amendment thereto.

Charter amendments were discussed under the caption "HMO History". The charter has not been amended since the previous exam date of December 31, 2005.

**Bylaws:**

The Bylaws of the HMO in effect at December 31, 2009, were adopted December 12, 2007.

The Bylaws may be amended or repealed either by the shareholders or the Board of Directors as provided by statute. Any change in the bylaws made by the Board of Directors, however, may be amended or repealed by the shareholders.

An annual meeting of shareholders shall be held on such date as designated by the Directors. Special meetings of the shareholders may be called by the Board of Directors, the president or the secretary, or by the holders of at least 10% of the votes entitled to be cast on any issue to be considered at such special meeting. Shareholder meetings shall be held at the principal office of the corporation or at any other place, within or without the State of Tennessee, as designated.

The Board of Directors of the HMO shall be the Board of Directors of PHP Companies, Inc., the parent company of the corporation. The number of directors and composition of the board; the qualification of board members; the method of election and term of office of each member; the resignation and removal of directors; and the method of filling vacancies on the board shall be determined under the provisions of Article II of the bylaws of PHP Companies, Inc.

The officers of the HMO shall be the chairman and vice chairman of the board of directors, the president/chief executive officer, the treasurer/chief financial officer, the secretary and such other officers of PHP as may be elected by the board of directors of PHP or appointed by the president of PHP. The election and qualification of officers, resignation and removal of officers, and the method of filling vacancies shall be determined under the provisions of Article V of the bylaws of PHP Companies, Inc., to the same extent and with the same force and effect as if such provision were incorporated expressly into the HMO's bylaws.

**MANAGEMENT AND CONTROL**

**Management:**

The Bylaws provide all corporate powers shall be exercised by or under the authority of and the business and affairs of the HMO managed under the direction of the Board of

Directors. As of December 31, 2009, the Board of Directors of the HMO was composed of the following:

James Harry Bloem  
Michael Benedict McCallister  
James Elmer Murray

As of December 31, 2009, the following persons held office in the HMO:

Michael B. McCallister	President and Chief Executive Officer
Larry D. Savage	Regional Chief Executive Officer
Douglas E. Haaland	Market President – Senior Products/Tennessee
C. Evans Looney	Market President – Tennessee
James H. Bloem	Senior Vice President, Chief Financial Officer & Treasurer
Thomas J. Liston	Senior Vice President – Senior Products
George A. Andrews M.D.	Vice President – Chief Medical Officer/Tennessee
George G. Bauernfeind	Vice President
J. Gregory Catron	Vice President
Joan O. Lenahan	Vice President and Corporate Secretary
Kathleen Pellegrino	Vice President & Assistant Secretary
George Renaudin	Vice President and Division Leader – Southern Division
William J. Tait	Vice President
Gary D. Thompson	Vice President
Melissa L. Weaver M.D.	Vice President
Ralph M. Wilson	Vice President
Frank M. Amrine	Appointed Actuary

The administrative and executive functions of the HMO are performed by staff provided by Humana Inc., under execution of a management agreement.

**Control:**

The HMO is 100% owned by PHP, a Tennessee company. PHP is a wholly-owned subsidiary of Humana Inc., which is a holding company domiciled in Delaware. An organizational chart is included at the last page of this examination report.

**CORPORATE RECORDS**

Minutes of meetings of the shareholders and Board of Directors of the HMO were reviewed for the period under examination and were found to be complete as to necessary detail and appear to adequately reflect the acts of the respective bodies.

**FIDELITY BOND AND OTHER INSURANCE**

The HMO is covered by a fidelity bond issued to Humana Inc., which specifies that any subsidiary of Humana Inc., is an insured. The coverage limits are as follows:

<u>Type of Coverage</u>	<u>Coverage Limits</u>
Employee Dishonesty Coverage	\$15,000,000

Retention on the policy is \$1,000,000. Coverage is underwritten by National Union Fire Insurance Company of Pittsburgh, Pa. which is licensed in Tennessee.

**TERRITORY**

As of December 31, 2009, the HMO was licensed to transact business only in the State of Tennessee. The Certificate of Authority for the State of Tennessee was reviewed.

