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FILED

JUN 28 2007

Department of Insurance
State of Idaho

Attorneys for Department of Insurance

BEFORE THE DIRECTOR OF THE DEPARTMENT OF INSURANCE
STATE OF IDAHO

IN THE MATTER OF:

Primary Health Network, Inc.

Idaho Certificate of Authority: 2792

NAIC Company Code: 60007

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)
) ORDER ADOPTING
) REPORT OF EXAMINATION
) AS OF DECEMBER 31, 2005

) Docket No. 18-2391-07
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The Report of Examination as of December 31, 2005 (Report) of Primary Health Network, Inc. (Company) was completed by examiners of the Idaho Department of Insurance (Department), signed the 30th day of May 2007 by the Examiner-in-Charge, David W. Emery, CFE, FLMI, and a verified copy was filed with the Department

effective May 30, 2007. A draft copy of the Report was delivered to the Company previously and the verified Report and management letter were transmitted to the Company electronically (PDF file, via e-mail) on May 30, 2007 to Mr. Elwood I. Kleaver, Chief Executive Officer. The verified Report is attached hereto and incorporated herein as Exhibit A.

RESPONSE

A written response was provided by the Company on June 13, 2007 with regard to the May 30, 2007 verified Report of Examination, as provided for under Idaho Code § 41-227(4). However, the Company requested in writing that this response not be included as part of the public record. Accordingly, said response has not been attached to this order.

WAIVER

Attached and incorporated herein as Exhibit B, is a Waiver signed by Mr. Kleaver, hand delivered on June 25, 2007. Based upon the Waiver/Exhibit B, this is a final order, and the Company has waived its rights to seek reconsideration and judicial review / appeal of this order.

ORDER

NOW THEREFORE, after carefully reviewing the above described Report of Examination, attached hereto as Exhibit A, and good cause appearing therefor, it is hereby ordered that the above described report, which includes the findings, conclusions, comments and recommendations supporting this order, is hereby ADOPTED as the final examination report and as an official record of the Department under Idaho Code § 41-227(5)(a).

DATED and EFFECTIVE at Boise, Idaho this 28th day of June 2007.



William W. Deal, Director
IDAHO DEPARTMENT OF INSURANCE

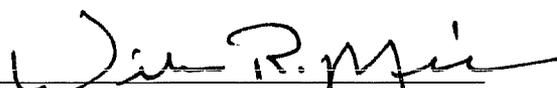
CERTIFICATE OF SERVICE

I hereby certify that on this 28th day of June, 2007, I caused to be served the foregoing document on the following parties in the manner set forth below:

Elwood I. Kleaver	<u> X </u>	certified mail
Chief Executive Officer	<u> </u>	first class mail
Primary Health Network, Inc.	<u> </u>	hand delivery
800 Park Blvd., Suite 760	<u> </u>	facsimile
Boise, Idaho 83712	<u> X </u>	e-mail
e-mail: ekleaver@primaryhealth.com		

Dennis V. Bruns	<u> </u>	certified mail
Chief Financial Officer	<u> </u>	first class mail
Primary Health Network, Inc.	<u> </u>	hand delivery
800 Park Blvd., Suite 760	<u> </u>	facsimile
Boise, Idaho 83712	<u> X </u>	e-mail
e-mail: dbruns@primaryhealth.com		

Georgia Siehl, CPA, CFE	<u> </u>	certified mail
Bureau Chief / Chief Examiner	<u> </u>	first class mail
Idaho Department of Insurance	<u> X </u>	hand delivery
700 W. State St., 3 rd Floor	<u> </u>	facsimile
Boise, Idaho 83720-0043	<u> X </u>	e-mail
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William R. Michels, MBA, CPA, CFE
Examination Supervisor
IDAHO DEPARTMENT OF INSURANCE

DEPARTMENT OF INSURANCE

STATE OF IDAHO



REPORT OF EXAMINATION

of the

PRIMARY HEALTH NETWORK, INC.

(NAIC Company Code 60007)

as of

December 31, 2005

EXHIBIT

A

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State of Idaho
DEPARTMENT OF INSURANCE

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WILLIAM W. DEAL
Director

Boise, Idaho
May 30, 2007

The Honorable William W. Deal
Director of Insurance
State of Idaho
700 West State Street
P. O. Box 83720
Boise, Idaho 83720-0043

Dear Director:

Pursuant to your instructions, in compliance with Section 41-219(1), Idaho Code, and in accordance with the practices and procedures promulgated by the National Association of Insurance Commissioners (NAIC), we have conducted an examination as of December 31, 2005 of:

PRIMARY HEALTH NETWORK, INC.

**800 PARK BLVD., SUITE 760
BOISE, IDAHO 83712**

hereinafter referred to as the "Company", at its offices in Boise, Idaho.

The following report of examination is respectfully submitted.

SCOPE OF EXAMINATION

This examination covers the period January 1, 2002 through December 31, 2005. The examination was conducted at the Boise, Idaho office of Primary Health Network, Inc. by examiners from the state of Idaho. The examination was conducted in accordance with Section 41-219(1), Idaho Code, the National Association of Insurance Commissioners (NAIC) *Financial Condition Examiners Handbook*, and the NAIC *Accounting Practices and Procedures Manual*. We performed our testing in order to achieve a confidence level commensurate with the risk assessed through utilization of the NAIC *Examiners Handbook*. Verification and valuation of assets, determination of liabilities and reserves, and an analysis and review of such other accounts and records as appropriate to the examination were also performed.

A Letter of Representation was signed by the Company attesting to the Company's ownership of all assets and to the nonexistence of unrecorded liabilities or contingent liabilities.

A risk assessment review of the Company's IT systems and controls was performed by Examination Resources, LLC (Atlanta, Georgia). There was some reliance placed on the 2005 certified public accountant's statutory audit report and work papers during the examination of the Company.

In addition to the Report of Examination, a Management Letter was issued to the Company by the Department which covered items that were not included in the Report, due to the materiality threshold or items that were related to proprietary, operational issues.

PRIOR EXAMINATION

The prior examination was conducted by the State of Idaho and covered the period from July 1, 1998 through December 31, 2001. The Comments and Recommendations contained in that Report and the Company's response to those comments and recommendations were as follows:

Capital Stock

The Company capital stock certificates did not support the \$1,000,000 reflected in its annual statements and general ledger. It is recommended the Company cancel any existing no-par value shares and issued \$1 par value stock to support the capital amount reflected in its annual statements to be in compliance with Idaho Code Sections 41-313 and 41-2804. It is also recommended that the Company maintain a capital stock registration ledger, including canceled certificates, to properly reflect the capital stock activity from inception.

Company Response

The correction of the stock certificate for Primary Health Inc.'s stock holdings of Primary Health Network, Inc. was corrected on February 21, 2003.

Capital Stock

Also the Company could not provide evidence that the members of the Board of Directors were shareholders for the period covered by this examination, which is required by Idaho Code Section 41-2835(3). It is recommended that the members of the Board of Directors be shareholders of the Company by owning at least one share of the Company's capital stock, as required by Idaho Code Section 41-2835(3).

Company Response

The Board members of the Company have each purchased a share of the stock of the Company as of February 19, 2003. Stock certificates were issued on February 21, 2003.

Surplus Debentures

As recommended in the prior examination report, it is again recommended that the Company obtain prior approval from the Director before the issuance, repayment, or forgiveness of any future surplus notes, to be in compliance with Idaho Code Section 41-2841.

Company Response

Thirty days advance notice will be given to the Director of the Department of Insurance in the event the Company again wishes to issue surplus notes. The Company does anticipate the repayment of the one existing surplus note in the future and will pursue such action only after written notice to and written authorization from the Director.

Surplus Debenture

It is recommended that the Company sign and date the corrected copy of the note and submit a copy to the Department, as requested in the Department's letter, dated July 10, 2000. The executed corrected copy should replace the current outstanding note, as the current note was never approved.

Company Response

The Company is willing to substitute a corrected surplus note for the existing surplus note, but the Company is unaware of the specific changes desired by the Department and will need additional information in order to make the desired changes.

Directors

As of the examination date, none of the members of the Board of Directors were shareholders of the Company, pursuant to Idaho Code Section 41-2835(3). It is recommended that the Company come into compliance.

Company Response

The Board members of the Company have each purchased a share of the stock of the Company as of February 19, 2003. Stock certificates were issued on February 21, 2003.

Officers

Article 4.1 of the Company's Bylaws states as follows:

Number, Qualifications, Election and Term of Office. The officers of the Corporation consist of a President, a Vice-President, a Treasurer, and a Secretary and such other officers as the Board of Directors may from time to time, deem advisable. Any two or more offices may be held by the same person, except that no person shall hold both the

offices of President and Secretary. The officers of the Corporation shall be elected by the Board of Directors at the annual meeting of the Board of Directors. Each officer shall hold office until the next annual meeting of the Board of Directors, and until a successor shall have been elected and qualified, or until the Director's death, resignation or removal.

It was noted in the above section that an error was made with regard to the officer serving "until the Director's death, resignation or removal." It should read, until the Officer's death, resignation or removal.

The review of the Board of Directors minutes for the period of examination indicated that no elections of officers were documented in the Board of Directors minutes for the years 1999, 2000, and 2001.

Also, the bylaws provide that one of the required officers of the Corporation to be a Treasurer; however, there is no indication in the Company's Board of Directors' minutes that there has been a Treasurer for the Company since Bryan Shaul resigned on February 12, 1999.

It is recommended that the Company correct the error noted in Section 4.1 of its bylaws, elect the required officers annually as provided in Section 4.1, and document the officers' annual elections in the minutes of the Board of Directors' minutes.

Company Response

The Board of Directors of the Company met on February 19, 2003 and elected officers to serve until the next annual meeting of the Board of Directors of the Company. All positions per the Company bylaws were filled. Additionally, the bylaws were amended on February 19, 2003 to correct the error noted concerning the reference to a Director's death, resignation, or removal rather than the appreciate reference to the Officer's death, resignation, or removal.

Committees

The Company was not able to provide minutes for any of the committee meeting covered by this examination. Nor were they able to provide evidence that the committees had been dissolved. The Company representative was not aware that any committee existed. It is recommended that the members of the committees be updated to include members of the current Board of Directors and that minutes be maintained of all committee meetings. If it is the Company's desire not to have any committees, it is recommended that during a meeting of the Board of Directors, they approve a resolution dissolving each of the committees and document such dissolution in the minutes of their meetings.

Company Response

The Company has been operating without standing committees for at least a few years. Consequently, at the February 19, 2003 meeting of the Board of Directors of the Company, the executive and other committees were dissolved in favor of the Board of Directors acting together on all appropriate items. When an occasional committee is required by circumstances, it will be appointed by the Board of Directors and empowered to address the unique issue for which it was formed. All changes in the bylaws approved by the Board of Directors at its February 19, 2003 Board meeting will be shortly forthcoming to the Department.

Conflict of Interest

No conflict of interest statements were available for the years 1998, 1999, 2000 and 2001. It is recommended that the Company's officers and directors execute conflict of interest statements and provide them for review at the annual Board of Directors' meetings and document the review in the corporate records.

Company Response

At the Company's Board of Director's meeting of February 19, 2003, a draft Conflict of Interest policy and Disclosure form were presented to the Board for its review and comment. The Board requested comments and suggestions from its members. The Board will make appropriate clarifications and revisions so that Conflict of Interest disclosure forms will be completed prior to the annual meetings of the shareholders and Board of Directors scheduled in May 2003.

Conflict of Interest

It appears that the conflict of interest statements completed in 2002 did not completely disclose all possible conflicts of interest for the officers and directors of the Company. The purpose of the form is for the individual to disclose any direct or indirect relationships, financial interests, affiliations, or obligations that the individual is involved with regarding the Company, subsidiaries or affiliates. It is not up to the individual signing the statement to determine if there is a conflict. The determination as to whether there is a conflict or potential conflict should be determined by the Board of Directors following their review of the completed statements. It is recommended that each director, officer, and specified employee fully disclose all financial interest, outside business affiliations or obligations, or any other interest or obligation that may cause real or apparent conflicts of interest on the conflict of interest statements.

Company Response

The Conflict of Interest forms will include full disclosure of any real and potential conflicts with the Company. The forms will be completed by each board member before the annual meetings of the shareholders and Board of Directors so that full disclosure and Board determination may be made at those meetings.

Amended and Restated Medical Provider Agreement

In reviewing the agreement, it was noted that there had been extensive correspondence between the Company and the Department with regard to this agreement. However, it appears that the agreement was never executed or signed by the parties. It also appears that the parties have been making fund transfers in accordance with the agreement, with the exception of the administrative fee for the ERISA program. It is recommended that the parties to the agreement execute and sign the agreement to justify the transfer of funds between the parties.

Company Response

As stated to the Examiner during the examination process, the document was fully executed and apparently misplaced. We will execute a new agreement and submit it to the Department.

Amended and Restated Medical Provider Agreement

The agreement provided for PHI to pay the Company \$10 per member per month for the ERISA Health Benefit Program for PHI employees; however, during the year 2001 the fees were calculated at the rate of \$15 per member per month. The administrative fee rate was changed and no amendment to the contract could be provided. The Company has not filed this amendment with the Director 30 days prior to its effective date, as required by Idaho Code Section 41-3807 and is therefore a violation. It is recommended that the Company file its agreements with affiliates, including amendments thereto, with the Directors for approval at least 30 days prior to the effective date.

Company Response

There was no amendment created to increase processing fees, so to the extent that fee payments were increased, it was error in internal processing rather than a change in the contract. A new agreement will be provided to the Department 30 days prior to its effective date will clarify any past discrepancies

Amended and Restated Medical Provider Agreement

The only contract, which was signed and executed that provided for an administrative fee for the ERISA Health Benefit Program for PHI employees, was the Administrative Services Agreement between PHI and Primary Health Plan Administrators, Inc. (PHPA). The agreement was effective February 1, 1998 and provided for a fee of \$10 per member per month to be paid to PHPA. As PHI is paying this fee to the Company, it is assumed this agreement was terminated. It is recommended that the Company officially terminate agreements that are not in force and retain the termination notices.

Company Response

The Company is putting in place a master contracts administration process that will provide additional security against future lost documents. It will also facilitate internal notification of documents that require termination.

Cost Allocation Agreement

The Company did not have an agreement in effect, which provided for this allocation. The Company was in violation of Idaho Code Section 41-3807(2)(d), which provides that the Company cannot enter into a transaction with its parent or affiliate unless the Company has notified the Director of the Department at least 30 days prior to the effective date of the transaction. This includes all management agreements, service contracts and all cost-sharing arrangements. Therefore, it is recommended that the Company execute an agreement and file such agreement with the Director in accordance with Idaho Code Section 41-3807(2).

Company Response

It was not our understanding that a formal agreement was required for the parent to provide services for its subsidiary. The internal provision of services and charges (or allocations) to the subsidiary for those services has been in place since the Company's inception with Department knowledge. Particularly at the end of 1999 when the Company discussed at length with the Department its proposed changes to the allocation process; there was no mention of the need to create a formal agreement. If it is the Department's position that such an agreement is required, we will draft such an

agreement and provide it to the Department (thirty) 30 days before the effective date of the formal agreement.

Consolidated Federal Income Tax Agreement

It was also noted that the Company's federal income taxes were consolidated with the taxes of its parent and other affiliates. The Company did not have an agreement, which provided for the consolidation. Therefore, the Company is in violation of Idaho Code Section 41-3807(2)(d). It is recommended that the Company execute an agreement and file such agreement with the Director in accordance with Idaho Code.

Company Response

It was not our understanding that the Company was required to have an inter-company agreement in place to consolidate federal income tax reporting, since such practice is a routine practice of business throughout the country and the state of Idaho. If it's the Department's position that such an agreement is required, we will include it in the general services agreement to be drafted and filed with the Department, as noted in the previous response.

Amended and Restated Medical Provider Agreement

In reviewing the agreement it was noted that both parties signed the agreement; however, the wording of the agreement reverted back to the original agreement with an effective date of July 1, 2000. Some of the Department's concerns, which were addressed in the correspondence between the Company and the Department, were not taken into consideration in this agreement. Furthermore, the Company is in violation of Idaho Code Section 41-3807(2)(d), as the agreement had not been filed with the Director of Insurance for approval thirty days prior to the effective date. It is recommended that the Company file agreements with its parent or affiliates in accordance with the Idaho Code, prior to implementing the agreement.

Company Response

Inasmuch as this recommendation is essentially related to the prior recommendation for completing and filing with the Department a corrected agreement, we refer you to the prior response.

Idaho Physicians Network Payor Agreement

Effective January 1, 2002, Primary Health Plan, which was an assumed business name (dba) for the Company, entered into this agreement with Idaho Physicians Network (IPN). It is recommended that the Company amend this agreement to properly reflect the Company's name as it appears on the Idaho Certificate of Authority.

Company Response

The Certificate of Authority was amended/corrected on January 31, 2003 to include the d/b/a Primary Health Plan.

Idaho Physicians Network Payor Agreement

Furthermore, the Company is in violation of Idaho Code Section 41-3807(2)(d), as the agreement had not been filed with the Director of Idaho Department of Insurance for approval thirty days prior to the

implementation of the agreement. It is recommended that the Company file all agreements with its parent or affiliates in accordance with the Idaho Code, prior to implementing the agreement.

Company Response

The Company, as stated previously, is establishing a contracts administration process that will provide substantially greater structure to our contracting process. Documents will be filed with the Department 30 days before effective date.

Minutes of Meetings

It was noted that the minutes did not reflect which Directors' meetings were designated as the annual meeting. The minutes did not reflect the Directors' election of officers for the years 1999 and 2000. It is recommended that the Company indicate in its minutes of the Board of Directors' meetings, which meetings are the annual meetings and which ones are the regularly schedule meetings. This same recommendation was made in the prior examination report dated June 30, 1998, as indicated by the comment for item number 6 of the PRIOR EXAMINATION section of that report.

Company Response

The Board of Directors reviewed and approved at its February 19, 2003 meeting a recommended structure to inform the Board of upcoming issues to ensure that subject matters are dealt with and recorded on a timely basis.

Minutes of Meetings

Section 2.1 of the bylaws provide for annual meetings of the shareholders to be held within 5 months after the close of the fiscal year of the Company. Section 7.2 indicated that the fiscal year shall be the calendar year ending December 31. The Company was not able to provide any minutes of the shareholders' meetings held during the examination period. During the years 1999 and 2000, the Company's shareholders did not elect the members of the Board of Directors. It is recommended that the Company's shareholders hold annual meetings pursuant to its bylaws and maintain minutes to document such meetings.

