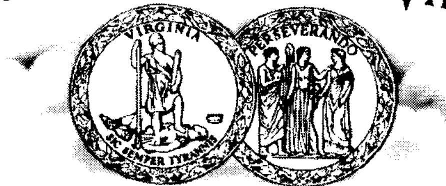
EXAMINATION REPORT
of
CARILION CLINIC MEDICARE RESOURCES, LLC
Roanoke, Virginia
as of
December 31, 2010

COMMONWEALTH OF VIRGINIA
STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

COMMONWEALTH OF VIRGINIA



JACQUELINE K. CUNNINGHAM
COMMISSIONER OF INSURANCE
STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

P.O. BOX 1157
RICHMOND, VIRGINIA 23218
TELEPHONE: (804) 371-9741
TDD/VOICE: (804) 371-9206
http://www.scc.virginia.gov/division/boi

I, Jacqueline K. Cunningham, Commissioner of Insurance of the Commonwealth of Virginia, do hereby certify that the annexed copy of the Examination Report of Carilion Clinic Medicare Resources, LLC as of December 31, 2010, is a true copy of the original report on file with this Bureau.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed to the original the seal of the Bureau at the City of Richmond, Virginia this 1st day of December, 2011

Jacqueline K. Cunningham
Commissioner of Insurance

(SEAL)

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Richmond, Virginia
August 11, 2011

Honorable Jacqueline K. Cunningham
Commissioner of Insurance
Richmond, Virginia

Dear Madam:

Pursuant to your instructions and by authority of Section 38.2-4315 of the Code of Virginia, an examination of the records and affairs of

CARILION CLINIC MEDICARE RESOURCES, LLC

Roanoke, Virginia

hereinafter referred to as the Company, has been completed. The report thereon is submitted for your consideration.

DESCRIPTION

The Company became licensed in Virginia on May 4, 2009 as a health maintenance organization ("HMO") pursuant to Chapter 43 of Title 38.2 of the Code of Virginia. This is the first examination of the Company by representatives of the State Corporation Commission's (the "Commission") Bureau of Insurance (the "Bureau"). This examination covers the period from the date of the Company's initial licensing through December 31, 2010.

HISTORY

The Company was issued a certificate of organization as a limited liability company in the Commonwealth of Virginia on November 14, 2008. At December 31, 2010, Carilion Services, Inc. ("CSI") is the sole member of the Company.

CAPITAL AND SURPLUS

At December 31, 2010, the Company's capital and surplus was $5,688,632. Capital and surplus was comprised of Gross paid in and contributed surplus of $90,000, Surplus notes of $23,000,000 and Unassigned funds of ($17,401,368). Gross paid in and contributed surplus and surplus notes were provided to the Company by CSI.

COMMONWEALTH OF VIRGINIA
STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

At December 31, 2010, CSI had issued the following subordinated surplus notes to the Company:

Issue Date	Surplus Note Principal	Amount Drawn	Date Drawn
February 18, 2009	$12,000,000	$10,090,000	April 29, 2009
		1,910,000	April 30, 2009
March 30, 2010	4,000,000	2,000,000	May 28, 2010
		2,000,000	June 10, 2010
August 10, 2010	7,000,000	3,000,000	November 23, 2010
		4,000,000	March 1, 2011

Interest on each surplus note is stated at six percent. At December 31, 2010, accrued interest on the surplus notes totaled $1,361,260.

NET WORTH REQUIREMENT

Section 38.2-4302 of the Code of Virginia states that an HMO licensed in Virginia shall maintain a minimum net worth in an amount at least equal to the sum of uncovered expenses, but not less than $600,000, up to a maximum of $4,000,000. 14 VAC 5-210-60 A requires that an HMO report the sum of its uncovered expenses for each three-month period ending December 31, March 31, June 30 or September 30. Because the sum of the Company's uncovered expenses for the three-month period ending December 31, 2010 was $5,983,909 the Company's minimum net worth requirement at December 31, 2010 was $4,000,000.

MANAGEMENT AND CONTROL

As of December 31, 2010, the restated operating agreement provides that CSI shall be the sole member. The restated operating agreement provides that the management, operation, and control of the Company and its business shall be vested in the Board of Directors (the "Board"). The number of directors on the Board shall be at least three but no more than nine and each director shall serve until such time as they resign or are removed by the sole member.

The Board may appoint from time to time one or more officers as they determine to be necessary or appropriate. Any such officers shall serve until their successors are duly appointed and qualified.