The HMO's service area in Tennessee consists of the following counties:

Anderson	Greene	Knox	Rhea
Blount	Hamblen	Loudon	Roane
Bradley	Hamilton	McMinn	Sevier
Campbell	Hancock	Meigs	Sullivan
Carter	Hawkins	Monroe	Unicoi
Claiborne	Jefferson	Morgan	Union
Grainger	Johnson	Polk	Washington

As of December 31, 2009, the HMO had written direct premium as follows in Tennessee:

<u>State</u>	<u>Accident and Health</u>	<u>Medicare Title XVIII</u>
Tennessee	<u>\$66,619,915</u>	<u>\$522,346,890</u>
Total	<u>\$66,619,915</u>	<u>\$522,346,890</u>

**PLAN OF OPERATION**

The company was formed to conduct business as a health maintenance organization and to carry on all activities ancillary thereto. State statutes define an HMO as "any person that undertakes to provide or arrange for basic health care services to enrollees on a prepaid basis."

The HMO contracts with healthcare professionals, healthcare facilities and group providers are as follows:

- Agreements with healthcare professionals reimburse providers through a fee-for-service basis for covered services at the lesser of the provider's billed charges or the most current appropriate point of service and preferred provider benefit program fee schedule.
- Healthcare facilities agreements compensate providers for inpatient services, outpatient services and emergency services, to be reimbursed at the lesser of billed charges or the scheduled rates included in the agreement.
- Group Provider agreements reimburse providers through a fee-for-service basis for covered services at the lesser of the provider's billed charges or the most current appropriate point of service and preferred provider benefit program fee schedule.
- Pharmacy benefits are serviced through a single prescription benefits manager who administers the pharmacy claims processing.

These contracts were reviewed for compliance with Tenn. Code Ann. § 56-32-105(c) which states that "HMO members must be relieved from any liability for services rendered by such providers except for reasonable co-payment and uncovered expenses".

The HMO's target market consists of both small employer groups consisting of three to twenty-five employees and large employer groups consisting of twenty-six or more employees. The HMO utilizes a network of brokers to market its fully funded products and a licensed sales staff for onsite or offsite Medicare seminars.

In 1998, the HMO entered into a risk-based contract with the Centers for Medicare and Medicaid Services (CMS) to provide or arrange for the provision of health care services to senior citizens who have both Medicare Part A and Medicare Part B entitlement. This contract, which is renewable annually, provides basic and supplemental benefits to enrollees as required under federal regulation. Members can also purchase additional benefits by paying premiums directly to the HMO.

Enrollment History:

<u>Year</u>	<u>Total members</u>	<u>Group</u>	<u>Title XVIII Medicare</u>
2005	41,547	14,553	26,994
2006	54,950	14,480	40,470
2007	60,380	16,421	43,959
2008	73,475	26,539	46,936
2009	67,161	18,618	48,543

## **MARKET CONDUCT ACTIVITIES**

In accordance with the policy of the Department, a market conduct review was made of the HMO as of December 31, 2009, in conjunction with this examination. The following items were addressed:

### **Filing and Approval of Policy Forms:**

The HMO is aware of the filing responsibility for various forms, agreements, etc., as well as "hold harmless" requirements for provider contracts pursuant to Tenn. Code Ann. § 56-32-105(c). Inquiries were made to the Department regarding any issues with current filings. The filings with the Department made by the HMO during the examination period were reviewed and no deficiencies were noted.

### **Underwriting:**

The HMO's underwriting guidelines were reviewed. The HMO maintains basic underwriting eligibility requirements for commercial groups and Medicare advantage customers.

### **Advertising:**

All advertising is based on individual products. The product advertising consists of direct mail, television spots, newspaper ads, member newsletters, and employer brochures, as well as the HMO's website ([www.cariten.com](http://www.cariten.com)). It is noted that as of the date of this Examination Report, the website redirects users to Humana Inc.'s website.