Company Response

See the comments above (Minutes of Meetings) pertaining to the minutes. This same structure will resolve the minutes of shareholders meetings.

Minutes of Meetings

Section 3.18 of the bylaws provides for the Board of Directors, by resolution by a majority of its members, to designate from its members an executive committee and such other committees, as they deem necessary. During the Board of Directors' meeting of April 18, 1999, the Board provided for the Audit and Finance Committee, Compensation Committee, and Compliance Committee. Other committees mentioned in the Board of Directors' minutes were the Strategic Opportunities Committee and the Nominating Committee. The Company was unable to provide copies of any minutes for meetings held by these committees. It is recommended that the Company committee members maintain minutes of their meetings.

Company Response

The Company's Board has been operating for the last few years as a Board committee of the whole when dealing with audit issues, strategic opportunities, and nominating committee matters, even though we had not formally dissolved the committee structure described in our By-laws. These committees were formally dissolved at the February 19, 2003 Board meeting in favor of the "committee of the whole" structure. Consequently, future minutes of activities will be exclusively documented in the minutes of Board meetings, unless a specific ad hoc committee is appointed for a designated purpose.

Minutes of Meetings

The minutes of the November 17, 1999 Board of Directors' meeting indicated the review of the September 30, 1998 Report of Examination of the Company by the Idaho Department of Insurance; however, the examination report, as filed with the Department of Insurance, was as of June 30, 1998. The Company should be more diligent in keeping its minutes.

Company Response

The date described in the minutes was in error. The September date reflected the date of a cover memorandum to the Board discussing the examination. We will be more diligent in the future.

Minutes of Meetings

The minutes of the meetings of the Board of Directors held on November 17, 1999, also indicated the Board of Directors approval of investments made during the period of July 10, 1998 to August 3, 1999; however, subsequent to August 3, 1999, no other investment transactions approvals were documented in the Board of Directors' minutes. Idaho Code Section 41-704 provides for the Board of Directors to document the approval of investments in the minutes of their meetings. It is recommended the Board approved the Company's investments and document such approval in the minutes of their quarterly meetings.

Company Response

The Board did review and approve the investments at its February 19, 2003 meeting and will routinely document such review and approval in the future in its minutes of meetings.

Active Agent Appointments

A list of appointments was obtained from the Department and compared to a listing provided by the Company. As of December 31, 2001, there were approximately 58 agent/agencies that appeared on the Department list of active agents that did not appear on the Company's list of active agents. It is recommended that the Company obtain a copy of the Department's current listing of active agent/agencies appointments, review their agent files and notify the Department of any terminations that have not been reported.

Company Response

The Company has recently printed a copy of the Department's list of active agents shown by the Department to have appointments with the Company. We are in the process of matching the listing with our records. We will inform the Department if discrepancies are noted.

Terminated Agent Appointments

Four inactive agent files were reviewed for copies of termination notices to the Department containing the reasons for the termination of the agent. Although the agent terminations were recorded at the Department, there were no copies of the termination notices in the agent's file nor could the Company produce a copy of those four notices. This is a violation of Idaho Code Section 41-1019(1)(2). It is recommended that the Company retain a copy of the agent appointment termination notifications that have been sent to the Department. The notification should indicate the reasons for the termination and a copy should be placed in the terminated agent's file in accordance with Idaho Code Section 41-1019(1)(2).

Company Response

To remedy split responsibilities that apparently resulted in documentation and/or filing problems, the Company has designated one person within the Company with the responsibility to maintain our agent/producer data base, including all appropriate letters of appointment, termination, etc. Appropriate policies and procedures are now under development.

Appointment Within 15 Days of Sale

The review resulted in three agents, which were not appointed within 15 days from the date that their agency contract was executed or the date the first insurance application was submitted. As the notice of agent's appointment or a notice of registration to operate under the appointment of an agency was not filed with the Department within fifteen days of the date of signing the contract or submission of a group application, the Company was in violation of Idaho Code Section 41-1018(2). It is recommended that the Company's agents or agencies be appointed in accordance with Idaho Code Section 41-1018(2).

Company Response

As part of the re-focused responsibilities described immediately above, the procedures to timely appoint producers and file such appointments with the Department are under development.

Agents Files

A review of 25 agent's files was made to determine if the files contained a signed contract, copy of the agent's license, and appropriate appointment documentation. It is recommended that the Company maintain its agents' or agency files in a manner so that all appropriate and necessary information or documentation is readily available.

Company Response

The centralization of responsibility for producer appointments and files will facilitate all documentation being filed appropriately in a single, central location.

Agent Files

One of the files reviewed was an active small insurance agency. The file included only a copy of the agency license and a memo that all commissions would be paid to the agency. The names of two active agents and one terminated agent were written on the file. Copies of those files were requested but could not be produced by the Company. The Agency is receiving commissions from the Company. It is recommended that the Company obtain a contract from the agents or the agency, copies of the active agents' disability licenses, and the appointment documentation either for the agency or the active agents.

Company Response

Part of our centralization of responsibility of producer appointments and documentation is an internal review of all appointment files to ascertain all information is current.

Agent Files

Since the agent signs the insurance application, it is necessary for the Company to have a copy of each registered agent's license indicating that the agent was licensed to write disability insurance. If the Company does not wish to have a contract with each of the remaining 44 agents, then there should be at least an agency contract between the insurance agency and the Company. It is recommended, in accordance with Idaho Code Section 41-1004(1), that the Company request a copy of the registered agent's licenses from the agency and retain those copies in the Company's agent files, or provide other verification that the agent was licensed to write disability insurance. It is also recommended that the Company obtain a signed contract from all of the insurance agencies.

Company Response

Our procedure to assure ourselves of obtaining and maintaining timely and current producer information will include obtaining appropriate licenses for producers and/or contracts.

Statutory Deposits

The Company was not able to provide evidence of the Department's approval for the withdrawal of \$50,000 par value of Idaho Falls, Idaho Rev. Dev. Agy. Rev. Tax Incr. bonds, with a rate of 8%, maturity of 10/01/2005; and CUSIP No. 451192AP3. It is recommended that the Company obtain the Department's approval prior to withdrawing securities held as statutory deposits.

Company Response

Previous discussions with the Department have raised the Department's concern for the performance of the bank trustee monitoring and initiating only after appropriate notification to and approval by the Department. The Company, with the Department's formal agreement, in early 2003 replaced the bank trust department managing statutory deposits on its behalf with the bank trustee that managed such activities for the Company prior to the switch in 2001.

Underwriting-Guidelines/Manuals

The language regarding the preexisting condition waiting period in the Group Underwriting Manual was not constant with the language reflected in the Company's Master Policy and Contract or the Member Handbook. It is recommended that the Company bring the language of its Underwriting Guidelines into accord with the language of the Master Policy and Contract and the Member Handbook.

Company Response

The language has been corrected.

New Business Review-Small Group

The waiver form utilized by the Company had a space to identify the reasons why the employee is waiving coverage. One completed waiver form did not have any reasons checked. The company indicated that the waiver was taken by phone and the underwriter did not follow up on the reason for the waiver. However, there was a signature on this form and, if the waiver was taken by phone, it is not known how the employee actually signed the waiver. One small group employer's application indicated there were five eligible full-time employees; however, only four employees were enrolled and there were no waiver forms in the file. In both cases the Company responded that the underwriting department had not followed up. In both cases this is a violation of IDAPA 18.01.69 (046.05). Without completed waivers in the files and in the case of waivers taken by phone, there is no way to determine if the employees were actually made aware of their rights of notification and/or the penalties imposed on late enrollees as described on the waiver form. It is recommended that the Company be more thorough in its follow up during the initial underwriting process, to make sure that the waiver forms that are received are complete, including the reasons for the waiver of coverage, and that a completed and signed waiver form is in the file for every eligible employee and/or dependent(s) who declines coverage. It is also recommended that a follow up review be completed upon the group's renewal to determine if any new eligible employees have been hired who are not covered by the plan and who have not completed a waiver form.

Company Response

Our new Director of Underwriting has already implemented various new practices within the Underwriting Department to ensure appropriate controls. We will continue to develop and incorporate specific procedures into both the Sales Department and Underwriting Department to ensure that waiver forms are obtained when appropriate, including a refusal to complete the underwriting until such waiver forms are received.

New Business Review-Small Group

Two of the small group files reviewed did not contain a completed census form. The Company responded that the census section on the Employer Application was no longer used and that the census comes from the rate sheet. This is a violation of IDAPA 18.01.69 (046.04). The rate sheet is prepared by the Company and not by the small employer. It is recommended that the Company make sure that a completed census, prepared by the employer, is included with each application for small group coverage received by the Company.

Company Response

A complete census form completed by the Employer is part of the procedures put into place by the new Director of Underwriting. Our internal marketing/sales force has received specific training on this issue, and communication has similarly been held with our producers. We will require an employer-completed census form in all future underwriting efforts.

Administrative Services Plans

Subsequent to March 1, 2001, all claim checks reflected the name of Primary Health Medical Group, Inc., a Company affiliate, and were drawn on a Primary Health Medical Group, Inc. bank account. It was also noted in 2001, that the Company was receiving the administration fee of \$10 per month, per member, instead of PHPA. There was no indication that the agreement with PHPA had been terminated or that an agreement providing for the fee to be paid to the Company had been executed. Failure to maintain a separate fiduciary trust account is a violation of the ERISA requirements for such plans. As the Company's ERISA plan terminated on May 1, 2002, it is recommended that any future ASO ERISA contracts written by the Company be maintained in separate fiduciary trust accounts. The fiduciary trust accounts should reflect all ERISA funds received and all claim checks written for the plan. Also, any claim checks from these accounts should include the name of the employer on the checks.

Company Response

The Company no longer has any ASO ERISA contracts or business and consequently no further action is contemplated at this time. In the event that ASO ERISA business is sold in the future, we will appropriately develop procedures and controls to ensure that we are in compliance with state and federal requirements.

The Women's Health & Cancer Act

The Act required that an initial one-time notification be made to all existing plan members no later than January 1, 1999. The Department Bulletin No. 00-2 specified that the required notice to be sent out not later than March 1, 2000. In response to a request for a copy of that mailing the company responded, "sometime in 2000 Primary Health did a mass mailing to all of the then active membership to inform them of their rights under the WHCRA legislation." However, the Company could not produce a copy of that mailing or any proof of mailing. The Company also stated that several changes in personnel may have contributed to the loss of the documentation. Without any documentation the Company cannot prove that they are in compliance with the WHCRA or that they have met the requirements of Department Bulletin 00-2. It is recommended that the Company maintain records that would document and support its compliance with Department Bulletins and federal acts.

Company Response

The Company sent notifications to its members in January 2003 and agrees that it will mail annual notifications to members informing them of their rights under the Women's Health & Cancer Act.

Gramm Leach Bliley Act

The Company made a filing with the Idaho Department of Insurance in March 2002 of the proposed Primary Health Privacy Policy notice. The filing included a copy of the proposed Privacy Notice that the Gramm Leach Bliley Act mandated be initially sent to all members no later than July 1, 2001. However, the Company has indicated that this notice has not yet been sent to members pending final resolution of issues raised by its special legal counsel. It indicated that the issues should be resolved by August 31, 2002 and a revised filing would be made, if applicable; and a first notice mailing would then be made to plan enrollees. It appears a revised filing would be necessary, as the current filing indicated that it will “become effective on or after April 15, 2002.” The members need to be made aware of the effective date of the Company’s policy, as it cannot be retroactive. The Company is not in compliance with the mandated initial financial Privacy Notice deadline requirement of the Gramm Leach Bliley Act. This is a violation of IDAPA 18.01.48. It is recommended that the Company send out the mandatory financial first privacy notice to all members. It is also recommended that the Company maintain records of the re-filing with the Department and complete documentation and evidence of the delivery of the initial notice to members as required by the Gramm Leach Bliley Act and IDAPA 18.01.48.

Company Response

The Company sent its GLB notice to its members in January 2003. Beginning effective January 2003, the Company will annually send a privacy notice consistent with GLB and HIPPA to its members.

Network Adequacy-Geographic Area

A listing provided by the Company indicated it had existing members in 37 counties; however, the listing provided by the Department indicated the Company had only filed to market in 31 counties and later withdrew from 4 of those counties. It was determined that the Company had not filed with the Department to market in the counties of Blaine, Lemhi, Camas, Custer, Idaho, and Nez Perce. As a result, the Company is in violation of Idaho Code Sections 41-3910(b) and 41-3906(j). It is recommended that the Company file, with the Department, any counties in which it intends to market its plans.

Company Response

The Company has filed for all counties in Idaho and has been approved for all counties except Idaho and Clearwater.

Network Adequacy-Geographic Area

The Company provided a listing indicating that 342 members reside in the counties of Blaine and Lemhi. The Company did not file documentation with the Department that indicated the Company has quality health care services readily available and accessible to the members of these counties. This is a violation of Idaho Code Section 41-3905(4), which states, in part, that a Company “...must have the intent to render and capability for rendering good quality health care services, which will be and are readily available and accessible to members in each geographic area in which it proposes to operate or operates...” It is recommended that the Company make the necessary filing with the Department for all counties, in which it intends to market or has existing members, evidencing its ability to provide adequate health care services to the members located in those counties.

Company Response

As addressed above, the Company is now compliant. No further action is contemplated at this time.

Network Adequacy-Geographic Area

The Company indicated they were not marketing in Camas, Custer, Idaho, and Nez Perce counties. The existing 22 members in these counties were employed by employers with a home office located in another county in which the Company had filed to market in. It is recommended that the Company file these counties with the Department and provide appropriate medical provider information, as required by Idaho Code Section 41-3905(4).

Company Response

As addressed above, the Company is now compliant.

Provider/Member Location Reports

The Company did not provide the ratio of members to providers for each county. It is recommended that the Company develop and maintain a ratio of providers and specialists available to the number of members in each zip code or county in order to meet the requirements of Idaho Code Section 41-3905(4). It is also recommended that the Company maintain a record of any providers that are not accepting new patients.

Company Response

The Company did provide the examiner with an Excel file that contained the number of members by county. The Company was not asked for a file that showed the specific divisions cited by the examiner. We believed the information that we provided fully satisfied the examiner's request. The Company is not aware of any specific statutory provision that describes or defines coverage adequacy. Our working assumption is that, having filed and been approved for all but two counties in Idaho, the coverage levels currently provided by the Company in all approved counties are adequate.

Provider Contracts

It is recommended that any contracts to provide physician services and/or ancillary healthcare services to members of the Company's health care plans be provided by direct contracts between Primary Health Network Inc. (PHN) and the providers of health care services, such as PHN and Idaho Physicians Network, Inc., and between PHN and Business Psychology Associates. It is also recommended that the Company pay close attention to ensure that all contracts and amendments with providers of health care services are properly executed with appropriate signatures and timely dates and that copies of such contracts are filed with the rates and forms division of the Department of Insurance.

Company Response

It has been the practice of the Company to utilize the "master" agreement with Idaho Physicians Network (IPN) as the primary agreement for provider services to be provided to members insured through the Company. We believe that practice, while not perfect, provides the members insured through the Company with a larger network of providers through the state of Idaho. Only to the extent that IPN is unable or unwilling to contract with a provider, whether physician, hospital or ancillary service provider, will the Company contract directly with a specific provider.

Provider Contracts

A copy of any contract between the Company and Primary Health Medical Group, Inc. (PHMG) was requested, since the Company's fully insured plan claims were being paid on PHMG check stock from a PHMG bank account as of March 1, 2001. The Company indicated there was no contract. PHMG was not an insurer nor was it licensed as third party administrator and this is a violation of Idaho Code Section 41-901. It is recommended that the Company execute an agreement with PHMG to provide for this service and that PHMG become a licensed third party administrator. Subsequently on November 15, 2002, the Company provided an Assignment and Assumption Agreement between PHI, PHMG, and the Company. The effective date was retroactive back to March 1, 2001. The agreement in general provided for PHI to transfer duties and responsibilities to PHMG as agreed upon, including the payment of all benefits for covered services. PHMG is not a licensed third party administrator.

Company Response

The agreement to administer the payment of claims for medical services is between the Company its parent, Primary Health, Inc. Primary Health, In. has separately contracted with Primary Health Medical group, Inc. to perform many of those administrative tasks on behalf of Primary Health, Inc. The Company does not contract with Primary Health Medical Group as a third party administrator, nor does it visualize Primary Health Medical Group as a third party administrator. The issue of which company's check stock is used to write a check is insignificant and does not determine which company ultimately shares or owns the financial liability. If the Department believes that either the parent company must 'write' the payment checks directly on its own check stock or separately license Primary Health Medical Group, Inc. as a third party administrator, the Company will require one of those changes to be made in its future contract discussions.

Provider Contracts

Subsequently on November 15, 2002, the Company provided an Assignment and Assumption Agreement between PHI, PHMG, and the Company. The effective date was retroactive back to March 1, 2001. The agreement in general provided for PHI to transfer duties and responsibilities to PHMG as agreed upon, including the payment of all benefits for covered services. This agreement was not filed with the Department; therefore, is a violation of Idaho Code Section 41-3807(2). It is recommended that the Company file and obtain approval of the Director pursuant to Idaho Code Section 41-3807(2).

Company Response

The cited agreement was formally put into place at the specific request of the examiner to satisfy the need to formalize the inter-company agreement. The Company perceived the need to satisfy the request of the examiner for "formal" documentation and thus, inadvertently, did not file the agreement 30 days in advance of the effective date. The Company will more closely monitor filing requirements with the Department as part of its contract administration efforts discussed previously in this response and will file all agreements with the Department thirty (30) days in advance of their effective date.

Provider Contracts

The review of claim disbursements indicated that Primary Health Medical Group, Inc.'s name was the only name on the checks and the bank account from which the Company's fully insured claims were

being paid. This is deceptive and misleading and thereby a violation of Idaho Code Section 41-1304. It is recommended that the Company establish accounts and procedures to provide that its claim disbursements for fully insured plans are paid from a Company bank account and on Company check stock.

Company Response

The issue of which company's check stock should be used for the claims was addressed in Provider Contracts, above. We do not believe the practice has been deceptive or misleading, nor are we aware of a single complaint to the Department about this practice.