At December 31, 2010, the Board and Officers were as follows:

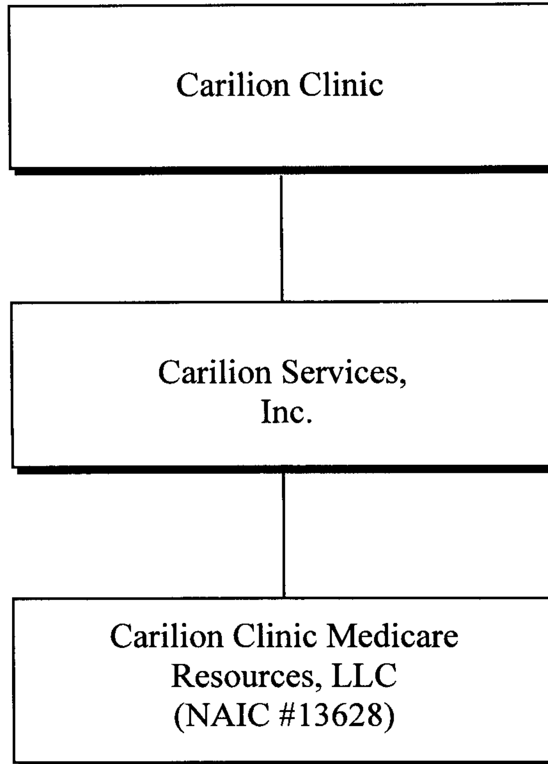
Directors	Principal Occupation
Nancy H. Agee	Executive Vice President Carilion Clinic Roanoke, Virginia
Donald E. Lorton	Chief Financial Officer Carilion Clinic Roanoke, Virginia
Edward G. Murphy, M.D.	President and Chief Executive Officer Carilion Clinic Roanoke, Virginia
Mark J. Werner, M.D.	Executive Vice President and Chief Medical Officer Carilion Clinic Roanoke, Virginia

Officers

Edward G. Murphy, M.D.	President
Donald E. Lorton	Treasurer
Briggs W. Andrews	Secretary
Nancy H. Agee	Executive Vice President

AFFILIATED COMPANIES

At December 31, 2010, CSI was the sole member of the Company and Carilion Clinic, a Virginia nonstock corporation, was the sole member of CSI. The chart on the following page illustrates the organizational structure of the Company and affiliated entities at December 31, 2010:


Carilion Clinic
Carilion Services,
Inc.
Carilion Clinic Medicare
Resources, LLC
(NAIC #13628)

TRANSACTIONS WITH AFFILIATES

Administrative Support Agreement

Effective February 25, 2009, the Company entered into an Administrative Support Agreement with CSI. According to the provisions of the agreement, CSI shall arrange, at the Company's request, administrative services to support the following functions:

Financial Services
Tax and Audit
Legal Services
Personnel
Public Relations
Information Technology Services
Medical Management Services
Disease Management Services
Credentialing Services

As compensation, the Company reimburses CSI its actual expense in performing such services in accordance with accepted cost allocation models. The Company incurred $299,769 and $90,284 in fees related to this agreement in 2010 and 2009, respectively.

Provider Agreements

The Company contracts with several subsidiaries of Carilion Clinic and CSI to provide hospital, physician and other medical services to its members.

MANAGEMENT AND SUPPORT SERVICES AGREEMENT

Effective July 1, 2009, the Company entered into a Management and Support Services Agreement with Beam Partners, LLC ("Beam"). According to the provisions of the agreement, Beam shall provide management and support services for the following functions:

Management Services

- Executive Director – Overall plan management and strategic guidance.
- Director of Administration – Executive Director support in overall plan management.
- Director of Marketing and Sales – Sales management and strategic guidance.
- Compliance Support – Guidance concerning applicable laws and regulatory agencies.
- Pharmacy Director – Pharmacy plan management and strategic guidance.

- Director of Business Processes and Operations – Coordinate internal operations.
- Director of Vendor Management - Vendor management including contract compliance.
- Director Network Management – Network management including strategic guidance, network adequacy and provider relation initiatives.
- Director Analytical Services – Support services and reporting relating to analysis of clinical and administrative expenses.
- Other functions, as agreed to by the Company and Beam.

Support Services

- Vendor Audits and health care cost analysis.
- Other functions, as agreed to by the Company and Beam.