### **Prompt Payment - Tenn. Code Ann. § 56-7-109**

At the Department's request, the HMO provided a data download of claims paid during 2009. This information included the date a claim was received, the date it became a "clean" claim, and the date that payment was issued. The examiners then used a random sample of this data to measure timeliness of payment. Tenn. Code Ann. § 56-7-109 requires payment within 21 days for electronic clean claims and 30 days for paper clean claims. The results of this claim review are as follows:

	<b>Total</b>	<b>Paper</b>	<b>Electronic</b>
Total Claims in Sample	79	21	58
Claims marked clean	78	21	57
Claims paid in 21 days or less	75	18	57
Claims paid in 22-30 days	2	2	0
Claims paid in 31-60 days	1	1	0
Claims paid in 61-120 days	0	0	0
Claims paid in 121+ days/unpaid	1	1	0

Claims timely paid

Paper  
95%

Electronic  
100%

The above numbers indicate that the HMO was in compliance with Tenn. Code Ann. § 56-7-109.

**Privacy Policy:**

The HMO has a written privacy statement that is supplied to its members annually in compliance with Tenn. Comp. R. & Regs., 0780-1-72. Such privacy statement is included on the HMO's website ([www.cariten.com](http://www.cariten.com)) under the section titled "Important Member Information". It is noted that as of the date of this Examination Report, the website redirects users to Humana Inc.'s website, where the information is located under "Privacy Practices".

**Policyholder Complaints:**

The HMO complaint handling practices were reviewed during the examination. The Company maintains a complaint register that records all pertinent information regarding the complaint including date received, date closed, complainant name, nature of complaint, and disposition. Grievance letters sent to members appear to be in compliance with Tenn. Code Ann. § 56-32-110.

**EXCESS LOSS AGREEMENT**

Prior to January 1, 2003, the HMO had a reinsurance agreement in place for Senior Health HMO products. It was determined this agreement was not cost beneficial and the coverage ended. At that time, the HMO established a reserve based on the monthly amount approximately equal to the per-member per-month premium rate of the prior catastrophic claim coverage.

**RETIREMENT PLAN AND OTHER EMPLOYEE BENEFITS**

The HMO has no employees. All business functions are performed by Humana Insurance Company and Humana Inc., under service agreements discussed under the caption, "Agreements with Parent, Subsidiaries and Affiliates".

### LOSS EXPERIENCE

As developed from applicable amounts included in the HMO's annual statements filed with the Department, the ratios of net losses incurred to net premiums earned for the period subject to this examination were as follows:

<u>Year</u>	<u>Medical Expenses Incurred</u>	<u>Net Premiums Earned</u>	<u>Loss Ratio</u>
2006	\$380,238,446	\$413,734,828	91.2%
2007	\$426,939,366	\$463,652,844	92.1%
2008	\$465,296,815	\$549,813,156	84.6%
2009	<u>\$511,750,591</u>	<u>\$588,966,805</u>	86.9%
Total	\$1,784,225,218	\$2,016,167,633	88.5%

### ACCOUNTS AND RECORDS

During the course of examination, such tests and audit procedures were made as were considered necessary, including substantial verification of postings, extensions and footings and reconciliation of subsidiary ledgers to control accounts where necessary. General ledger trial balances were reconciled with copies of annual statements for the years 2006, 2007, 2008, and 2009.

The HMO files an annual Risk Based Capital Report. Total adjusted capital, post tax at December 31, 2009 was \$78,982,204. This amount exceeds the authorized control level risk-based capital amount of \$20,292,140.

An audit of the HMO is conducted annually by the accounting firm of PricewaterhouseCoopers, LLP.

Books and records of the HMO are kept at the home office location:

1420 Centerpoint Blvd.  
Knoxville, Tennessee 37932

### STATUTORY DEPOSITS

In compliance with statutory requirements, the HMO maintained the following deposits at December 31, 2009:

<u>Where Deposited and Description</u>	<u>Par Value</u>	<u>Statement Value</u>	<u>Market Value</u>
<b>Tennessee</b>			
US Treasury Note, Due 11/15/12, 4.0%, Cusip # 912828AP5	\$2,050,000	\$2,036,557	\$2,189,810
US Treasury Note, Due 1/15/11, 4.25%, Cusip # 912828ES5	200,000	199,546	207,500
US Treasury Note, Due 3/31/11, 4.75%, Cusip # 912828FA3	250,000	249,721	262,265
US Treasury Note, Due 1/31/13, 2.875%, Cusip # 912828HQ6	500,000	506,034	517,695
US Treasury Note, Due 3/31/14, 1.75%, Cusip # 912828KJ8	550,000	550,547	536,938
US Treasury Note, Due 4/30/14, 1.875%, Cusip # 912828KN9	500,000	489,051	489,725
<b>Total deposit held for the benefit of all enrollees of the HMO in Tennessee</b>	<b>\$4,050,000</b>	<b>\$4,031,456</b>	<b>\$4,203,933</b>