Intermediary Contracts

The amendments were also between Express Scripts, Inc. and Primary Health, Inc., which identified itself as a health maintenance organization (HMO). It is recommended that a new contract be executed between Primary Health Network, Inc. (the Company) and Express Scripts. It is also recommended that any references to health maintenance organization or HMO be removed from the contract in accordance with Idaho Code Section 41-3917.

Company Response

A new contract has been executed between the Company and Express Scripts.

Annual Disclosures

Company management indicated that the Company did not provide financial statements to its membership. This is a violation of Idaho Code Section 41-3914(1)(a). It is recommended that the Company develop a plan for providing its membership with an annual financial report in accordance with Idaho Code Section 41-3914(1)(a).

Company Response

The Company is now in the process of developing a plan for providing annual financial disclosure to members. We had assumed that the annual statutory audit conducted by our outside auditors and provided to the Department satisfied this requirement. We are contemplating the inclusion of the financial statements (without footnotes) on our website and in an annual mailing to members at time of renewal.

Annual Disclosures

The language on the inside of the front page indicated the directory was compiled by Idaho Physicians Network, Inc. (IPN) and indicated that the directory is updated quarterly, but that the continued participation of any one provider or hospital cannot be guaranteed. It stated that frequent verification is necessary to confirm IPN's participation provider status and to call Primary Health customer service at the phone numbers provided. At the bottom of every page thereafter, there is a statement that Primary Health, Inc. will make every effort to ensure the information in this Participating Provider Directory is current and updated regularly. Primary Health, Inc. is not the licensed insurance company and should not be the one making such statements in the provider directory. It is recommended that this statement in the provider directory be amended to reflect Primary Health Network, Inc.

Company Response

The Company will revise the wording of the directories to ensure that the Company's name is the entity referenced as making every effort to ensure timely provider information.

Annual Disclosures

It did not appear that Idaho Code Section 41-3914(1)(e), regarding a description of how the qualifications of participating providers may be obtained, was included in the Members Handbook. The handbook did contain a whole page on Choosing a Provider; however, it did not include any specific description with regard to how and where the qualifications of participating providers could be obtained. Upon further review this information was available on the Company's website, but there was no mention in the handbook that such information was available on the website or specifically where the member can call to obtain that information if access to a website is not available. It is recommended that the Company include in the Members Handbook more specific information on how a member may obtain a description of the qualifications of participating providers.

Company Response

The Company will add to its future Member Handbook a description of the process a member may take to learn more about a provider's qualifications.

Open Enrollment

The failure of the Company to provide evidence supporting the open enrollment period is a violation of Idaho Code Section 41-3919(2). It is recommended that the Company develop a method of notifying and/or reminding the employers annually and monitoring that the open enrollment period has taken place.

Company Response

It has been the Company's understanding that the Employer offers a period of open enrollment to its employees to enroll in the insurance program contracted by the Employer. It is not clear to Company management how it can monitor or enforce enrollment period requirements on its Employer groups. The Company will modify its renewal "amendment" to provide a notice to the Employer that it is to provide a notice to all employees of the availability of group health insurance and further to require the Employer to attest that it has provided such notice to its employees.

Advisory Panels

A review of the website did not reveal a site where a member could provide feedback on the policy, operations, grievance procedures, etc. This is a violation of Idaho Code Section 41-3916. It is recommended that the Company establish an advisory panel, or alternative mechanism, in order to get member's input on matters of policy and operations and comment on the changes to the plan's grievance procedures.

Company Response

The Company is evaluating alternative methods to provide a feedback mechanism for members as the means to satisfy the advisory panel requirement.

Grievance System

Idaho Code Section 41-3918(a) also requires that a description of the grievance system procedures be filed with the Director on an annual basis. The Department had no record of receiving this information. The Company advised that it has filed a Member Handbook and Master Policy with the Director; however, those documents are not filed on an annual basis. They were filed as form filings and are not re-filed until the Company has actually made changes in the documents. It is recommended that the Company annually file a copy of the most current grievance procedures along with the summary grievance report.

Company Response

The Company includes its Grievance System description in its Member Handbook, which is filed with the Department. To accommodate the recommendation we will file the Grievance System description annually in separate filing with the Department.

Grievance System

In addition, Idaho Code Section 41-3918(2) states: "...Grievances involving other persons shall be referred to such persons with a copy to the Director." The Department had no record of having ever received any such information. The Company responded with a copy of the Primary Health, Inc. Incident Reporting document, a copy of the Primary Health Human Resources Policies and Procedures #HR520 Provider Review Process and a copy of the IPN Review Process; however, no copies of grievance letters involving other persons were provided. It is recommended that the Company establish a method in its grievance procedures to provide the Director with copies of any complaint letters to medical providers, or other persons, regarding the quality of care in accordance with Idaho Code Section 41-3918(2).

Company Response

The Company has no record of receiving a formal grievance about a provider or "other person" as described in the narrative of the examination. The consolidated entity Primary Health, Inc., of which the Company is a part, maintains an incident reporting system. When a complaint or concern is expressed about the service received from within some portion of the consolidated entity other than the Company, it is immediately directed to the appropriate area for follow-up. If, in the future, a complaint about an "other person" is made to the Company, we will forward it to the appropriate party and copy same to the Department.

Primary Health Website

Primary Health Plan was an assumed business name (dba) utilized by Primary Health Network, Inc. Representing the dba as being a licensed insurance company, prior to Department approval and amending its Certificate of Authority, is a violation of Idaho Code Section 41-1304, which states, in part, that no person shall make, publish, disseminate, circulate, or place before the public any assertion, representation or statement with respect to the business of insurance which is untrue, deceptive or misleading. It is recommended that any references on the website to a managed care insurance company, managed care company or group health insurance carrier, be limited to the name as it appears on the Idaho Certificate of Authority.

Company Response

The use of Primary Health Plan as an appropriate d/b/a has been previously addressed in this response. We will review the website as part of our on going enhancement process and purge any inappropriate references as to the nature of the Company.

Complaint Log and Complaints

The Company did not maintain a complaint log for complaints and inquiries received from the Department of Insurance; however, they did develop one for 2001, during the course of this exam, entitled Department of Insurance – Complaint Log – 2001. The log format contained the date the complaint was originally received, the member name and group number, the Department file number, the issue, and the date of the Company’s response to the Department. However, it did not contain the final disposition of the complaint or the time it took to process the complaint as required by Idaho Code Section 41-1330. It is recommended that the log be expanded to include the disposition and/or outcome of all complaints and the length of time it took to process the complaint from the date of first receipt by the Company, to the date of final response to the Department.

Company Response

The Company’s Complaint Log will be expanded to include the information described in the recommendation.

Grievance Register

It was noted that three HMO plan claims were denied for Magnetic Resonance Imaging (MRI’s) testing for lack of proper referral and/or pre-certification. Two of the physicians who failed to refer were listed in the Participating Provider Directory as Primary Care Providers and the third was a nurse practitioner also listed as a Primary Care Provider. This is a violation of IDAPA 18.01.26(015.03). As of September 1, 2001, the Company adopted a one time exception rule, which would allow a denial, based upon a lack of proper pre-certification or referral, to be reconsidered one time and education regarding such pre-treatment requirements would also be given at that time. However, in the case of the Company’s HMO plan, the burden for the lack of proper provider referrals or referrals for testing cannot be delegated to the patient, if the primary care provider failed to initiate the referrals according to IDAPA 18.01.26(015.03). It is recommended that the Company educate their primary care providers and their office staff in regards to matters of written and/or any other referral requirements.

Company Response

The Company will continue to expand its education efforts to all contract providers to avoid incidents where referrals were not appropriately obtained. It should be noted that the company’s contracts with Employers and its Member Handbooks clearly describe when referrals are required and the process the member needs to follow to be sure a referral is appropriate obtained, notwithstanding the Company’s one-time education protocol.

Grievance Register

Ten grievance files were selected for review; however, the Company was not able to provide five of the files. This is a violation of Idaho Code Section 41-3911(2). It is recommended that the grievance files that are logged in the grievance register be maintained so that they are readily available for review during the examination, and that such files are retained until the completion of the next examination.

Company Response

The Company is now in the process of developing stronger grievance file archiving and retrieval procedures.

Grievance Register

The files reviewed indicated that any adverse decision letters advised of the member's further right of appeal for requesting a Presidential Grievance review. Pursuant to the NAIC Market Conduct Examiner's Handbook, Chapter VIII, Section C, Standard 4, Number 7, it is recommended that, in cases of an adverse determination continuing through the Presidential Grievance review, a notice of the covered person's right to contact the Director of the Department be added to the Presidential Grievance review letter of final determination, which includes the Director's phone number and address.

Company Response

The Company will revise its letter to a member in the case of an adverse decision in a grievance hearing that the member has the right to a presidential grievance review.

Fraudulent Claims Procedures

The Company did not maintain a written fraud and/or suspected fraudulent claim procedure guideline. It is recommended that the Company develop a written fraud and/or suspected fraudulent claim procedure for notifying the Department, pursuant to Idaho Code Section 41-290.

Company Response

The Company is developing a written fraud and/or suspected fraud claim procedure, both for purposes of internal use and for purposes of notification to the Department.

Advertising File.

As the Company was unable to provide advertising records prior to May 2001, and were not able to locate the binder containing all filings made with the Department for the period May through November 2001, the Company is in violation of Idaho Code Section 41-3911(1)(2), with regard to records retention, and also IDAPA 18.01.24(024.01), which states in part: "...All such advertisements shall be maintained in said file for a period of either four years or until the filing of the next regular report on examination of the insurer, whichever is the longer period of time." It is recommended that the Company maintain adequate records and retain them in accordance with the Idaho Code and rules.

Company Response

The Company is developing policies and procedures to ensure appropriate archiving of all filings with the Department and has directed its Compliance Manager to develop those procedures..

Advertising File

The Company provided an advertising filings list and the supporting print media, direct mail, and radio ads, which began with a filing made on December 20, 2001. The Company indicated there were no television ads in 2001. It was noted that four of the ads, intended for use in 2002, included the statement "Primary Health Plan is an Idaho company." Primary Health Plan was an assumed business name (dba) for the Company. However, the Company's name, as reflected on its Idaho Certificate of Authority, is "Primary Health Network, Inc."; this is the company name licensed in Idaho to transact insurance, not Primary Health Plan. As noted earlier, under the review of the Company's website, the Primary Health Plan dba, although previously registered with the Idaho Secretary of State, expired on January 11, 2002 and was later reinstated on October 17, 2002. In conclusion, referring to the dba as an Idaho company, prior to Department approval and amendment of the Certificate of Authority, may be considered deceptive, misleading and a violation of Idaho Code Section 41-1304; which states in part:

...no person shall make, publish, disseminate, circulate, or place before the public...any assertion, representation or statement with respect to the business of insurance...which is untrue, deceptive or misleading.

It is recommended that the Company use the name that is reflected on its Idaho Certificate of Authority in all advertising and sales materials.

Company Response

The d/b/a issue has been previously discussed in the Company's responses.

General Accounting

As noted in several instances through this report, the Company was unable to provide some of the requested documentation or records. The examiner in some cases had to revert to obtaining copies of some of the requested documentation from the Department. It is recommended that the Company maintain adequate records and documentation as required by Idaho Code Section 41-3909.

Company Response

The Company maintains thorough record keeping in its general account area. While the examination report noted several instances where documentation was not readily available upon request, the Company commented on those issues in the specific areas noted by the examiner. The Company will continue to monitor and improve, where necessary, its record keeping requirements.

Cash and Short term Investments

The asset consisted of \$888,363 in the Company's operating and money market accounts. The amount was \$526,078 less than that reported by the Company in its 2001 annual statement. This reduction was due to the fact that the certificate of deposit was in the name of Primary Health, Inc. instead of the Company. Also the certificate of deposit was used as collateral for the promissory note between Zions Bank and Primary Health, Inc. Therefore, the \$526,078, which represents the balance of the certificate of deposit, has been not admitted on the balance sheet of this report.

Company Response

The Company reported both to the Department and to the bank the error in the naming of the certificate of deposit as soon as it came to our attention. The examiner reported it as an immediate deficiency to the Department before inquiring of the Company. If the examiner had inquired of the Company, he would have found that the certificate of deposit in question resulted from the sale of other investment securities of the Company, and the Company had immediately upon the transition of securities and consistently throughout all subsequent reporting periods, recorded the certificate of deposit as an asset of the Company. The certificate of deposit was not used as collateral for a loan to the Company because there simply was never a loan from the bank holding the certificate of deposit to the Company or any related entity. What had occurred was an agreement between the Company and the bank stating that if short-term funds were needed the certificate of deposit could be used as collateral at that time. Inasmuch as the short term borrowing would have been expected to be made in the name of the Company, even though the certificate of deposit would then have been encumbered negating its use as an admitted asset, the net cash from the loan proceeds would have been an admitted asset. Thus, it is the strongly held belief of the Company that the \$526,078 was properly an admitted asset and no deficiency ever existed. The point became moot when the Department acknowledged the "correction " of the "deficiency'.

Cash and Short term Investments

In reviewing the Company's bank statements, it was noted that funds were being transferred electronically from the Company's operating account to Primary Health Medical Group's claims account and operating account. There were no contracts or agreements, which provide for such transfers between the Company and Primary Health Medical Group. The Company has an agreement with Primary Health, Inc. with regard to the capitation of benefits.

Company Response

We again acknowledge that there were no formal contracts or agreement, in this case, for the transfer of funds. We will develop an all-encompassing, inter-company service agreement as described previously in this response to document the services performed by one related entity to the other.

Federal Income Tax Recoverable

The Company's asset for Federal Income Taxes Recoverable in the amount of \$78,680, represented an over payment of premium taxes to the State of Idaho. A review of the Company's premium tax returns, indicated that the Company's was calculating its premium tax on collected premiums, instead of on gross direct premium written, as required by Idaho Code Section 41-402(b). The recalculation of the Company's 2001 annual statement indicated an increased tax liability by an immaterial amount and no change was made to the balance sheet of this report. It is recommended that the Company calculate and pay its premium taxes using gross direct premiums written, in accordance with Idaho Code Section 41-402(b). It is also recommended that, when determining the gross direct premiums written, the Company not reduce this amount by the Contra Premium Adjustment Allowance (Termination Reserve).

Company Response

While described under the category of Federal Income Tax Recoverable, the comment more appropriately refers to the method used by the Company to calculate premium taxes. The Company believes it is calculating premium tax consistently with Idaho 41-402 (b). The Company will review its premium tax calculation with its independent auditors and will make appropriate adjustments when needed.

Interest Maintenance Reserve & Asset Valuation Reserve

The Company's annual statement reflected the above asset and liability in the same amount. It appeared the Company calculated the Asset Valuation Reserve and then made an offsetting entry in the same amount for the Interest Maintenance Reserve. According to the Company's calculation in its annual statement, the Interest Maintenance Reserve should have been zero. The examination calculations for the Asset Valuation Reserve resulted in a zero amount. No changes were made to the balance sheet of this report, as the items offset each other, with the surplus result being zero. It is recommended that the Company calculate the Asset Valuation Reserve and the Interest Maintenance Reserve in accordance with the NAIC annual statement instructions.

Company Response

The Company will review the NAIC method of calculating both accounts in its statutory filings and make appropriate changes where needed.

Commissions to Agents Due and Accrued

As of December 31, 2001, the Company's liability for Commission to Agents was \$104,972, which was \$40,145 more than the amount reflected in the Company's 2001 annual statement. The Company calculations were made on an expense to revenue matching method using earned premiums, which resulted in the understatement of the liability in the amount of \$40,145. Commission accruals and payments should be based on the agent's monthly written premiums, which more accurately reflects the liability as of the examination date. The liability has been increased as of December 31, 2001 and the change reflected on the balance sheet of this report. It is recommended that the Company use the agent's written premiums in its calculations to more accurately determine the commission liability amount.

Company Response

The Company pays its producers commissions on premiums collected. As there is a continually changing difference between premiums written and collected, there will continue to be an adjustment process at year-end or at any interim period. The Company will review its method of accounting for commissions due to producers and make changes where appropriate.

Payable to Parent, Subsidiaries, and Affiliates

It was also noted that the balance in the accounts was an ongoing balance, the Company did not made any settlements during the year. It is recommended that the balance in accounts between the Company and its parent or affiliates be settled periodically.

Company Response

The Company will "settle" inter-company accounts with its parent and affiliates periodically.

Payable to Parent, Subsidiaries, and Affiliates

The activity review indicated that funds were transferred between the Company, Primary Health, Inc. and Primary Health Medical Group, Inc. Transactions with PHI, the Company's parent, and PHMG, a Company affiliate, must be provided for pursuant to an agreement between the parties. As both are within the Primary Health Group, the agreements need to be filed and approved as required by Idaho Code Section 41-3807. It is recommended that the Company execute agreements, which provide for these fund transfers, and that the agreements are filed in accordance with Idaho Code Section 41-3807.

Company Response

As described previously in these response (Cost Allocation Agreement), the Company will develop a comprehensive, inter-company service agreement to clarify the role of one company within the related group of companies as services are provided to another. This document will be filed with the Department in accordance with Idaho requirements.

Company's Response (Summary)

The conclusion of the examination that the Company did not meet the minimum capital and surplus requirements pursuant to Idaho Code Section 41-313 is incorrect. We believe the substance behind to Idaho Code Section 41-313 is incorrect. We believe the substance behind the incorrect statement is the suggested disallowance of a certificate of deposit in the amount of \$526,078. The Company has inserted a lengthy response to the examination finding that the certificate of deposit should not be admitted as a Company asset. The Company believes the response addresses why the certificate of deposit was in fact a legal and valid Company asset. The response also describes that the certificate of deposit has always been accounted for and continues to be accounted for by the Company and its affiliates as an asset of Primary Health Network, Inc. When the \$526,078 is correctly returned to the equity balance as of December 31, 2001, the Company is well over the minimum capital and surplus requirements pursuant to Idaho Code Section 41-313. While we concur that the subsequent acknowledgement by the Department that the Company's current compliance with capital requirements of Idaho Code Section 41-313 renders the issue moot, we believe strongly that the portrayal of the Company as noncompliant through the narrative of the examination is not valid.

HISTORY AND DESCRIPTION

The Company was incorporated under the laws of the State of Idaho on April 20, 1993, under the name Primary Health, Inc. The Company's name was changed to Primary Health Network, Inc. on November 26, 1993; it commenced business on October 1, 1996.