As compensation, the Company pays Beam the greater of hourly fees for services provided by the Executive Director, Director of Administration, Director of Marketing and Sales, Pharmacy Director, Director of Business Processes and Operations, Director of Vendor Management, Director of Network Management and Director of Analytical Services or $20,000 per month. In addition, at the end of each quarter, the Company pays Beam a management fee equal to the greater of fifteen percent of the payments for management services paid or payable for the immediately preceding calendar quarter or $10,000. Further, at the end of the second and fourth calendar quarters, Beam shall be entitled to an incentive fee equal to fifteen percent of the management services paid or payable for the preceding semiannual period. The incentive fee is contingent upon the attainment of performance objectives agreed upon by the Company and Beam. The Company shall also reimburse Beam all travel and out of pocket expenses incurred in performing the above described management and support services. The Company paid $3,070,355, or a monthly average of $255,863, and $4,554,747, or a monthly average of $379,562, in fees related to this agreement in 2010 and 2009, respectively.

ADMINISTRATIVE SERVICES AGREEMENT

Effective March 18, 2009, the Company entered into an Administrative Services Agreement with TMG Health, Inc. ("TMG"). According to the provisions of the agreement, TMG shall provide administrative services to include all member enrollment services, member premium billing, claims processing and payment, member call center services and managed care information systems to support the preceding services. As compensation, the Company pays TMG a per-member per-month (PMPM) rate based on enrollment with the minimum number of billable members equaling 1,500 as outlined below:

Enrollment	PMPM Rate
0 – 1,500 Members	$20.40
1,501 – 2,500 Members	$13.00
2,501 – 5,000 Members	$9.75
5,001 – 10,000 Members	$8.50
Over 10,000 Members	$8.25

In addition, the Company pays certain transaction based service fees and information system access fees outlined in the agreement. The Company paid $632,066 and $158,992 in fees related to this agreement in 2010 and 2009, respectively.

TERRITORY AND PLAN OF OPERATION

At December 31, 2010, the Company's service area, as reported in its 2010 Annual Statement, included the cities of Bedford, Lexington, Radford, Roanoke and Salem and the counties of Bedford, Botetourt, Craig, Floyd, Franklin, Giles, Montgomery and Roanoke.

Medical services are provided by physicians in independent practice within the Company's service area. Each member chooses a primary care physician ("PCP") from a list of the Company's primary providers. The PCP is responsible for coordinating all of the member's health care needs. Except in emergencies, a member must obtain services only from, or prearranged by, their PCP. Specialty physicians are available only with a referral from a PCP. All hospital admissions must be arranged by the member's PCP and approved in advance by the Company. In addition, the Company offers a point of service option which allows a member to receive services from outside of the Company's participating network of providers.

At December 31, 2010, the Company offered the following three Medicare Advantage Plans to members all with a prescription drug benefit:

1. Carilion Clinic Medicare Health Plan (HMO). The plan has a $0 premium and members receive a set of predetermined and prepaid services provided by the Company's network of physicians and hospitals. Network primary care visits are $20.

2. Carilion Clinic Medicare Health Plan (HMO-POS) Low-Option. The plan has a $30 monthly premium and members can determine whether they want to receive certain designated services inside or outside the Company's provider network. Network primary care visits are $10 and the plan specifies which services are available outside of the provider network.

3. Carilion Clinic Medicare Health Plan (HMO-POS) High-Option. The plan has a $60 premium and members can determine whether they want to receive certain designated services inside or outside the Company's provider network. The plan provides additional coverage for inpatient hospital care, lower co-payments for primary care and specialist office visits as well as lower co-payments and additional coverage for certain ancillary services. Network primary care visits are $0 and the plan specifies which services are available outside of the provider network.

Medicare Advantage members account for 100% of the Company's enrollment at December 31, 2010.

CONFLICT OF INTEREST

The Company has adopted a conflict of interest policy. The objective of the policy is to ensure that directors, officers, employees and others acting on behalf of the Company avoid conflicts of interest or commitments that have the potential to significantly affect the Company's interests or compromise objectivity in carrying out Company responsibilities. To ensure compliance with the policy, the Company has established procedures which require directors, officers and any employee with a direct or indirect financial interest to sign a conflict of interest disclosure form annually.

FIDELITY BOND AND OTHER INSURANCE

At December 31, 2010, the Company was listed as a named insured on a commercial crime policy with a $5,000,000 limit of liability, subject to a $75,000 deductible, to insure against losses arising from dishonest acts of its officers and employees. Additionally, the Company was listed as a named insured on a commercial general liability policy, an umbrella liability policy, a commercial property insurance policy, a business automobile liability policy, a directors and officers liability policy, a managed care liability policy and a workers compensation and employers liability policy.