### AGREEMENTS WITH PARENT, SUBSIDIARIES AND AFFILIATES

The Company had three agreements with affiliated companies in effect as of December 31, 2009. The following are summaries of the agreements:

#### Administrative Services Agreement

This agreement between the HMO, Humana Insurance Company and Humana Inc., became effective on January 1, 2009. Under the agreement, Humana Insurance Company agrees to provide administrative services to the HMO, including salaries, benefits and payroll taxes, telephone and data communication, travel and entertainment expenses, printing, postage, dues and subscriptions, office supplies and software. Such services will be charged at cost. Settlement of fees due under the agreement is to take place weekly, based on an estimate of expected costs. A final settlement is to be made quarterly, which is to be supported by a statement of actual costs. Fees will be collected by Humana Inc., who will also perform any necessary banking and accounting administrative duties necessary to fulfill the terms of the agreement.

The agreement is automatically renewed on the first day of each January for an additional one year term, unless notice is given of non-renewal by any party to the others at least 90 days prior to the end of the current term. This agreement was filed on Form D and was approved by the Tennessee Department of Commerce and Insurance on January 26, 2010.

### Corporate Services Agreement

This agreement between the HMO and Humana Inc. became effective on January 1, 2009. Under the agreement, Humana Inc., agrees to provide services, management and oversight to the HMO, including medical and product management, executive management, information systems, financial services, legal services, and human resources management. The HMO will pay a maximum of 14% of premium, plus a maximum of \$22 per member per month for ASO membership for the service provided. Settlement of fees due under the agreement is to take place weekly, based on an estimate of expected costs. A final settlement is to be made quarterly, which is to be supported by a statement of actual costs.

The agreement is automatically renewed on the first day of each January for an additional one year term, unless notice is given of non-renewal by any party to the others at least 90 days prior to the end of the current term. This agreement was filed on Form D and was approved by the Tennessee Department of Commerce and Insurance on January 26, 2010.

### Tax Allocation Agreement

This agreement between the HMO and Humana Inc., was made effective as of October 31, 2008. Under the agreement, Humana Inc., will file consolidated tax returns for all members of its affiliated group. The consolidated tax liability will be apportioned among the members of the affiliated group in accordance with the ratio which that portion of the consolidated tax liability attributable to each member of the group having tax liability bears to the consolidated tax liability, pursuant to Internal Revenue Code Section 1552(a)(1) and Regulation 1.1522-1(a)(2). The parties are to settle balances owed within 30 days. This agreement was filed on Form D and was approved by the Tennessee Department of Commerce and Insurance on January 26, 2010.

### PECUNIARY INTEREST - TENN. CODE § 56-3-103

All Humana Inc., employees, including directors and officers, file an annual Conflict of Interest Information Disclosure and Agreement and complete an annual Ethics Training course. Such policies require the individual to disclose any potential conflicts as they arise. No conflicts with regards to pecuniary interests have been disclosed.

### COMMISSION EQUITY

There is no excess of loss agreement in effect at December 31, 2009. Therefore, no commission equity could exist.

### **DIVIDENDS OR DISTRIBUTIONS**

The Board of Directors declared an ordinary dividend of \$560 per share to be paid to PHP on March 27, 2009. This dividend was paid on May 14, 2009. PHP then distributed the dividend to Humana Inc.

### **LITIGATION**

As of December 31, 2009, the HMO was not currently involved in any legal proceeding which was deemed to be material.

### **SUBSEQUENT EVENTS**

On March 22, 2010, the Board of Directors declared an ordinary dividend of \$220 per share to be paid to PHP. This dividend was paid on April 1, 2010.