As stated in the Amended and Restated Article of Incorporation approved by the Director of Insurance on March 2, 1999, the purpose of the Company, formed as a managed care organization, was to offer managed care plans, including managed care plans for which a certificate of authority is required, all as defined in Title 41, Chapter 39, Idaho Code.

The Company's Certificate of Authority No. 2792 was issued effective August 22, 1995, authorizing the Company as a Health Maintenance Organization. The Company's certificate of authority was reissued on May 7, 1998, to comply with the Idaho legislative enactment of the Managed Care Reform

Act, Chapter 39 of the Idaho Code. The current certificate authorizes the Company to transact the business of Disability, including Managed Care, in the State of Idaho.

The Company is 100% owned by Primary Health, Inc. (PHI). Primary Health, Inc. owns 60% of Idaho Physicians Network, and also owns 100% of Riverside Benefit Administrators, a third party administrator.

CAPITAL STOCK AND PAID-IN SURPLUS

On March 2, 1999, the Director of the Department of Insurance approved amendments to the Company’s Articles of Incorporation, which provided for the Company’s capital common stock to change from 1,000,000 authorized shares, with no par value, of which 100 shares were issued and outstanding, to 5,000,000 authorized shares, with a \$1 par value, of which 1,000,006 shares were issued and outstanding. Idaho Code Section 41-2804 provides for the par value of the Company’s capital stock to be at least \$1.

A review of the Company’s annual statements for the years 2002, 2003, 2004, and 2005, reflected common capital stock of \$1,000,000 for Year 2002 and \$1,000,006 for each year 2003 through 2005.

During a review of the 2004 retirement of a surplus note, due to the Parent Company (PHI), it was observed that the Company incorrectly adjusted the Gross Paid-In Surplus account and the Unassigned Funds accounts. The incorrect accounting treatment resulted in misstatements to the aforementioned line items on the annual statements for years 2004 and 2005. There was no effect, however, on the total surplus.

The following adjustments need to be made to correctly reflect these accounts:

Gross Paid-In Surplus:	Annual Statement Balance	Examination Adjustment	Balance Per Examination
2002	11,722,094		11,722,094
2003	11,722,094		11,722,094
2004	11,922,094	(200,000)	11,722,094
2005	11,922,094	(200,000)	11,722,094

Unassigned Surplus:

2002	(10,461,861)		(10,461,861)
2003	(10,401,009)		(10,401,009)
2004	(10,314,002)	200,000	(10,114,002)
2005	(9,971,741)	200,000	(9,771,741)

It is recommended that the Company book the following reclassification in the general ledger, starting with their June 30, 2007 quarterly statement (filing due date of August 15, 2007), in order to correctly reflect the Gross Paid-In Surplus and Unassigned Surplus accounts in future financial statements:

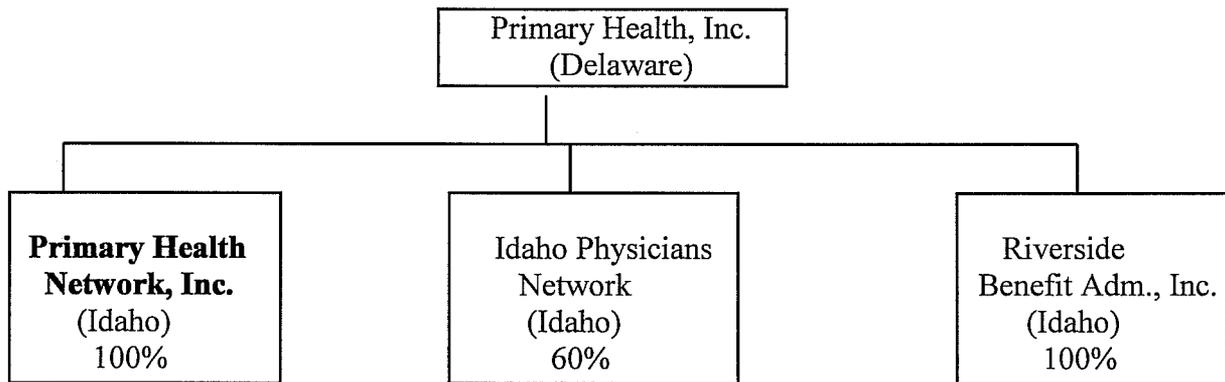
	Dr.	Cr.
Gross Paid-In Surplus.....	200,000	
Unassigned Surplus.....		200,000

SURPLUS DEBENTURES

As of December 31, 2001, the Company had one surplus note outstanding, which was issued on March 31, 2000, in the amount of \$200,000 and was approved by the Idaho Department of Insurance on July 10, 2000. The note was issued to Primary Health, Inc., the Company's parent. It accrued interest at the rate per annum. The note had a repayment schedule with \$66,666 due and payable on March 31, for the years 2001 and 2002, and \$66,668 due and payable on March 31, 2003. As noted earlier, the Company retired this note at year-end 2004.

MANAGEMENT AND CONTROL

The Company is a member of an insurance holding company system, as defined in Section 41-3801, Idaho Code. Primary Health, Inc. is the ultimate controlling person. The affiliates of the holding company system include the following:



The Company's Form B Holding Company Registration Statements for the period under examination were reviewed. The most recent filing was timely filed (for calendar Year 2005), which appears to be current and valid.

The management and control of the Company is guided by a Board of Directors consisting of five persons. Idaho Code states that in no event shall the number of directors be less than five nor more than fifteen.

According to the Company Bylaws, the Annual Meeting of the shareholders shall be held within five months after the close of the fiscal year of the Company. The regular meeting of the Board of Directors shall be the same day and at the same location as the Annual Meeting of the shareholders. Special Meetings of the Board may be called by the Board, the President of the Company or by holders of not less than twenty percent of all shares entitled to vote at the meeting.

Directors and Officers

The following persons were serving as directors and officers at December 31, 2005:

Directors:

<u>Name</u>	<u>Business Address</u>
Dennis V. Bruns	Boise, ID
Steve P. Clay**	Boise, ID
Elwood I. Kleaver	Boise, ID
Marnie Packard	Boise, ID
James S. Stroo*	Boise, ID

All of the above directors are also officers of Primary Health, Inc. (PHI), the Company's parent.

*James S. Stroo resigned and left the Company in January, 2006 and the director position was replaced by David Self.

**Steve P. Clay resigned and left the Company in November 2006 and the director position was replaced by Mark Ammons.

Officers:

Elwood I. Kleaver	President
Dennis V. Bruns	Secretary/Treasurer
Steve P. Clay***	Vice President

*** Steve P. Clay resigned and left the Company in November 2006 and the position of Vice President was replaced by David Self.

Section 4.1 of the Bylaws state that the officers of the Corporation shall be a President, a Vice President, a Treasurer and a Secretary, and may have other officers as the Board of Directors may prescribe. Any two or more offices may be held by the same person, except no person shall hold both the offices of President and Secretary.

Committees

The Bylaws authorize the Board of Directors, by resolution, to designate two or more of its members to constitute an executive committee and such other committees as they deem desirable. As of February 19, 2003, the minutes reflect that the Board of Directors dissolved all committees.

Conflict of Interest

In 2003, the Company adopted a revised conflict of interest policy and disclosure form. Each of the Directors completed a conflict of interest questionnaire. It appears that the revised policy and form provides adequate disclosure from the directors and officers with regard to any conflict of interest. However, there was no formal approval of the conflict of interest policy by the Board of Directors. It is recommended that the approval of the conflict of interest policy be recorded in the Board minutes.

Contracts and Agreements

As of December 31, 2005, the Company was party to a number of agreements. The major agreements are summarized as follows:

(1) Amended and Restated Medical Provider Agreement

This agreement between the Company and its parent, Primary Health, Inc. (PHI), became effective on September 1, 2003. Under the terms of this agreement, PHI agrees to provide and arrange for all covered services required by the members. All healthcare services provided to members shall be consistent with generally accepted standards of practice. PHI shall provide covered services at medical office locations approved by the Company.

PHI shall have access to the Company's books and records. PHI shall pay all bills for covered services less applicable deductibles and co-pays. PHI shall maintain, at PHI's expense, general and professional liability coverage in a form and amount acceptable to the Company.

The Company shall establish a system of member identification and shall identify participating professionals and participating hospitals to members with whom the Company has executed an agreement either directly or through Idaho Physicians Network.

The Company will compensate PHI in a monthly amount determined by reference to the amount of the total premiums earned by the Company during the month (79%); changed to 80% effective January 1, 2005. Such payment shall be due and payable, in full, no later than 10 days following the month for which premium is earned.

This agreement shall commence upon the effective date and shall continue in effect until terminated. Either party may terminate this agreement upon breach by the other party, but only if (a) the non-breaching party first gives the other party 30 days written notice of the breach; and (b) the breaching party fails to cure the breach within such 30 day period. Either party may terminate this agreement without cause upon 60 days prior written notice to the other party.

(2) Management and Administrative Services Agreement

This agreement between the Company and PHI, became effective on September 1, 2003. Under the terms of this agreement, PHI agrees to provide management, strategic planning, budgeting, marketing, human resources, IT services, facility space, and other financial and executive management services. PHI agrees to provide the Company all such administrative services as are usual and customary to the management and operation of an Idaho domiciled health insurance company

The Company shall reimburse PHI for reasonable and properly documented expenses incurred by PHI in connection with performance under this agreement, including all compensation and benefits to the employees of PHI hereunder, including all federal, state, local and other withholdings and similar taxes and payments. PHI derives no profit from such reimbursement. All amounts due pursuant to this agreement shall be settled via inter-company accounts, which in turn shall be balanced and "zeroed out" in a manner consistent with general corporate practices but no less than one (1) time per year. All amounts due shall be paid or may be satisfied by way of offset against any obligation of the parties to each other.

The funds of the Company shall not be co-mingled with funds of PHI. PHI shall comply with all state, local and federal laws, regulations, and ordinances that apply to the operation and management of the Company's business.

Termination may be effected by written notice; 30 days prior notice is required by either party.

(3) Payor Agreement

This agreement between Idaho Physicians Network (IPN) and Primary Health Plan (PHP) (Primary Health Network, Inc. d/b/a Primary Health Plan) became effective on January 1, 2002. Under the terms of this agreement, IPN shall enter in to agreements with healthcare providers for the purpose of providing healthcare services to participants. Discounts provided by any healthcare provider shall be passed to PHP clients. IPN shall use its best efforts to maintain a network of sufficient number of healthcare providers. IPN shall preprocess all claims submitted by participating providers. IPN may provide to PHP a fee schedule which PHP will use to pay claims. IPN shall produce a periodic directory for the purpose of communicating the names of the network providers to participants. IPN shall maintain professional liability insurance and such other insurance as IPN deems appropriate to cover the responsibilities of IPN.

PHP shall notify IPN with a sixty (60) days advanced notice when circumstances force PHP to consider using another network. PHP shall produce and provide all necessary marketing materials on a timely basis in order to effectively promote the advantages to participants of using participating providers. PHP shall provide IPN the current and updated enrollment of Health Benefit Plans and information concerning benefits provided to participants. PHP shall forward all payment due to participating providers within thirty(30) days following receipt of an undisputed, properly completed claim. PHP shall maintain appropriate errors and omissions insurance and any other appropriate insurance covering its responsibilities. PHP shall cooperate with IPN to resolve problems with participating provider claims as quickly as possible. PHP shall pay IPN a fee of \$1.215 per member per month. It shall be paid to IPN monthly and is payable by the 15th of the month.

The term of this agreement is one year commencing on January 1, 2002 and shall automatically renew on a year-to-year basis. Either party has the option of not renewing or terminating this agreement with or without cause upon ninety (90) days written notice to the other party

(4) Consolidated Federal Income Tax Agreement

It was recommended in the last Report of Examination that the Company needed to have a consolidated federal tax agreement. In the Company's response to the exam report comment, the Company agreed to mention the consolidated tax return arrangement in the general services agreement. Based on the review of the administrative and services agreement (general services agreement), the examiner noted that the detail was not disclosed regarding the Company's share in the consolidated federal tax return filed by its parent. Specifically, language was absent regarding the timing and disposition of tax credits due to the Company, or conversely any additional tax liability accruing to the Company. It is recommended, again, that the Company enter into a detailed, written consolidated federal tax return agreement with its parent, Primary Health, Inc.; and that this agreement be filed with the Department (Form D filing).

Related Parties

During the review of the transactions between related parties it was discovered that:

1. The Company's parent (PHI) borrowed money from the Company without the Department of Insurance's approval in 2003 and 2004. This was in violation of Idaho Code Section 41-3807(2)(a)(i). The practice was stopped in early 2005 due to the improved financial condition of the Company and its parent.
2. The Company's accountant transferred funds between the Company and the parent without prior written authorization.
3. The Company's accountant transferred funds from the Company to its parent using his own discretion. The amounts ranged from about \$200,000 to \$800,000 each time, with such transfers occurring about four times a month. No monthly settlement, however, was noted on the intercompany account payable to the parent.
4. The Company's accountant failed to maintain a detailed audit trail (including supporting schedules) to keep track of the transactions with its parent, PHI. He solely relied on the G/L account 2490 to keep track of the account balance that included capitation fees and other expenses payable to PHI.

Accordingly, it is recommended that:

1. The Company obtain the proper approvals from the Department of Insurance for borrowed money as required by Idaho Code Section 41-3807(2)(a)(i) on future similar transactions,
2. That proper written authorization is obtained, and documented, within the Company prior to making funds transfers,
3. To make certain that the intercompany accounts are settled monthly,
4. That the Company maintain a detailed audit trail to track and categorize the transactions with its parent, PHI. This may take the form of the establishment of separate general ledger accounts for capitation fees and other expenses payable to PHI.

CORPORATE RECORDS

Articles of Incorporation and Bylaws

The Company amended its Articles of Incorporation to bring them into compliance with Idaho Code Section 41-2804, February 18, 1999. The Amended Articles of Incorporation were approved by the Idaho Department of Insurance on March 2, 1999. No other changes to the Articles of Incorporation were noted during the examination period.

Also approved in the February 18, 1999 Board of Directors' meeting was an amendment to the Company's bylaws. The amended bylaws were filed with the Department of Insurance. The Company also amended its bylaws on September 10, 2003. The Idaho Department of Insurance approved the amended bylaws on September 25, 2003. It appears that the Company has complied with its bylaws during the period under examination (2002-2005).

Minutes of Meetings

Section 3.5 of the Company's bylaws states that the annual meeting of the Board of Directors shall be held following the annual meeting of the shareholders, which is to be held within 5 months after the close of the fiscal year of the Company. The minutes of the Board of Directors' meetings held during the examination period were reviewed. Board meetings were well attended by the directors; however, in many occasions, the Company did not record the absence or the resignation of a director in the minutes. It is recommended that the Company record the absence or the resignation of a director in the minutes. There is no record in the board minutes that the last report of examination was presented to or reviewed by the board of directors. It is recommended that the presentation of the report of examination be recorded in the board minutes.

Investments were approved by the directors during the period under examination. All of the Company's directors are officers and employees of its parent, Primary Health, Inc.

The Company has adhered to its bylaws with regard to Section 2.1 (Annual Meeting of the Shareholders), Section 3.5 (Annual Meeting of the Board of Directors) and Section 3.6 (Regular meeting of the Board of Directors). No violations of the Idaho Code were noted.

FIDELITY BOND AND OTHER INSURANCE

Fidelity Bond

As of December 31, 2005, the Company is a principal named insured on a commercial crime (employee dishonesty) policy. The limit of coverage is \$100,000 with a deductible of \$1,000. The policy was issued by Travelers Casualty and Surety Company of America, Hartford, Connecticut, which was authorized to do business in the State of Idaho. The coverage did not satisfy the minimum fidelity coverage suggested in the NAIC Financial Condition Examiner's Handbook, which recommended a minimum of \$250,000. Subsequently, effective March 1, 2007, the coverage was increased to \$300,000 with a deductible of \$3,000.

Other Insurance Coverages

Other insurance coverage maintained by the Company included directors and officers liability, managed care errors and omissions, business owners policy (general liability, property, and business income), boiler and machinery (computer and telephone systems), an ultra catastrophe liability (umbrella), and workers compensation coverages.

All insurance coverages maintained were issued by companies licensed in the State of Idaho. The Company had no employees during the examination period. All of the employee services were provided by employees of Primary Health, Inc., the Company's parent.

The certification signed by management acknowledged that no losses had been suffered due to dishonest or fraudulent acts.

PENSION AND INSURANCE PLANS

The Company had no employees. All personnel serving the Company are employees of Primary Health, Inc. (PHI), which allocated the cost of the salary and benefits to the Company through a management agreement. The agreement was summarized in a previous section of the report under the caption "Contracts and Agreements."

PHI's Employee Handbook contained a description of the Company's employee benefits, leave policies, and general information. The key benefits or programs available to the employees, upon the first of the month following 60 days of continuous employment, are listed below:

Holidays and Paid Personal Time Off	Dental Insurance Coverage
Funeral Leave and Jury Duty	Employee Assistance Program (Psychological)
Family and Medical Leave	401(k) Retirement Savings Plan
Group Health Coverage	Pre-Tax Dependent Care and Health Care Expense Account
Vision Care	Pre-Tax Medical and Dental Premium Account
Group Life, Long Term Disability and Accident Death and Dismemberment Insurance	

TERRITORY AND PLAN OF OPERATION

The Company was a disability insurer authorized to offer managed care plans as defined in Title 41, Chapter 39, Idaho Code. The Company was licensed in the State of Idaho only, and operates under Certificate of Authority No. 2792.

Operations of the Company were conducted from its main administrative office located in Boise, Idaho. The Company offered a managed care plan (HMO), a preferred provider plan (PPO), a point of service plan (POS). Currently the HMO plan is offered in Ada, Canyon, Jerome and Twin Falls counties. The PPO and POS plans are marketed in 25 counties, which includes the previously named counties.

Producer Licensing

Sampling

The following samples were taken in accordance with the NAIC Financial Condition Examiners Handbook, 2006 version, page 3-8 with Intended Reliance on Internal Controls – Low, Level of Risk Identified as High, Allowable Error Rate 10% with 0 Deviations in a sample of 22.

Active Company Appointments

There were 274 entries on the Department of Insurance (DOI) active company appointment list as of December 31, 2005. This number is not reflective of the total active producer force, as the Company appoints many brokerage agencies and the agency producers are registered to operate under the one appointment that the agency has with the Company. The DOI list and the Company list of active producer/agencies were compared. There were 415 entries on the Company listing of active agents; therefore, there were approximately 141 agents on the Company list that did not appear on the DOI listing but were registered with the DOI to operate under their respective agency appointment.

The DOI and the Company listing of active agents were compared as to content. There were 16 discrepancies on the Company listing. At least nine of the discrepancies on the Company listing involved agents that were at one time registered to operate under an agency appointment with the Company, and then had left the agency or moved to another agency, etc. The discrepancies were subsequently reviewed and resolved satisfactorily. No material exceptions were noted, but a recommendation will follow.

Because the Company fundamentally appoints agencies, and the producers for that agency that are registered to operate under that one agency appointment, it is recommended that the Company contact all appointed agencies at least on an annual basis for an updated list of producers registered to operate under that agencies' existing appointment with the Company.

A sample of 22 active files was selected from the Company Producer Agency Appointments list by means of an Excel random number formula. Files were reviewed as to signed contracts and support documentation and current licensing. Current Errors and Omissions insurance is a condition of the contract, therefore these were also reviewed. There were four out of the 22 that contained recently expired E & O insurance and the Company was notified of these. No material exceptions were noted in this review.

Inactive/Company Terminated Appointments

The DOI list of Inactive Company Appointments was utilized to select a sample of 22 for a terminated file review. Normally the time period reviewed would be those terminations occurring in 2002 through 2005, however, there were very few terminations in 2005 and since the purpose of this review is to determine the Company current termination procedures, it was determined to include the significant number of terminations that occurred in 2006. Those terminations prior to 2002 and those in 2007 were deleted from the DOI/PHN listing.

The 22 inactive/terminated files were reviewed as to termination documentation and the reasons for termination. There were two files without termination documentation, however the reasons for termination were verified with the DOI and no material exceptions were noted.

Contract Review

The Primary Health Network, Inc. Producer Agreement is a 10-page document not identified by a form number. The Agreement consists of the basic contract, an Absolute Compensation Agreement, Addendum I Business Associate Agreement, dated effective April 14, 2003, and an additional Addendum to Business Associate Agreement, dated effective August 1, 2004. The contract contains, but is not limited to, the standard provisions such as appointments and terminations, compensation and producers responsibilities including audits, advertising, litigation and hold harmless language among others. The Company Agency Agreement is not identified by a form number. It is an eight page document containing much the same language as the Producer Agreement and the Addendum I Business Associate Agreement dated April 14, 2003 is attached. The Company has indicated that existing, as well as new, producers are required to sign a new contract if/when a newer version is issued. Both the appointed brokerage agencies and the producers registered to operate under that appointment are required to sign a contract.

Commissions Review

A sample of 22 was selected from a population field of 152 commission paid entries in December 2005. The sample was selected by means of an Excel random number formula. The Commission statements for December 2005 were reviewed and compared to the Company Commission Schedules in force during that time period. One commission rate deviated from the schedule but was satisfactorily explained. No exceptions were noted.

STATUTORY AND SPECIAL DEPOSITS

As of December 31, 2005, the Company had provided the following deposits in trust for the State of Idaho, through the office of the Director of the Department of Insurance, in order to comply with Section 41-316A and Section 41-3905(7), Idaho Code.

The following investments were verified as being held as a custody deposit with Farmers & Merchants Bank, Boise, Idaho for the protection of all policyholders and/or creditors. A written confirmation from Farmers & Merchants Bank and the Idaho Department of Insurance confirmed the holding of the following:

<u>Description</u>	<u>Par Value</u>	<u>Market Value</u>	<u>Statement Value</u>
Boise Univ. Ref. St., 5.05%, Due 4/1/2008	50,000	51,556	50,672
Boise Univ. Rev., 4.2%, Due 4/1/2021	150,000	148,637	155,528
Cassia & Twin Falls, 5.1%, Due 8/1/2009	25,000	25,264	25,393
Elmore Cnty. Sch. Dist., 4.75%, Due 7/31/2007	125,000	126,073	126,047
Fremont & Madison Cnty, 5.5%, Due 8/1/2013	10,000	11,128	10,665
Idaho Hsg & Fin Assn, 4.65%, Due 7/1/2012	5,000	4,994	5,199
Idaho Hsg & Fin Assn, 4.7%, Due 7/1/2011	95,000	98,847	94,980
Idaho Hsg & Fin Assn, 3.85%, Due 7/1/2011	55,000	55,000	55,354
Idaho Hsg & Fin Assn, 3.5%, Due 7/1/2009	30,000	29,912	30,094
Idaho Hsg & Fin Assn, 4.4%, Due 7/1/2014	50,000	50,958	50,389
Idaho Health Facs Auth, 4.95%, Due 7/1/2006	20,000	20,166	20,068
Idaho Health Facs Auth Rev, 5.0%, Due 12/1/2018	115,000	119,137	116,625
Idaho Bldg. Auth Rev, 4.375%, Due 9/1/2013	5,000	5,159	5,167
Idaho St Bldg. Auth Rev, 3.375%, Due 9/1/2011	170,000	167,578	168,825
Idaho St. Univ.Ref./Im, 5%, Due 4/1/2022	245,000	254,616	248,521
Totals	<u>\$1,150,000</u>	<u>\$1,169,025</u>	<u>\$1,163,527</u>

The deposit met the general requirements and provisions of Idaho Code Sections 41-316A, 41-803 and 41-804.

The Company did not complete Schedule E – Part 3 – Special Deposits of the annual statement as required by the NAIC Annual Statement Instructions. It is recommended that the Company complete this schedule in future annual statements. Subsequent to December 31, 2005, the Company did complete Schedule E – Part 3 – Special Deposits in the 2006 annual statement.

GROWTH OF THE COMPANY

The Company's Growth for the years indicated, as taken from its Annual Statements (or as adjusted by the examination report) is shown in the following schedule:

<u>Year</u>	<u>Net Admitted Assets</u>	<u>Liabilities</u>	<u>Surplus</u>	<u>Net Gain (Loss) From Operations</u>	<u>Premiums Written</u>
2001*	\$ 2,359,916	\$ 487,245	\$1,872,671	\$ 8,048	\$19,483,569
2002	\$ 3,315,600	\$ 855,539	\$2,460,061	\$ (31,339)	\$23,426,997
2003	\$ 3,179,908	\$ 658,817	\$2,521,091	\$ 86,377	\$23,406,638
2004	\$ 3,123,945	\$ 515,846	\$2,608,099	\$281,373	\$23,883,506
2005*	\$ 4,145,237	\$1,194,878	\$2,950,359	\$336,556	\$25,752,089

* As determined by Examination

LOSS EXPERIENCE

The ratio of benefits and underwriting expenses incurred to premiums earned, as reported in the Company's Annual Statements are scheduled below:

<u>Year</u>	<u>Premium Earned</u> <u>(1)</u>	<u>Policy benefits Incurred</u> <u>(2)</u>	<u>Expenses Incurred</u> <u>(3)</u>	<u>Total Benefits and Expenses</u> <u>(2)+(3)=(4)</u>	<u>Ratio to Earned Premium</u> <u>(4)/(1)=5</u>
2001	\$19,483,569	\$15,586,837	\$4,510,966	\$20,097,803	103.2%
2002	\$23,426,998	\$18,788,563	\$5,328,325	\$24,116,888	102.9%
2003	\$23,406,638	\$18,632,015	\$3,097,262	\$21,729,277	92.8%
2004	\$23,883,506	\$18,867,971	\$4,785,287	\$23,653,258	99.0%
2005	\$25,752,089	\$20,601,669	\$4,934,662	\$25,536,331	99.2%

REINSURANCE

As of December 31, 2005 the Company did not have any reinsurance coverage in effect.

INSURANCE PRODUCTS AND RELATED PRACTICES

Policy Forms

Plans and Coverages

The Company basically writes, but is not limited to, small group managed care policies. There is one Master Policy for which an appropriate schedule of benefits is added as an Addendum III to the Master Policy. There are four plans available, Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), Point of Service (PPO) and Health Savings Account (HSA) plans. Various deductible and coinsurance options are available and the policy provides for both in and out of network benefits with a lifetime benefit maximum of \$1,000,000.00. They also write one blanket disability policy for Northwest Nazarene University.

Risk Retention Limits

The Company does not have a reinsurance policy. Primary Health, Inc. (PHI), the parent company, does have an Excess Provider Policy that has a \$125,000 deductible per claim and a \$2,000,000.00 lifetime maximum, but this is not considered to be reinsurance.

Retention levels would be those amounts above deductibles, coinsurance and co-pays and any internal policy maximums.

The Company does cede to the Idaho Small Employer High Risk Program (SEHRP) and had approximately 98 enrolled applicants as of 12/31/05. Per excerpts from the Company's Underwriting Policies and Procedures, a program deductible of \$13,000 and a program coinsurance of 10% of the next \$87,000 were stipulated. However, these figures were not effective until 7/1/07. For 2005 Idaho Code, Section 41-4711 (9)(d)(i) stipulated a "\$5,000 deductible and 10% of the next \$50,000 of benefit payments.

Policy Form Filings

The Company provided listings of policy form filings for the time period of 2002 through 2005. The DOI provided a listing of the Company policy forms filed during the period of January 2001 through December 2005. The lists were compared and no exceptions were noted.

It is now a requirement by the DOI, due by February 15 of the succeeding year for each previous year, that a Company needs to submit a listing of the forms they had filed with the DOI in the prior year. The Company list is then compared with the DOI listing on file and any discrepancies are noted and the Company is so advised. In follow up with the DOI, it was determined that the list filed with the DOI in 2006, for the 2005 filings, was in accordance with DOI records and a "no discrepancy" letter was sent to the Company on 5/8/06. No exceptions were noted.

Annual Actuarial Rate Certification

The Company did provide copies of the mandatory annual Actuarial Rate Certification letters, for 2002 through 2005, in accordance with Idaho Code, Section 41-4706 (5)(b). Because the copies provided were unsigned and not on letterhead, this matter was reviewed with the DOI and it was determined that the Company had actually filed their actuarial rate certifications for the years 2002 through 2005. No exceptions were noted.

Annual Rates and Rate Manual Filings

It was noted, during the Policy Form Filings review, that the Company did "file certified" the Small Group Rates and Rate Manuals and amendments with the DOI during 2003, 2004 and 2005.

Underwriting

Sampling

All of the samples below, unless otherwise indicated, were selected by means of ACL utilizing the Financial Examiners Handbook – 2006, page 3-8, Intended Reliance on Internal Controls – Low, Level of Risk Identified as High, Allowable Error Rate 10% resulting in samples of 22.

Certificate of Group Health Plan Coverage

The Certificate of Group Health Plan Coverage was reviewed for group insurance plans. The Company does issue separate certificates for each participant and each beneficiary if the information is not identical. The language and format of the certificate does conform to HIPPA and I.D.A.P.A. Rule 18.01.69 and no exceptions were noted.

Open Enrollment

The Company provided copies of the Primary Health Network, Inc. Small Employer Group and Large Employer Addendum I Group Requirements. Addendum I provides the explanation and requirements and the dates of an “open enrollment period” for that group. This agreement must be executed by signatures of both Primary Health Network, Inc. and the group policyholder. An executed example of an existing small group was provided for review and no exceptions were noted.

The Women’s Health & Cancer Act

The Company has indicated the initial notice was sent to members in January 2003 and provided proof of a mass mailing. The Company Members Handbook for 2005, page 37 contains the information that is required to be provided to members on an annual basis. The handbook is given to new enrollees initially and subsequently a new Members Handbook is provided to all enrollees on an annual basis. This would satisfy the requirements of The Women's Health and Cancer Rights Act. No exceptions were noted.

Privacy Acts

The Company does have an Administrative & HR Policies & Procedures #704, 705, 706, 707 and 708 in place. The procedures indicate a date of February 18, 2003 and November 1, 2003 and were last revised on January 1, 2006. The procedures include, but are not limited to, definitions of the Privacy Rule, protected information, uses and disclosures of private information, member individual rights, the procedures for securing protected health information, compliance with and violations of the Company policies and penalties thereof.

The Company has indicated the initial Notice of Privacy Practices (NOPP) notice was sent to members in January 2003 and provided proof of a mass mailing. Subsequently, they fulfilled the annual requirement of providing the Notice of Privacy Practices (NOPP) to members by providing members with a Primary Health Plan Member Handbook at initial enrollment and by providing new handbooks on an annual basis thereafter. The Notice of Privacy Practices is included as the last two pages of the handbook and advises members of their basic and/or privacy rights and where to obtain additional information if needed. This would appear to satisfy the initial and annual notice requirements of the Gramm-Leach-Bliley (GLB) Act and IDAPA 18.01.48 and the Health Insurance Portability and Accountability Act (HIPAA). No exceptions were noted.

Intermediary Contracts

All contracts with Express Scripts, Inc., Davis Vision, Willamette Dental of Idaho, Inc. are now between the aforementioned companies and either Primary Health Network (PHN), Inc. and/or the dba Primary Health Plan and have been properly executed. The Behavioral Psychology Associates (BPA) provider of mental health care and substance abuse was last executed in 1997 and the contract was between Primary Health, Inc., the holding company, and BPA. Although PHN provided additional copies of interim amendments to the BPA contract there is no evidence that the contract was ever executed to be between PHN and BPA as was recommended in the previous exam. As a subsequent event, as of 1/1/07, there is a new contract in place to provide Employee Assistance Program (EAP) services. The parties to the contract are Primary Health, Inc. (PHI) and APS Healthcare Bethesda, Inc. of Silver Spring, MD. The Company advised, "It was done this way on purpose to provide services for both PHN and the third party administrator affiliate, Riverside Benefits Administrators, Inc." This does not preclude the fact that all contracts that provide health services to members need to be between the licensed insurance company and the provider of such services.

It is again recommended that all contracts to provide health care services to members of the Company be between the licensed insurance company, Primary Health Network, Inc., and/or dba Primary Health Plans, and the provider of such health care services.

New Business Written – 2005

A sample of 22 was selected by means of ACL from a population field of 159 new business small groups written in 2005. The files were provided in hard copy and consisted of the Employer application and employee enrollment forms along with other required enrollment documentation, census, supporting tax forms, etc.

For small group enrollment purposes, Rule IDAPA 18.01.69 (046)(.14) requires the inclusion of an employer completed census of eligible employees and dependents and support documents such as a W-2 Summary Wage and Tax Form or a certification of information by a Small Employer as to the current census information.

IDAPA 18.01.69 (046)(.05) also requires an employer to secure a signed waiver for each employee and/or dependents who decline an offer of coverage. The waiver needs to indicate the reasons for declination and needs to include a statement of special enrollment rights and warnings of the penalties imposed on late enrollees. Two different employee waiver forms were utilized during this time period, one was included on page three of the member application ISE-APP-12-2003 form and the other was a stand-alone waiver form WHCCA 12/03. Both forms contained the required language and no exceptions were noted in the format of the waiver.

Twenty one of the hard copy small group files were reviewed as to content to include employer enrollment forms, census and supporting tax forms or employer certification forms, employee applications and employee waivers of coverage forms, rating sheets and first billings. Age/gender rate brackets were reviewed for equality. The names of writing agents were also noted and proper appointments at time of sale were validated. The Company does use a "Checklist For Inputting a Sold Group." The date that the master policy and member handbooks were mailed/delivered is recorded on this checklist and the dates were verified by "Remarks" printouts from the Company system. All master policies and handbooks were delivered within 21 days of the policy effective date and this would be considered a reasonable time period. One hard copy file could not be produced by

the Company and although some information was produced for that group from other sources, the census information and any waivers were not available for review. Since there was some information available and because the other 21 files were exceptionally well detailed and documented, there is no reason to indicate that the missing file would not have contained the required information. No exceptions were noted.

Cancelled/Non-renewed policies

There were a total of 97 groups that were cancelled/non-renewed in 2005. The main purpose of this review is to identify if the Company is canceling/non-renewing policies in accordance with the policy language and/or at the request of the policyholder. Those groups terminated by the Company were either for non-payment of premium or for reasons in accordance with the policy language and/or the small groups no longer fulfilled the minimum Idaho Code requirements to qualify as a small group. All reasons for cancellation/non-renewal appear to be valid and no exceptions were noted.

Small Group Declined New Business - 2005

Two small groups were declined in 2005. Both were declined for valid reasons and no exceptions were noted.

Network Adequacy - Service Areas

The Company has indicated they have filed to service all counties in Idaho except Idaho and Clearwater counties. This was verified with the DOI and no exceptions were noted.

Provider Adequacy

The Company provided a Participating Provider Directory that is produced by Primary Health Plan/Primary Health Network, Inc. Participating Physicians, Ancillary Professionals, Ancillary entities, Facility-Based Groups and Participating Pharmacies are listed by name of pertinent Idaho city. They are also categorized by specialty, i.e. Family Practice, Internal Medicine, etc. The Directory also provides a coding to indicate if the particular physician has a practice that is closed to new patients and/or is board certified.

Guaranty Association

As of December 31, 2005, the Company was a member of the Idaho Life and Health Guaranty Association in accordance with Idaho Code Section 41-3931.

Treatment of Policyholders

Complaints

The Company does maintain a complaint record of complaints received from the Department of Insurance (DOI) in accordance with Idaho Code, Section 41-1330. The records for 2002 through 2005 were provided for review and are entitled Department of Insurance Complaint Log and specify the year. There were four complaints recorded in 2005, six in 2004, four in 2003 and eight in 2002. The number of complaints received matched what was received by the DOI and no exceptions were noted.

As to the format of the complaint log, the previous exam recommended that the disposition of the complaint and the length of time it took to process the complaint from the date of first receipt by the Company to the date of final response to the Department be added to the log. The disposition has been added but the response time has not.

It is again recommended that the Company add a column to the complaint log to include the total amount of time necessary to finalize the complaint in accordance with Idaho Code, Section 41-1330.

There were only four DOI complaints recorded in 2005, so a review of complaint files was waived. Since the Company basically writes managed care, more specific attention will be paid to Grievances and Appeals files.