As of March 31, 2011, the HMO had transferred all of its commercial membership to affiliated entities. All remaining members are Medicare members.

## FINANCIAL STATEMENT

There follows a statement of assets, liabilities and statement of income at December 31, 2009, together with a reconciliation of capital and surplus for the period under review, as established by this examination:

### ASSETS

	<u>Ledger Assets</u>	<u>Assets Not Admitted</u>	<u>Net Admitted Assets</u>
Bonds	\$57,829,343		\$57,829,343
Cash, cash equivalents, and short-term investments	<u>49,728,502</u>	<u>          </u>	<u>49,728,502</u>
Subtotals, cash and invested assets	107,557,845	0	107,557,845
Investment income due and accrued	749,011		749,011
Uncollected premiums and agents' balances in the course of collection	6,405,786	1,285,963	5,119,823
Accrued retrospective premiums	6,046,360		6,046,360
Amounts receivable relating to uninsured plans	4,310,788		4,310,788
Net deferred tax asset	456,011		456,011
Receivables from parent, subsidiaries and affiliates	3,236,939	3,236,939	0
Health care and other amounts receivable	1,007,940		1,007,940
Aggregate write-ins for other than invested assets	<u>319,651</u>	<u>319,651</u>	<u>0</u>
Totals	<u>\$130,090,331</u>	<u>\$4,842,553</u>	<u>\$125,247,778</u>

**LIABILITIES, SURPLUS, AND OTHER FUNDS**

	<u>Covered</u>	<u>Uncovered</u>	<u>Total</u>
Claims unpaid	\$37,288,171	\$1,351,637	\$38,639,808
Unpaid claims adjustment expenses	1,993,037		1,993,037
Aggregate health policy reserves	148,054		148,054
Aggregate health claim reserves	222,920	8,080	231,000
Premiums received in advance	1,998,866		1,998,866
General expenses due or accrued	1,375,990		1,375,990
Liability for amounts held under uninsured plans	157,736		157,736
Aggregate write-ins for other liabilities	<u>1,721,083</u>	<u>          </u>	<u>1,721,083</u>
Total Liabilities	\$44,905,857	\$1,359,717	\$46,265,574
Common capital stock			\$100,000
Gross paid in and contributed surplus			\$31,214,528
Unassigned funds (surplus)			<u>47,667,676</u>
Total capital and surplus			\$78,982,204
Total liabilities, capital and surplus			<u>\$125,247,778</u>

**STATEMENT OF REVENUE AND EXPENSES**

	Uncovered	Total
Member months	XXX	817,212
Net premium income	XXX	<u>\$588,966,805</u>
Total revenues	XXX	\$588,966,805
<b><u>MEDICAL AND HOSPITAL</u></b>		
Hospital/medical benefits	\$17,251,929	\$415,438,331
Other professional services		6,865,576
Emergency room and out of area	649,329	26,072,659
Prescription drugs		<u>63,374,025</u>
Subtotal	\$17,901,258	\$511,750,591
<b><u>LESS</u></b>		
Total medical and hospital	\$17,901,258	\$511,750,591
Claims adjustment expenses		10,823,809
General administrative expenses		<u>34,546,276</u>
Total underwriting deductions	\$17,901,258	\$557,120,676
Total underwriting gain or (loss) (Total revenue less Total underwriting deductions)	XXX	\$31,846,129
Net Investment income earned		2,806,301
Net realized capital gains or losses		<u>1,431,473</u>
Net investment gains or (losses)		\$4,237,774
Aggregate write-ins for other income or expenses		<u>(8,852)</u>
Net income or (loss) before income taxes after capital gains tax and before all other federal income taxes		\$36,075,051
Federal income taxes incurred		<u>\$13,207,249</u>
Net income (loss)		<u>\$22,867,802</u>

**CAPITAL AND SURPLUS ACCOUNT**

Capital and surplus prior reporting year		\$108,321,487
Net income	\$22,867,802	
Change in net deferred income tax	3,225,989	
Change in non-admitted assets	556,926	
Dividends to stockholders	<u>(56,000,000)</u>	
Net change in capital and surplus		<u>(29,339,283)</u>
Capital and surplus end of reporting period		<u>\$78,982,204</u>