Grievance System and Reports

The Company does have a Complaint and Grievance Procedure in place that appears in the Primary Health Network Inc. Master Policy and Contract and in the Primary Health Plan Member Handbook 1/06. There are three steps available in the procedure to file grievances and appeals and they are as follows:

1. The initial filing is received by customer service and a response to be provided in seven days.
2. If the member is not satisfied, the second step goes before the Administrative Grievance Committee, the member will receive notice of time and place for a Committee hearing within five working days of receipt by the Grievance Coordinator and member will be given the opportunity to attend. Member will receive a formal written decision of the Committee within fifteen days of the formal hearing but if grievance is not resolved a member will receive a progress report every thirty days until resolved.
3. If still not satisfied a member may make a final Appellate Review. Upon receipt of a request a final ruling will be made and member will receive a written decision within thirty days from member's request for an Appellate Review.

The Grievance System and Appeals process appears to meet the requirements of Idaho Code, Section 41-3918 (1). No exceptions were noted.

In the prior exam the last appeal in the process was a Presidential Grievance appeal that appears to have been replaced by the Appellate Review. There was a recommendation made that the last appeal final disposition letter to the member be amended to include the name, address and phone number of the Department of Insurance. The Appellate Review denial letters do contain the name of the Consumer Affairs Division of the Idaho Department of Insurance and the phone number. This is considered adequate and no exceptions were noted.

There were 149 Grievances filed in 2005. A sample of eleven Grievances was selected by means of an Excel random number formula and one Appellate review was selected that was the only Appellate denial in 2005. Files were provided and reviewed; response times appeared to be adequate based upon receipt of all pertinent information. However, there is still one issue outstanding for which a recommendation was made in the prior exam. This issue is in regards to referrals made by the Primary Care Physician (PCP) or lack thereof. The prior exam recommendation is as follows:

Grievance Register. It was noted that three HMO plan claims were denied for Magnetic Resonance Imaging (MRI's) testing for lack of proper referral and/or pre-certification. Two of the physicians who failed to refer were listed in the

Participating Provider Directory as Primary Care Providers and the third was a nurse practitioner also listed as a Primary Care Provider. This is a violation of IDAPA 18.01.26(015.03). As of September 1, 2001, the Company adopted a one time exception rule, which would allow a denial, based upon a lack of proper pre-certification or referral, to be reconsidered one time and education regarding such pre-treatment requirements would also be given at that time. However, in the case of the Company's HMO plan, the burden for the lack of proper provider referrals or referrals for testing cannot be delegated to the patient, if the primary care provider failed to initiate the referrals according to IDAPA 18.01.26(015.03). It is recommended that the Company educate their primary care providers and their office staff in regards to matters of written and/or any other referral requirements.

There was one HMO grievance noted in the current sample where the claim was originally denied because the Primary Care Physician (PCP) had not requested the referral with the Company. The member subsequently appealed the denial but in this case the member had already received the "One-Time Exception to Pre-Certification Requirements" on 12/10/03 along with what the Company refers to as the "education letter" regarding how the member is totally responsible for verifying that his/her physician has actually made the required pre-certification with the Company.

IDAPA 18.01.26(015.03) does indicate that the "Managed Care Organization (MCO) Provider or the MCO shall initiate the referrals and inform its providers of their responsibility to provide written referrals and any specific procedures that must be followed." (emphasis added) In the "Addendum III, Schedule of Benefits" that accompanies the Member Handbook, there are many references to the reduction of benefits and/or denial of benefits when the pre-certification requirements are not met. There are many references in the Member Handbook to refer to the "Addendum III, Schedule of Benefits. In the "One-Time Exception" letter and the attached "Pre-Certification Process for In-Network Benefits, but it appears very clear that the Company is holding the member totally responsible for making sure that the primary care physician has made the referral and/or pre-certification and notified the Company.

Idaho Code, Section 41-3915 (4) indicates as follows:

(4) No managed care organization shall contract with any provider under provisions which require a member to guarantee payment, other than the specified co-payments, deductibles and coinsurance to such provider in the event of nonpayment by the managed care organization for any services rendered under contract directly or indirectly between the member and the managed care organization.

In brief, the Participating Physician Agreement indicates, "Physician shall comply with all administrative requirements of Payor concerning the referral process and review of referrals. It further indicates, "Physician agrees to comply with all administrative requirements applicable to each Payor, including Precertification/Preauthorization procedures." It was noted that the Participating Ancillary Provider Agreement and the Participating Facility Agreement fundamentally contain the same language.

As a noteworthy fact in general, it was noted that the entire population field of grievances filed in 2005 was a total of 149. Five were HMO products of which one was denied and four were granted a one-time-exception for failure to pre-certify. There were 94 more Preferred Provider Plans (PPO) and Point of Service Plans (PSO) that received one-time-exceptions for failure to pre-certify. This is two thirds of the entire population of grievances filed in 2005 and indicates

a potential of 99 members and their families that will be denied benefits the next time a participating physician fails to pre-certify. With those numbers it appears very clear that contracting physicians have not been very well educated about the referral and pre-certification process and are not complying with the provisions of the contract and or the managed care organization.

It appears there is a violation of Idaho Code, Section 41-3915(4) and IDAPA 18.01.26 (015.03) in regards to the Company managed care plans in that the member cannot be held responsible, or have benefits reduced and/or denied by the managed care organization because the primary care physician failed to initiate an in-network referral and/or pre-certification. This violation may also extend to the PPO plans, where a preferred provider is involved, and the POS plans that require the selection of a Primary Care Physician (PCP), in regards to any such plans that are subject to Chapter 39, Idaho Code. A review of the Addendum III Schedule of Benefits for both PPO and POS plans indicates some of the same language as the referrals and pre-certifications required by the HMO Schedule of Benefits. Two-thirds of the total grievances filed in 2005 were in regards to lack of pre-certification and even though the majority were granted one-time-exceptions it does indicate a serious problem in the area of pre-certification.

In the case of any Company plans, that require the selection of a Primary Care Physician (PCP), the burden for the lack of proper filing of provider referrals or and/or pre-certification procedures cannot be delegated to the patient, if the primary care provider failed to initiate the referrals, and/or the managed care organization failed to receive those physician referrals and pre-certifications to other in-network providers according to IDAPA 18.01.26(015.03).

It is again recommended that the Company put more emphasis on educating their primary care providers and their office staff in regards to the importance of written and/or any other referral and/or pre-certification requirements of the group contracts. This would be not only in regards to the Company group contract language but also as per the participating physician contract where a failure to follow the specified requirements of the Payor might constitute a breach in contract.

Grievance Report Filings

In follow up with the Department of Insurance (DOI) the Company has been filing their annual grievance reports in accordance with Idaho Code, Section 41-3918 (1)(a)(b).

Quality of Care Filings

The Company indicated there were no Quality of Care grievances filed during the current exam time period through 2005, however, they did provide one that was filed in 2006 that was handled internally because of a "lack of procedure" in place. Idaho Code, Section 41-3918(2) states that, "Grievances involving other persons shall be referred to such persons with a copy to the Director." Although the Company indicated there were no Quality of Care complaints in the prior exam, a recommendation was made. The Company response to that recommendation was:

Company Response: The Company has no record of receiving a formal grievance about a provider or "other person" as described in the narrative of the examination. The consolidated entity Primary Health, Inc., of which the Company is a part, maintains an incident reporting system. When a complaint or concern is expressed about the service received from within some portion of the consolidated entity other than the Company, it is immediately directed to the appropriate area for

follow-up. If, in the future, a complaint about an "other person" is made to the Company, we will forward it to the appropriate party and copy same to the Department

As for the current exam, the Company advised they had no Quality of Care procedure in place. The Company advised there were no such complaints in 2005 but as a subsequent event the Company did provide one for 2006 that was handled internally because of a lack of procedure. The issue was concerning the lack of provision of a radiology report by a medical provider and a subsequent billing received for that service. It appears the billing to the member was withdrawn based upon the member's letter to the medical provider and no official grievance was ever filed with the Company. However, the Company did advise the member that because of the contract in place, the claim would be paid. One such complaint is not really an issue, however, there still needs to be a procedure in place as per Idaho Code, Section 41-3918(2).

It is recommended again that the Company develop a process in regards to quality of care complaints and add it to their own written grievance procedures. A copy of any such complaints is to be provided to the Director of the DOI. The fact that PHI may have an "incident reporting system" does not fulfill the obligation of the insurance company to fulfill the requirements of Idaho Code, Section 41-3918(2).

Advisory Panels

Idaho Code, Section 41-3916 requires that a Company establish an advisory panel or other reasonable alternative mechanism for receiving feedback from members on matters of policy and operation and/or at a minimum to review and comment upon any proposed changes to: "(a) the managed care plan's grievance procedures..." There was a recommendation made in the prior exam, however the Company has acknowledged they do not have an Advisory Panel nor do they have an alternative mechanism in place. There was a brief discussion with the Compliance Manager for the Company about some possible methods of fulfilling at least the minimum requirement with an annual mailing of proposed plan changes inviting feedback from members with a form to return to the Company.

It is again recommended that the Company needs to establish an Advisory Panel and/or an alternative mechanism for members to provide, at the minimum, feedback on any proposed changes to the plan grievance procedures. Any plan to utilize an alternative "reasonable mechanism" to fulfill the requirements of Idaho Code, Section 41-3916 should be submitted to the DOI for review.

Utilization Management Program

The Company does have Utilization Review Procedures. Copies of the Care Management Credentials of the Medical Director and the key Registered Nurse (RN) personnel were provided. Copies of the Care Management Policies & Procedures was also provided including, but not limited to, such areas as Medical Necessity and Denial of Benefits, Standards of Practice, Member Correspondence – Pre-certification/Authorization Letters and Utilization management along with copies of procedure flow charts and example denial letters. The Company does have a Utilization Management Program in place in accordance with Idaho Code, Section 41-3930.

Quality Assurance and Quality Improvement Program

The Company provided a copy of the "Idaho Physician's Network (IPN) Quality Assurance and Quality Improvement Program" and indicated it was developed by the former president of IPN. The "Program" calls for the appointment of a "Quality Assurance Committee," a "Chairperson of QA Committee" and "Quality Assurance Assigned staff." The plan calls for quarterly committee meetings.

However, the plan is not dated or signed, no committee members are named and there are no records of any such Quality Assurance committee meetings provided. Upon further review the Company indicated the Quality Improvement Program was proposed by the former president of IPN but never implemented. Since the Quality Assurance and Improvement programs are required essentially for Medicare Select programs, and this company currently does not write Medicare Select programs, it is not considered to be pertinent at this time.

Claims

Unless otherwise specified, all claims samples indicated below, were selected by means of ACL in accordance with the Financial Examiners Handbook – 2006, page 3-8. For this exam, samples in general of 22 were selected with Intended Reliance on Internal Controls – Low, Level of Risk Identified as Medium with 10% allowable error rate and 0 deviations.

Fraudulent Claims

The Company has indicated that there were no fraudulent claims reported or filed during the entire exam period of calendar years 2002-2005.

Fraudulent Claims Procedures

The Company did advise they do not have a fraud team or unit in place but did provide a detailed listing of fraud investigation steps by email, however there was a recommendation made in the prior exam about developing written procedures. Based upon the fact that the Company does not have a fraud team, unit and or designated personnel, they should have at a minimum a set of written fraud procedures available to claims and/or other company personnel.

It is again recommended that the Company develop a written fraud and/or suspected fraudulent claim procedures for purposes of internal use and for purposes of notification to the Department.

Claims Checks

Claims checks are on Primary Health, Inc. (PHI), the holding company, check stock and are drawn on a PHI bank account. This appears to be acceptable to the DOI. In the previous exam checks were on Primary Health Medical Group (PHMG) check stock and drawn on a PHMG bank account. A recommendation was made, but PHMG is now only a shell and therefore the recommendation was not pursued at this time.

Provider Claims Submission Procedures

The Company provided a claims flow procedures explanation. In brief, claims received by mail at the corporate office are handled by the claims analysts. They are subsequently sorted by type of claim form (UB92 or HCFA1500). The HCFA1500 claims are then forwarded to Future Vision Technologies, paper claims are converted to electronic claims which are then loaded by the Company IT Operations staff into the American International Systems, Inc. (AMISYS) claims system in preparation for processing.

Once a week the IT Operations staff runs a claims payable extract which correlates the Explanation of Benefits for Members (EOBs) and the Explanation of Payment for providers (EOPs). The information is then referred electronically to Advanced Business Fulfillment who then prints, matches the checks

with the EOPs, then mails the EOPs to the providers and EOBs to the members. There are also other sizeable check amount reviews and additional signatures required as part of the claims process.

General Handling – Paid Claims 2005

A sample of 22 was selected by means of ACL from a managed care population field of 50,749 claims paid in 2005. Claims were reviewed on the company AMISYS system. The claim number, member number and name, group number and name, effective date of group policy and member, date of service, the date the claim was received and paid, were reviewed along with the calculation figures. Timely processing of payment of claims was reviewed. No exceptions were noted.

For the Northwest Nazarene University (NNU) claims, a blanket disability policy, a sample of 11 was selected by means of ACL from a population field of 54 claims paid in 2005. Because of the size of the population field, the sample of 11 was selected with Intended Reliance on Internal Controls – low, Level of Risk Identified as Low and a 20% Allowable Error Rate and 0 Deviations. Claims were reviewed on the company AMISYS system. The claim number, member number and name, effective date of coverage, date of service, the date the claim was received and paid, were reviewed along with the calculation figures. Timeliness of payment was noted, but student health benefit policies are not subject to Chapter 56 in regards to timely payment of claims. No exceptions were noted.

Claims Denied in 2005

A sample of 22 was selected by means of ACL from a population field of 27,037 managed care claims denied in 2005. Claims were verified as to claim number, group and member identification numbers and effective dates, dates of service, receipt and denial. Six claims were denied as duplicate and were verified as to having been paid previously. Ten claims were not really denied but were applicable to deductible. All others were denied for acceptable reasons. No exceptions were noted.

For Northwest Nazarene University (NNU) there were only a total of 17 claims denied that constituted the entire 2005 population field, therefore, all denied claims were included in the review. Because of the extremely limited population field, there were only a total of five actual named members in the sample, each with several different claim numbers. Eleven claims were paid, five claims were duplicates and had been paid previously, the rest applied to deductible or co-pay or denied for other miscellaneous acceptable reasons. Timeliness of payment was noted but student health benefit policies are not subject to Chapter 56 in regards to timely payment of claims. No exceptions were noted.

Pre-existing Claims Review

A sample of 22 was selected by means of ACL from a total population field of 135 claims denied as pre-existing in 2005. Claims were again reviewed on the AMISYS system. The entire processing procedure was reviewed on the 22 claim including group and member effective dates, member hire dates, prior coverage, pre-existing time period dates, dates of service, received and processed dates and remarks section on the AMISYS system as they pertain to investigation of the claims and pertinent letters. No exceptions were noted.

Litigated Claims

The Company has indicated there were no litigated claims for Primary Health Network (PHN) during the entire exam period of calendar years 2002-2005.

Advertising

Primary Health Network, Inc. website

The Company web page, located at primaryhealth.com, was reviewed. It contains access to the Provider Directory and instructions on how to select a medical provider, complete with maps to locate providers. A Member Handbook that can also be downloaded, areas on benefit education, various forms for enrollment and prescription formulary information are also included, along with a customer service section with pertinent phone numbers for customer assistance, care management and new business sales. There is also a news and event area where Company press releases and Broker Venture Newsletter are published periodically.

Advertising File

The Company has indicated that they utilize advertising print media in direct mail, newspaper, billboards and in pieces provided to producers. Forms to be utilized in 2002 through 2005 were submitted to the Department of Insurance. Copies of the ads and copies of the Department of Insurance date stamped as filed certified letters were provided. Each ad was compared to the forms filed listing and the Department of Insurance date stamped letters and no exceptions were noted.

There was little to no information available as to where the above filed ads ultimately were published. The Company indicated that they do not maintain a file and/or copies and/or record of any such published newspaper or other media ads. IDAPA 18.01.24(024)(01) indicates in part:

Advertising File. Each insurer shall maintain at its home or principal office a complete file containing every printed, published or prepared advertisement...with notation attached to each such advertisement, which shall indicate manner and extent of distribution...

All such advertisements shall be maintained in said file for a period of either four years or until the filing of the next regular report on examination of the insurer, whichever is the longer period of time.

The Company failed to provide copies of advertisements in the prior exam and a recommendation was made at that time. The Company has not complied with that recommendation. It is again recommended that the Company develop a file and/or binder system to retain copies of all published media ads of any kind indicating the dates that the ads were published and the manner and extent of distribution. If any particular policy is addressed in any published ads, then the policy form number of that particular policy must be indicated in the ad. This would include any direct, newspaper, periodical, phone book, billboard and/or any other published media that is presented for public viewing.

The company has indicated that they do not have a written policy and/or procedure or guidelines with regard to advertising. IDAPA 18.01.24(024)(02) indicates that the Company must maintain "control over advertisement." Currently the company has indicated that "agents are allowed to use the Company name in their advertising materials, but we do not have a prior approval process." It is recommended that the Company develop written procedures and require prior approval of any such advertising utilizing the Company name before use in the agent "advertising materials."

Certificate of Compliance on Advertising

IDAPA 18.01.24(024)(02) requires that each insurer must file a Certificate of Compliance, executed by an authorized officer of the Company, stating that to the best of their knowledge all advertisements published by the insurer during the preceding year were in accordance with the insurance laws of Idaho. The Certificate is to be filed with the annual statement. The Department of Insurance did advise that the Company filed the annual Advertising Certificate of Compliance for 2005 but the Certificate of Compliance requirement has been discontinued starting this year.

ACCOUNTS AND RECORDS

General Accounting

The Company's accounting records were maintained on an accrual basis. Monthly accounting reports included general ledger, income and disbursement journals, and various supporting reports for deposits, disbursements, premium, losses and commissions.

The Company's computerized information system utilized two software packages, the Amisys Managed Care System (Amisys), and the MAS90 Accounting System (MAS90).

Amisys was originally installed in May of 1996 and currently there were no plans for any significant upgrades to the system. Amisys maintained all health plan data, including but not limited to membership, claim, and financial data. Amisys is not currently interfaced with the Company's accounting system. All transactions from the Amisys system must be inputted manually into the general ledger.

MAS90 operated on a HP LH PRO server and maintained all general ledger data on a GAAP basis. Premium and claim information were provided on a weekly basis to the MAS90 system. Company users access both the Amisys and MAS90 systems via a Novell network.

The Company stated that it had taken all reasonable and affordable steps to secure its information in preparation of a disaster through backups and off-site storage.

The Company's 2005 general ledger (G/L) and non-ledger amounts were reconciled to the Company's 2005 annual statement filed with the Idaho Department of Insurance. An accounting spreadsheet was prepared supporting the reconciliation with no exceptions.

During the review of the Company detail G/L, it was noted that the Company had purged the 2002 detail G/L; it is recommended that the Company maintain records from the date of the last examination. Subsequent to December 31, 2005, the Company discovered that the 2002 records could be retrieved from backup tapes, if necessary. However, the process would be hard since the technology for those backup tapes is now obsolete, making the reproduction difficult.

The Company only filled out column 3, general administrative expenses, on Part 3 – Analysis of Expenses, of the Underwriting and Investment Exhibit on the 2005 Annual Statement. According to the annual statement instructions for this page, costs for managed care activities must be allocated between claim adjustment expenses and general administrative expenses. The instructions state:

Costs for managed care activities must be allocated between claim adjustment expenses and general administrative expenses. Claims adjustment expenses should be allocated to either cost containment expenses or other claim adjustment expenses, in accordance with SSAP No. 85, Claim Adjustment Expenses, Amendments to SSAP No.55, Unpaid Claims, Losses and Loss Adjustment Expenses. Allocate claim adjustment expenses to (either in cost containment expenses, Column 1 or other claim adjustment expenses, Column 2.)

A reporting entity that pays any affiliated entity (including a managing general agent) for management, administration or service of all or part of its business or operations shall allocate these costs to the appropriate expense classification item (salaries, rent postage, ect.) as if these costs had been borne directly by the Company. Do not report management, administration, or similar fee as one-line expenses. The reporting entity may estimate these expense allocations based on a formula or other reasonable basis.

It is recommended that the Company comply with these annual statement instructions.

The Company and its parent, Primary Health Inc. (PHI) did not maintain work papers to calculate tax credit, tax liability and the loss carryover from prior years for each entity within the group and was therefore not in compliance of Statements of Statutory Accounting Principles (SSAP) No. 10, paragraph 12:

In the case of a reporting entity that files a consolidated income tax return with one or more affiliates, income tax transactions (including payment of tax contingencies to its parent) between the affiliated parties shall be recognized if:

1. Such transactions are economic transactions as defined in SSAP No. 25 – Accounting for Disclosures about Transactions with Affiliates and Other Related Parties;
2. Are pursuant to a written income tax allocation agreement; and
3. Income taxes incurred are accounted for in a manner consistent with the principles of FAS 109, as modified by this statement.

The Company did not have a detailed, written tax agreement with PHI. (See recommendation under Contracts and Agreements – (4) Consolidated Federal Income Tax Agreement of the examination report.)

This may also be in violation of Idaho Code Section 31-3807(d), which states:

The books, accounts, and records of each party shall be maintained as to disclose clearly and accurately the precise nature and details of the transaction, including such accounting information as is necessary to support the reasonableness of the charges or fees to the respective parties.

It is recommended that the Company and PHI establish and maintain work papers to determine the federal tax recoverable or payable for each entity within the group.

The review of the Notes to Financial Statements of the 2005 Annual Statement showed that the Company did not comply with the proper disclosures required by SSAP No. 10 – Income Taxes, paragraphs 22 and 23. These paragraphs state in part:

22. A reporting entity shall also disclose the following:
 - a. The amounts, origination dates and expiration dates of operating loss and tax credit carryforwards available for tax purposes; and
 - b. The amount of federal income taxes incurred in the current year and each preceding year, which are available for recoupment in the event of future net losses.

23. If a reporting entity's federal income tax return is consolidated with those of any other entity or entities, the following shall be disclosed:
 - a. A list of names of the entities with whom the reporting entity's federal income tax return is consolidated for the current year; and
 - b. The substance of the written agreement, approved by the reporting entity's Board of Directors, which sets forth the manner in which the total combined federal income tax for all entities is allocated to each entity which is party to the consolidation. (If no written agreement has been executed, give an explanation of why such an agreement has not been executed.) Additionally, the disclosure shall include the manner in which the entity has an enforceable right to recoup federal income taxes in the event of future net losses which may incur or to recoup its net losses carried forward as an offset to future net income subject to federal income taxes.

It is recommended that the Company comply with paragraphs 22 and 23 of SSAP No. 10 – Income Taxes in future annual statement.

Independent Accountants

Deloitte & Touche LLP, Boise, Idaho was the Company's independent auditor for the years 2002 to 2005, which coincides with the period covered by this examination. Deloitte & Touche LLP has been the independent auditor for the Company since 1997.

The independent auditor's report issued for the year ending December 31, 2005, indicated the accompanying statutory balance sheets and related statements presented fairly, in all material respects, the financial position of the Company on a statutory basis. In compliance with IDAPA 18.01.62, the independent auditors' report for the period under examination was filed with the Idaho Department of Insurance.

The independent auditor's 2005 audit report and supporting workpapers, which consisted mainly sampling workpapers were made available. Some reliance was placed on the independent auditor's workpapers during this examination. However, when excerpts from the auditor's report were used as support during this examination, such excerpts were denoted to indicate that utilization.

Actuarial Opinion

During 2000, the Company was permitted by the Idaho Department of Insurance to transfer the reserves for health claims and administrative costs to Primary Health, Inc. (PHI), the Company's parent, pursuant to the Medical Services Agreement. This agreement, which was effective July 1, 2000, provided for the transfer of all claim related reserves to PHI for a monthly consideration of 80% of total premiums earned by the Company.

Therefore, the Company's 2005 annual statement did not reflect any health claim reserve liability. A review of the Deloitte & Touche's audit report for PHI as of December 31, 2005, indicated that PHI had accounted for an estimated reserve of \$3,637,539 for pending and unreported claims.

A statement of actuarial certification regarding the loss reserves, actuarial liabilities, and related items reported by the Company in its 2005 annual statement was made by Steven P. Clay, ASA, MAAA, the chief actuary of Primary Health Inc.

The opinion further stated the amounts established for reserves for outstanding liability:

- are computed in accordance with those presently accepted actuarial standards which specifically relate to the opinion required here, as promulgated from time to time by the Actuarial Standards Board.
- are based on actuarial assumptions relevant to contract provisions and appropriate to the purpose for which the Statement was prepared;
- meets the requirements of the Insurance Law and regulation of the State of Idaho;
- make a good and sufficient provision for all unpaid claims of the company under the terms of its contracts and agreements;
- are computed on the basis of assumptions consistent with those used in computing the corresponding items in the annual statement of the preceding year-end; and
- include appropriate provision for all actuarial items which ought to be established.

The actuary certified to a total reserve amount of \$3,637,539 for incurred but reported claims for the period ending December 31, 2005, including reserve and administrative costs. The reserve was composed of the following:

Incurred but Unpaid Claims	\$3,503,783
Unpaid Claim Margin	54,678
Administrative Expense	<u>79,078</u>
Total Claims Reserve	<u>\$3,637,539</u>

See the Notes to Financial Statements later in this report regarding examination procedures related to this reserve.

Evaluation of Controls and Information Systems

A limited EDP exam was conducted for the Idaho Department of Insurance by IS Specialist, Jenny L Jeffers, CISA, AES (Certified Information Systems Auditor, Automated Examination Specialist) of Examination Resources, LLC at the Company's Boise office. Ms. Jeffers' review coincided with the examination period. The EDP examination was performed in accordance with the guidelines and procedures set forth in the Exhibit C, Evaluation of Controls in Information Systems Questionnaire (ISQ) from the NAIC's Financial Condition Examiners Handbook. Mr. Jeff Gross served as IS exam coordinator for the Company.

Scope

- Determine the major systems through which the data of Primary Health for the participating state plans flows.
- Review the NAIC IS Questionnaire responses from the company and follow up on any issues.
- Observe the physical and system controls in place at the Main Computer Facility – ISQ Section E
- Review the system security measures regarding access to all major systems –ISQ Sections I and L
- Review the Business Continuity and Disaster Recovery Plan-ISQ Section J
- Review Web access and e-Business – analyze controls regarding privacy – ISQ Section K

- Determine the reliability of the controls and thus the reliability of the data as put forth by the company.

Procedures

- Interviews with key personnel as determined to be needed from the ISQ review
- Review of documentation of controls – printed and provided electronically
- Testing of controls

Determine the major systems through which the data of the Primary Health flows

Primary Health major financially significant systems include:

Amisys 3000 – this system is being replaced in 2007 by Advanced Amisys, which will be running on an HP9000 rather than an HP3000. This upgrade will include changing the operating system as well as the Amisys system. Amisys is a major administrative healthcare system that is widely used in the industry. The system is parameter driven which allows for extensive flexibility in the setup process allowing a wide variety of plans and benefit packages to be administered with the basic package. This flexibility also allows for the setup to be done badly or incorrectly and for the results to be a problem that is not discovered for a period of time. The Primary Health Amisys setup has been in place for many years. The setup will be kept the same for the upgraded system. Although changes are made to the functionality of the system, there are no changes made to the core program. All changes are modifications and are peripheral to the core program. Additionally, Jeff Gross, Director of IT does not allow any programs developed by the company to modify the core database of the Amisys system.

MAS90 is the system used for GL and financial processing. This system is used in its native form and no changes are made to it. At this time, IT does not consider the MAS90 system under their control. This could cause issues during Disaster Recovery. The infrastructure is maintained by the IT Department but access to the system is not under the IT department and upgrades are performed by the vendor.

The following ISQ areas, reviewed by the examiner, were the subject of detailed recommendations and observations communicated to the Company in the form of a detailed management letter:

- ISQ Section A – Management Control
- ISQ Section B – Organizational Control
- ISQ Section C – Changes to Applications
- ISQ Section D – System and Program Development
- ISQ Section E – Operations
- ISQ Section F – Processing Controls
- ISQ Section G – Documentation
- ISQ Section H – Outside Services
- ISQ Section I – Logistical and Physical Services
- ISQ Section J – Contingency Planning
- ISQ Section L – Wide Area Network (WAN) and Internet Controls

Findings Regarding IS Controls and Data Integrity

Based on the overall results of the detailed review of the IS Controls at Primary Health, utilizing standards prescribed by the NAIC, the IS examiner found weaknesses in controls covering the exam period.

Therefore, it is recommended that the Company put into operation the IS examiner's detailed management letter recommendations. This shall include the preparation by the insurer of a comprehensive plan of implementation, consisting of a specific time-line for putting into place the corrections. This plan will be required to be filed with Idaho Department of Insurance on or before August 15, 2007.

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FINANCIAL STATEMENTS

The financial section of this report contains the following statements and exhibits:

Assets as of December 31, 2005

Liabilities, Capital and Surplus as of December 31, 2005

Reconciliation Of Examination Changes To The Balance Sheet

Statement of Revenue and Expenses, For the Year Ending December 31, 2005

Capital and Surplus Account, For the Year Ending December 31, 2005

Reconciliation Of Capital and Surplus, December 31, 2001, to December 31, 2005

ASSETS

As of December 31, 2005

	<u>Ledger Assets</u>	<u>Assets not Admitted</u>	<u>Examination Adjustments</u>	<u>Admitted Assets</u>
Bonds (see Note 1)	\$1,174,821	\$ 0	\$ 0	\$1,174,821
Stocks:				
Preferred stocks	0	0	0	0
Common stocks	0	0	0	0
Real estate:				
Properties occupied by the company	0	0	0	0
Properties held for sale	0	0	0	0
Cash and short-term invest. (see Note 2)	2,891,932	0	0	2,891,932
Interest income due and accrued	16,478	0	0	16,478
Uncollected premiums in course of Collection	34,512	0	0	34,512
Deferred premiums booked but deferred and not yet due	0	0	0	0
Amounts recoverable from reinsurers	0	0	0	0
Funds held by or dep. w/ reinsurance co.	0	0	0	0
Other amounts receivable – reinsurance	0	0	0	0
Current federal income tax recoverable	0	0	0	0
Net deferred tax asset	0	0	0	0
Guaranty funds receivable or on deposit	0	0	0	0
Electronic data processing equipment	19,713	0	0	19,713
Furniture and equipment	0	0	0	0
Receivable from parent	0	0	0	0
Other assets nonadmitted	0	0	0	0
Health care receivables	7,781	0	0	7,781
Other assets	<u>15,810</u>	<u>15,810</u>	<u>0</u>	<u>0</u>
 Total Assets	 <u>\$4,161,047</u>	 <u>\$15,810</u>	 <u>\$ 0</u>	 <u>\$4,145,237</u>

LIABILITIES, CAPITAL AND SURPLUS

As of December 31, 2005

	<u>Examination</u>	
	<u>Adjustments</u>	
Claims unpaid		\$ 0
Accrued medical incentive pool; and bonus amounts		0
Unpaid claims adjustment expenses		0
Aggregate health policy reserves		0
Aggregate life policy reserves		0
Property/casualty unearned premium reserves		0
Aggregate health claim reserves (see Note 3)		0
Premiums received in advance		473,496
General expenses due or accrued (see Note 4)		221,669
Current federal and foreign income tax payable		0
Net deferred tax liability		0
Ceded reinsurance premiums payable		0
Amounts withheld or retained for the account of others		0
Remittance and items not allocated		0
Borrowed money		0
Amounts due to parent, subs and affiliates (see Note 5)		499,713
Payable for securities		0
Funds held under reinsurance treaties		0
Liability for amounts held under uninsured A&H plans		0
Aggregate write-ins for other liabilities		<u>0</u>
Total Liabilities		<u>\$ 1,194,878</u>
Common capital stock		\$ 1,000,006
Gross paid in and contributed surplus	(200,000)	11,722,094
Surplus notes		0
Unassigned funds (surplus)	<u>200,000</u>	<u>\$ (9,771,741)</u>
Total Capital and Surplus	<u>0</u>	<u>\$ 2,950,359</u>
Total Liabilities, Surplus and Other Funds		<u>\$ 4,145,237</u>

RECONCILIATION OF EXAMINATION CHANGES
TO THE BALANCE SHEET

Total Capital and Surplus - Per Company			<u>\$2,950,359</u>
LIABILITIES, SURPLUS AND OTHER FUNDS	Per <u>Company</u>	Per <u>Exam</u>	Increase (Decrease) <u>In Surplus</u>
Gross paid in and contributed surplus	\$11,922,094	\$11,722,094	\$ (200,000)
Unassigned funds (surplus)	<u>(9,971,741)</u>	<u>(9,771,741)</u>	<u>\$ 200,000</u>
Totals	<u>\$ 1,950,353</u>	<u>\$ 1,950,353</u>	<u>\$ 0</u>
Net Increase (Decrease) in Surplus			<u>\$ 0</u>
Total Capital and Surplus - Per Examination			<u>\$2,950,359</u>

STATEMENT OF REVENUE AND EXPENSES

For the Year Ending December 31, 2005

	<u>Per</u> <u>Company</u>	<u>Exam</u> <u>Adjustment</u>	<u>Per</u> <u>Examination</u>
Net premium income	\$25,752,089	\$ 0	\$25,752,089
Change in unearned premium reserve	0	0	0
Fee-For-Service	0	0	0
Risk revenue	0	0	0
Aggregate write-in for other health revenue	0	0	0
Aggregate write-in for non-health revenues	<u>0</u>	<u>0</u>	<u>0</u>
Total Revenue	<u>\$25,752,089</u>	<u>0</u>	<u>\$25,752,089</u>
Hospital and Medical:			
Hospital/medical benefits	20,601,669	0	20,601,669
Other professional services	0	0	0
Outside Referrals	0	0	0
Emergency room and out-of-area	0	0	0
Prescription drugs	0	0	0
Aggregate write-in for other hosp/medical	0	0	0
Incentive pool, withhold adj-bonus amounts	<u>0</u>	<u>0</u>	<u>0</u>
Subtotal	20,601,669	0	20,601,669
Less:			
Net reinsurance recoveries	<u>0</u>	<u>0</u>	<u>0</u>
Total Hospital and medical	20,601,669	0	20,601,669
Non health claims (net)	0	0	0
Claims adjustment expenses	0	0	0
General administrative expense	4,934,662	0	4,934,662
Increase in reserves for life/A&H contracts	<u>0</u>	<u>0</u>	<u>0</u>
Total underwriting deductions	25,536,331	0	25,536,331
Net underwriting gain or (loss)	<u>215,758</u>	<u>0</u>	<u>215,758</u>
Net investment income	121,010	0	121,010
Net realized capital gains	<u>(212)</u>	<u>0</u>	<u>(212)</u>
Net Investment gains (losses)	120,798	0	120,798
Net gain or (loss) agts' or prem balances	0	0	0
Aggregate write-in other income or expense	0	0	0
Net income or (loss after capital gains and before all other federal income taxes	<u>336,556</u>	0	<u>336,556</u>
Federal income taxes incurred (see Note 6)	<u>0</u>	<u>0</u>	<u>0</u>
Net Income (Loss)	<u>\$336,556</u>	<u>\$0</u>	<u>\$336,556</u>

CAPITAL AND SURPLUS ACCOUNT

For the Year Ending December 31, 2005

	<u>Per Examination</u>
Capital and surplus, December 31, previous year	<u>\$2,608,099</u>
Net income	\$ 336,556
Change in valuation basis of aggregate policy and claim reserves	0
Change in net unrealized capital gains or (losses)	0
Change in net deferred income tax	0
Change in nonadmitted assets	5,706
Change in provision for reinsurance	0
Change in surplus notes	0
Capital changes:	
Paid in	0
Surplus adjustments:	
Paid in	0
Aggregate write-ins for gains and losses in surplus:	<u>0</u>
Net change in capital and surplus	<u>\$ 342,262</u>
Rounding	(2)
Capital and surplus, December 31, current year	<u>\$2,950,359</u>

RECONCILIATION OF CAPITAL AND SURPLUS

December 31, 2001 through December 31, 2005

	<u>2001</u>	<u>2002</u>	<u>2003</u>	<u>2004</u>	<u>2005</u>
Capital and Surplus, Beginning of Year	\$2,513,989	\$1,872,671	\$2,460,061	\$2,521,091	\$2,608,099
Net Income (Loss)	8,048	(31,339)	86,377	281,373	336,556
Net Unrealized Gains and Losses	0	0	0	0	0
Increase (Decrease) in Common Stock	0	0	6	0	0
Increase (Decrease) in Contrib. Capital	0	0	0	0	0
Increase (Decrease) in Surplus Notes	875,000	0	0	(200,000)	0
Change in Net Deferred Income Tax	0	0	0	0	0
Change in Nonadmitted Assets	(517,567)	617,779	(21,363)	5,635	5,706
Change in Asset Valuation Reserve	429	950	760	0	0
Cumm. Effect Change in Acct. Princ.	(132,228)	0	0	0	0
Aggregate Write-in for gains/(losses)	<u>0</u>	<u>0</u>	<u>(4,750)</u>	<u>0</u>	<u>0</u>
Net Change in Capital and Surplus	(641,318)	587,390	61,030	87,008	342,262
Rounding					(2)
Capital and Surplus, End Of Year	<u>\$1,872,671</u>	<u>\$2,460,061</u>	<u>\$2,521,091</u>	<u>\$2,608,099</u>	<u>\$2,950,359</u>

NOTES TO THE FINANCIAL STATEMENT

Note 1 Bonds

\$1,174,821

The review of Schedule D, Part 1 – Bonds showed that the Company reported all of its bonds with the designation of “1”. However several of these bonds were not recorded on the NAIC SVO data base with a designation of “1”. Further review revealed that these bonds should have been designated as “1FE”. The Company is also required to maintain the proper documentation to prove that the bonds qualify for the designation “1FE”. It is recommended that the Company comply with the proper designation as required by the NAIC in future annual statements and maintain the proper documentation to support the designation.