**RECONCILIATION OF CAPITAL AND SURPLUS  
FOR THE PERIOD UNDER EXAMINATION**

	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
<b>Surplus as regards policyholders December 31, Previous Year</b>	\$26,978,082	\$27,697,784	\$33,085,829	\$33,588,535	\$108,321,487
Net Income	7,930,081	9,609,844	16,361,440	56,054,197	22,867,802
Change in net deferred income tax	0	9,325,291	(7,065,981)	(5,496,775)	3,225,989
Change in non-admitted assets	(7,182,728)	(13,574,731)	(8,792,763)	24,175,530	566,926
Dividends to stockholders	0	0	0	0	(56,000,000)
Aggregate Write ins for gains or (losses) in surplus	<u>(27,651)</u>	<u>27,651</u>	<u>0</u>	<u>0</u>	<u>0</u>
<b>Surplus as regards to policyholders December 31 Current Year</b>	<b><u>\$27,697,784</u></b>	<b><u>\$33,085,839</u></b>	<b><u>\$33,588,535</u></b>	<b><u>\$108,321,487</u></b>	<b><u>\$78,982,204</u></b>

**ANALYSIS OF CHANGES IN FINANCIAL STATEMENT AND COMMENTS  
RESULTING FROM EXAMINATION**

Although minor differences in various items were noted during the course of the examination, none were considered to produce a material effect on surplus, either singly or in the aggregate.

**SUMMARY SCHEDULE FOR "ANALYSIS OF CHANGES  
IN FINANCIAL STATEMENT AND COMMENTS RESULTING FROM EXAMINATION"  
AS THEY AFFECT SURPLUS**

No schedule or comment is applicable. All noted differences were below the threshold established for examination purposes.

**COMMENTS AND RECOMMENDATIONS**

The following list presents a summary of comments noted in this report:

**Comments:**

The Custodial Agreement with JP Morgan Chase Bank did not contain the required language as referenced in Tenn. Comp. R. & Regs. § 0780-1-46. It was recommended to the Company that the agreement be modified to fully comply with this regulation. An amendment containing the language required by Tenn. Comp. R. & Regs. § 0780-1-46 was executed prior to the completion of the examination.

## CONCLUSION

Insurance examination practices and procedures, as promulgated by the NAIC, have been followed in connection with the verification and valuation of assets and the determination of liabilities of Cariten Health Plan Inc. of Knoxville, Tennessee.

In such manner, it was determined that, as of December 31, 2009, the HMO had admitted assets of \$125,247,778 and liabilities, exclusive of capital, of \$46,265,574. Thus, there existed for the additional protection of the policyholders/enrollees, the amount of \$78,982,204 in the form of common capital stock, gross paid-in and contributed surplus, and unassigned funds (surplus).

The above amount of net worth does comply with the amount required pursuant to Tenn. Code Ann. § 56-32-112. At December 31, 2009, the required net worth under the referenced statute is \$12,584,502.

The courteous cooperation of the HMO's officers and Humana employees extended during the course of the examination is hereby acknowledged.

Respectfully submitted,

  
Rhonda Bowling-Black, CFE  
Examiner-in-Charge  
State of Tennessee  
Southeastern Zone, N.A.I.C.

  
Sandy Banks  
Insurance Examiner  
State of Tennessee  
Southeastern Zone, N.A.I.C.

  
David Bobo  
Insurance Examiner  
State of Tennessee  
Southeastern Zone, N.A.I.C.

**AFFIDAVIT**

The undersigned deposes and says that she has duly executed the attached examination report of Cariten Health Plan Inc. dated June 24, 2011 and made as of December 31, 2009, on behalf of The Department of Commerce and Insurance, State of Tennessee. Deponent further says she is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of his knowledge, information and belief.

Rhonda Bowling-Black  
Rhonda Bowling-Black, CFE  
Examiner-in-Charge  
State of Tennessee  
Southeastern Zone, N.A.I.C.

Subscribed and sworn to before me  
this 24<sup>th</sup> day of  
June, 2011

Notary Kira Burnett

County Davidson  
State TN

Commission Expires January 6, 2014