Note 2 Cash and Short-term Inversments

\$2,891,932

The Company has \$1,891,932 in its checking accounts and one CD for \$1,000,000. These amounts were properly reported on Schedule E, Part 1 of the 2005 Annual statement.

Note 3 Aggregate health policy reserves

\$0

Through the Amended and Restated Medical Provider Agreement between the Company and its parent, Primary Health Inc. (PHI), the Company agrees to pay 80% of its premium revenue to PHI and PHI agrees to assume all of the Company's claims liability that includes paying all of the Company's claims. As a result, the Company did not establish or report any unpaid claims liabilities at each year-end on its balance sheet. However, PHI did establish and report a reserve titled "Estimated liability for pending and unreported claims" in the amount of \$3,637,539 in its 2005 consolidated financial statements. This amount actually represents the unpaid claims liabilities of the Company. The examiner understands that the Company bears the ultimate responsibility for its claims, even though PHI is the one paying the Company's claims and reporting the unpaid claims liability on the consolidated financial report. The examiner tested the adequacy of reserve for pending and unreported claims reported by PHI at the consolidated financial statement level as of December 31, 2005. In addition, the examiner tested the accuracy of the claims data by means of a statistical sample through the use of ACL software. The Deloitte & Touche workpapers relating to this reserve were also reviewed to supplement the examination of this account.

Specifically, the examiner reviewed 2005 CPA workpapers relating to the Company's pending and unreported claims reserved reported on PHI's financial statements and the testing of underlying data. The CPA's projected reserve for the Company's pending and unreported claims at year-end 2005 was \$3,325,000, which was \$312,539 less (8.6%) than amount presented on PHI's consolidated financial statements; therefore, the estimated liability for pending and unreported claims reported in PHI's consolidated financial statements appears adequate. No problems were noted during the review of the CPA's testing of the Company's claims data as of December 31, 2005.

Additionally, related to the claims development, the examiner obtained statistical data of all the claims paid in 2006 from PHI's IT department. The claims paid in 2006 were sorted by service date and a subtotal for all the claims paid in 2006 with the service date in 2005 and prior years was created. This was compared to the subtotal amount reported by PHI for pending and unreported claims at its 2005 consolidated financial statements.

The subtotal for claims paid in 2006 with the service date in 2005 and prior years was \$2,631,531. This was \$1,006,008 less than the amount presented by PHI in its 2005 consolidated financial

statements (\$3,637,539). Therefore, based on the subsequent one-year claims development, the amount presented by PHI appears adequate.

The examiner also reconciled total claims paid in 2006 on the IT reports to PHI's worksheet and G/L. There is a difference of \$707,293 (4%) between the total on the IT reports (\$19,966,617) and PHI's worksheet/GL (\$20,673,910). Both the Company accountant and the IT personnel could not figure out the reason for the difference. It is recommended that PHI reconcile the statistical data (IT) to the G/L at least annually. This discrepancy, however, had no impact on the Company's financial statements as of December 31, 2005.

The underlying accuracy of the Company's 2006 individual paid claims data was also tested. The examiner obtained detail claims data of all of the claims paid in 2006 from Company's IT department. Using ACL, a random sample of 22 (the sample size was based on the risk criteria mentioned earlier in the exam report) was selected from this population. The examiner agreed the selected claims, including the claim number, member number, service date, received date, paid amount, paid date and check number to the claims data recorded in the Company's claim data base. The following attributes were verified from the paid claims database to cancelled checks: check number, paid date and amount paid. No discrepancies were noted during the review.

Finally, the PHI actuary's worksheet for the Company's loss development was reviewed. The annual loss ratio of the Company business was 72% and 73% for 2004 and 2005 respectively; the loss ratio for 2006 was projected to be 81%, which is slightly higher than the industry standard of 80%.

Note 4 General expenses due or accrued

\$221,669

The review of the premiums received revealed that the Company reduced the total premiums received as reported in Schedule T of the Annual Statement by \$1,102,683. The reduction consisted of the following:

Premiums from PHI Employees	<u>\$490,798</u>
Premiums from Davis Vision	186,096
Premiums from BPA (Mental Health)	<u>270,029</u>
Total taxable premiums	456,125
Premium from Willamette Dental (pass-through)	100,216
Premium from Jefferson Pilot (pass-through)	<u>55,544</u>
Total pass-through premium	155,760
TOTAL PREMIUM REDUCTION	<u>\$1,102,683</u>

The Company also reduced the general expenses by a similar figure. Thus, the net income would remain the same.

The Department concluded that it was incorrect for the Company to reduce the total Schedule T premium collections by the entire \$1,102,683 as shown above. The only offset that should have occurred was that of the total pass-through premium (see above) of \$155,760.

By reducing the total premium collected, the Company underreported the amount of premium taxes. Since the premium tax amount is less than the tolerable error established for this Company, no adjustment in the examination financial statement has been made. It is, however, recommended that the Company properly report all taxable premiums and pay the proper amount of premium tax in future annual statements. It is also recommended that the Company amend its 2005 and 2006 premium tax returns and pay the additional taxes due.

It is further recommended that premium income related to benefits provided by Davis Vision and BPA be reported under premiums on the annual statement.

The Company characterized the reduction in total collected premiums for PHI employees as constituting constructive contributions to a PHI self-funded health care plan. However, it is the Department's understanding that a separate, single-employer, employee benefit trust has not been set-up for this purpose; nor have any federal registration filings made with the U.S. Department of Labor. Therefore, it is recommended that the Company comply with the ERISA laws for a single-employer self-funded plan or, alternatively, treat the plan as fully insured and subject to premium tax.

Note 5 Amounts due to parent, subsidiaries and affiliates \$499,713

The Company has \$405,694 that it owes to its parent company for the Management and Administrative Services Agreement and \$80,000 for the Amended and Restated Medical Provider Agreement. The Company also owes \$14,019 to Idaho Physicians Network for the use of the network as per the Payor Agreement. These amounts all appear to be reasonable.

Note 6 Federal Income Taxes Incurred \$0

Although the Company reported a positive statutory net income in 2005, due to its participation in the filing of a consolidated tax return with PHI, there was no tax expense (or conversely a tax benefit) attributable to the Company (due to prior-year loss carry forwards).

SUMMARY, COMMENTS, AND RECOMMENDATIONS

Summary

The results of this examination disclosed that as of December 31, 2005, the Company had admitted assets of \$4,145,237 liabilities of \$1,194,878, and capital and surplus of \$2,950,539. This amount meets minimum capital requirements as determined by Idaho Code § 41-313.

Comments and Recommendations

Page Description

26 Capital Stock and Paid In Surplus - It is recommended that the Company book the following reclassification in the general ledger, starting with their June 30, 2007 quarterly statement (filing due date of August 15, 2007), in order to correctly reflect the Gross Paid-In Surplus and Unassigned Surplus accounts in future financial statements.

	Dr.	Cr.
Gross Paid-In Surplus.....	200,000	
Unassigned Surplus.....		200,000

28 Conflict of Interest - It is recommended that the approval of the conflict of interest policy be recorded in the Board minutes.

30 Consolidated Federal Income Tax Return – It is recommended, again, that the Company enter into a detailed, written consolidated federal tax return agreement with its parent, Primary Health, Inc.; and that this agreement be filed with the Department (Form D filing).

31 Related Parties - It is recommended that:

1. The Company obtain the proper approvals from the Department of Insurance for borrowed money as required by Idaho Code Section 41-3807(2)(a)(i) on future similar transactions,
2. That proper written authorization is obtained, and documented, within the Company prior to making funds transfers,
3. To make certain that the intercompany accounts are settled monthly,
4. That the Company maintain a detailed audit trail to track and categorize the transactions with its parent, PHI. This may take the form of the establishment of separate general ledger accounts for capitation fees and other expenses payable to PHI.

32 Minutes of Meetings - It is recommended that the Company record the absence or the resignation of a director in the minutes. There is no record in the board minutes that the last report of examination was presented to or reviewed by the board of directors. It is recommended that the presentation of the report of examination be recorded in the board minutes.

- 34 Active Agent Appointments - Because the Company fundamentally appoints agencies, and the producers for that agency that are registered to operate under that one agency appointment, it is recommended that the Company contact all appointed agencies at least on an annual basis for an updated list of producers registered to operate under that agencies existing appointment with the Company.
- 39 Intermediary Contracts - It is again recommended that all contracts to provide health care services to members of the Company be between the licensed insurance company, Primary Health Network, Inc., and/or dba Primary Health Plans, and the provider of such health care services.
- 41 Treatment of Policyholders – Complaints - It is again recommended that the Company add a column to the complaint log to include the total amount of time necessary to finalize the complaint in accordance with Idaho Code, Section 41-1330.
- 43 Treatment of Policyholders – Grievance System and Reports - It is again recommended that the Company put more emphasis on educating their primary care providers and their office staff in regards to the importance of written and/or any other referral and/or pre-certification requirements of the group contracts. This would be not only in regards to the Company group contract language but also as per the participating physician contract where a failure to follow the specified requirements of the Payor might constitute a breach in contract.
- 44 Treatment of Policyholders – Quality of Care Filings - It is recommended again that the Company develop a process in regards to quality of care complaints and add it to their own written grievance procedures. A copy of any such complaints is to be provided to the Director of the DOI. The fact that PHI may have an “incident reporting system” does not fulfill the obligation of the insurance company to fulfill the requirements of Idaho Code, Section 41-3918(2).
- 44 Treatment of Policyholders – Advisory Panels - It is again recommended that the Company needs to establish an Advisory Panel and/or an alternative mechanism for members to provide, at the minimum, feedback on any proposed changes to the plan grievance procedures. Any plan to utilize an alternative "reasonable mechanism" to fulfill the requirements of Idaho Code, Section 41-3916 should be submitted to the DOI for review
- 45 Treatment of Policyholders – Fraudulent Claims Procedures - It is again recommended that the Company develop a written fraud and/or suspected fraudulent claim procedures for purposes of internal use and for purposes of notification to the Department.
- 47 Advertising - It is again recommended that the Company develop a file and/or binder system to retain copies of all published medias ads of any kind indicating the dates that the ads were published and the manner and extent of distribution. If any particular policy is addressed in any published ads, then the policy form number of that particular policy must be indicated in the ad. This would include any direct, newspaper, periodical, phone book, billboard and/or any other published media that is presented for public viewing.

47 Advertising - It is recommended that the Company develop written procedures and require prior approval of any such advertising utilizing the Company name before use in the agent “advertising materials.”

49 Accounts and Records - The Company only filled out column 3, general administrative expenses, on Part 3 – Analysis of Expenses, of the Underwriting and Investment Exhibit on the 2005 Annual Statement. According to the annual statement instructions for this page, costs for managed care activities must be allocated between claim adjustment expenses and general administrative expenses. The instructions state:

Costs for managed care activities must be allocated between claim adjustment expenses and general administrative expenses. Claims adjustment expenses should be allocated to either cost containment expenses or other claim adjustment expenses, in accordance with SSAP No. 85, Claim Adjustment Expenses, Amendments to SSAP No.55, Unpaid Claims, Losses and Loss Adjustment Expenses. Allocate claim adjustment expenses to (either in cost containment expenses, Column 1 or other claim adjustment expenses, Column 2.)

A reporting entity that pays any affiliated entity (including a managing general agent) for management, administration or service of all or part of its business or operations shall allocate these costs to the appropriate expense classification item (salaries, rent postage, ect.) as if these costs had been borne directly by the Company. Do not report management, administration, or similar fee as one-line expenses. The reporting entity may estimate these expense allocations based on a formula or other reasonable basis.

It is recommended that the Company comply with these annual statement instructions.

49 Accounts and Records - It is recommended that the Company and PHI establish and maintain work papers to determine the federal tax recoverable or payable for each entity within the group.

50 Accounts and Records - It is recommended that the Company comply with paragraphs 22 and 23 of SSAP No. 10 – Income Taxes in future annual statement.

53 Evaluation of Controls and Information Systems - It is recommended that the Company put into operation the IS examiner's detailed management letter recommendations. This shall include the preparation by the insurer of a comprehensive plan of implementation, consisting of a specific time-line for putting into place the corrections. This plan will be required to be filed with Idaho Department of Insurance on or before August 15, 2007.

61 Bonds - It is recommended that the Company comply with the proper designation as required by the NAIC in future annual statements and maintain the proper documentation to support the designation.

62 Aggregate Health Policy Reserves - It is recommended that PHI reconciles the statistical (IT)

data to the G/L at least annually.

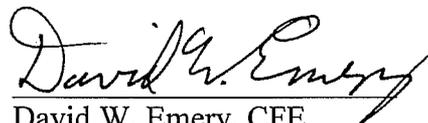
- 63 General expenses due or accrued - It is recommended that the Company properly report all taxable premiums and pay the proper amount of premium tax in future annual statements. It is also recommended that the Company amend its 2005 and 2006 premium tax returns and pay the additional taxes due.
- 63 General expenses due or accrued - It is further recommended that premium income related to benefits provided by Davis Vision and BPA be reported under premiums on the annual statement.
- 63 General expenses due or accrued - It is recommended that the Company comply with ERISA laws or, alternatively, treat the plan as fully insured and subject to premium tax.

CONCLUSION

The courteous assistance and cooperation extended by the officers and employees of the Company during the course of this examination is acknowledged and appreciated.

In addition to the undersigned, Claudia Schwartz, CIE, Senior Market Conduct Examiner, and Kelvin Ko, CFE, Senior Insurance Examiner, from the Idaho Department of Insurance; and Jenny Jeffers, CISA, AES (IT examiner) of Examination Resources, LLC, participated in the examination.

Respectfully submitted,

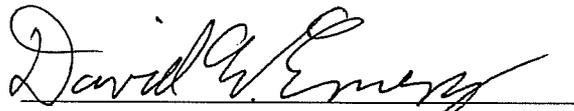


David W. Emery, CFE
Senior Insurance Examiner
Department of Insurance
State of Idaho

AFFIDAVIT OF EXAMINER

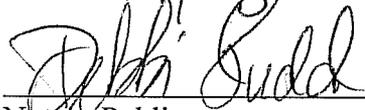
State of Idaho
County of Ada

David W. Emery, being duly sworn, deposes and says that he is a duly appointed Examiner for the Department of Insurance of the State of Idaho, that he has made an examination of the affairs and financial condition of Primary Health Network, Inc. for the period from January 1, 2002 through December 31, 2005, including subsequent events, that the information contained in the report consisting of the foregoing pages is true and correct to the best of his knowledge and belief, and that any conclusions and recommendations contained in the report are based on the facts disclosed in the examination.



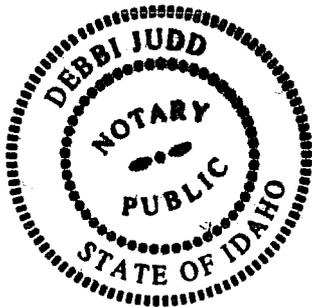
David W. Emery, CFE, FLMI
Examiner-in-Charge
Department of Insurance
State of Idaho

Subscribed and sworn to before me the 30th day of May, 2007 at Boise, Idaho



Notary Public

My commission Expires: 7/30/2010



State of Idaho
DEPARTMENT OF INSURANCE

C.L. "BUTCH" OTTER
Governor

700 West State Street, 3rd Floor
P.O. Box 83720
Boise, Idaho 83720-0043
Phone (208)334-4250
FAX # (208)334-4398

WILLIAM W. DEAL
Director

WAIVER

In the matter of the Report of Examination as of December 31, 2005, of:

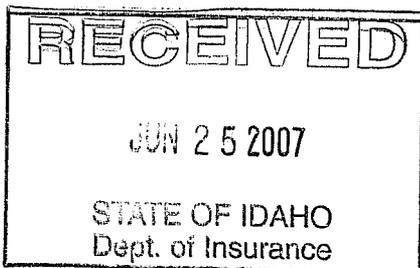
**Primary Health Network, Inc.
800 Park Blvd., Suite 760
Boise, Idaho 83720-0043**

By executing this Waiver, the Company hereby acknowledges receipt of the above-described examination report, verified as of the 30th day of May 2007, and by this Waiver hereby consents to the immediate entry of a final order by the Director of the Department of Insurance adopting said report without any modifications.

By executing this Waiver, the Company also hereby waives:

1. its right to examine the report for up to thirty (30) days as provided in Idaho Code section 41-227(4),
2. its right to make a written submission or rebuttal to the report prior to entry of a final order as provided in Idaho Code section 41-227(4) and (5),
3. any right to request a hearing under Idaho Code sections 41-227(5) and (6), 41-232(2)(b), or elsewhere in the Idaho Code, and
4. any right to seek reconsideration and appeal from the Director's order adopting the report as provided by section 41-227(6), Idaho Code, or elsewhere in the Idaho Code.

Dated this 25TH day of JUNE, 2007



PRIMARY HEALTH NETWORK, INC.

ELWOOD A KLEVER JR

Name (print)

Elwood A Klever Jr

Name (signature)

Chief Executive Officer

Title

EXHIBIT

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