PROVIDER AGREEMENTS

Medical Services

The Company has entered into agreements with numerous PCPs and specialist physicians to render, provide or arrange for the provision of covered health care services to members. The Company compensates participating physicians in accordance with the current Medicare fee schedule attached to each individual agreement.

Hospital Care

The Company has entered into agreements with a number of Carilion Clinic affiliated hospitals in its service area to provide covered hospital services to its members. The Company compensates these hospitals in accordance with the current Medicare fee schedule attached to each individual agreement.

Other Health Care Services

The Company has entered into various ancillary service agreements. These agreements provide vision services, pharmacy services, laboratory services, transportation services, home health care, skilled nursing care and physical therapy. Compensation is based on arrangements set forth in each agreement.

BENEFITS

The general benefits available to the Company's Medicare Advantage members when provided by PCPs, specialist physicians and other professional providers and approved by the Company are as follows:

1. Physician Services
2. Preventive Care and Screening Tests
3. Hospital Services
4. Hospice Care
5. Vision and Hearing Services
6. Skilled Nursing Facility Services
7. Home Health Care Skilled Services
8. Orthopedic and Prosthetic Devices
9. Ambulance Services
10. Emergency Services
11. Mental Health Services
12. Durable Medical Equipment

Exclusions generally include any services considered not reasonable and necessary according to the standards of Original Medicare; experimental medical and surgical procedures, equipment and medications; private hospital rooms; private duty nurses; cosmetic surgery; routine dental care; eyeglasses and routine eye examinations; chiropractic care; and routine foot care. The above are general summaries of coverages and exclusions and are not intended to be all inclusive.

GROWTH OF THE COMPANY

The following data is representative of the growth of the Company for the two-year period ending December 31, 2010. The data is compiled from the Company's filed Annual Statements and the current examination report.

Year	Total Admitted Assets	Total Liabilities	Total Capital & Surplus
2009	$4,062,729	$6,865,601	($2,802,872)
2010	10,933,115	5,244,483	5,688,632

Year	Total Revenue	Net Investment Gains	Medical & Hospital Expenses	Administrative Expenses	Pre-Tax Income (Loss)
2009	$0	$7,902	$0	$6,460,500	($6,452,598)
2010	1,937,109	17,220	1,718,410	10,296,865	(10,060,946)

The Company's enrollment data at year-end is illustrated as follows:

Year	Number of Members
2009	0
2010	280

EXCESS LOSS INSURANCE

Effective January 1, 2010, the Company entered into an Excess HMO Reinsurance Agreement with Westport Insurance Corporation ("Westport"). For eligible hospital services, the deductible is $100,000 per member for each policy year. Once the deductible has been reached in a policy year, Westport will reimburse the Company 90% of all eligible hospital expenses. Eligible hospital expenses are limited to an average daily maximum of $5,000. The maximum excess insurance payable under this agreement for any one member shall not exceed $1,000,000 in a policy year and $2,000,000 lifetime. The agreement includes a continuation of coverage endorsement in the event of the Company's insolvency.

SPECIAL RESERVES AND DEPOSITS

At December 31, 2010, the Bureau required the Company to maintain a minimum deposit of $1,910,000 with the Treasurer of Virginia.

SCOPE

This is a full scope financial condition examination initiated and conducted under the provisions of Article 4, Chapter 13 of Title 38.2 of the Code of Virginia. The examination covers the period from the Company's initial licensure, May 4, 2009, through December 31, 2010. Assets were verified and liabilities established at December 31, 2010.

The examination was conducted in accordance with the NAIC Financial Condition Examiners Handbook. The Handbook requires that the Bureau plan and perform the examination to evaluate the financial condition and identify prospective risks of the Company, assess corporate governance, identify and assess inherent risks within the Company, and evaluate system controls and procedures used to mitigate those risks. An examination also includes assessing the principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation, management's compliance with Statutory Accounting Principles and annual statement instructions when applicable to domestic state regulations.

All accounts and activities of the Company were considered in accordance with the risk-focused examination process.

FINANCIAL STATEMENTS

There follows a statement of financial condition at December 31, 2010; a statement of revenue and expenses for the year ending December 31, 2010; a reconciliation of capital and surplus for the period under review; and a statement of cash flow for the year ending December 31, 2010. The financial statements are presented in accordance with Statutory Accounting Principles.

ASSETS

	Assets	Nonadmitted Assets	Net Admitted Assets
Cash and short-term investments	$6,859,787		$6,859,787
Subtotals, cash and invested assets	$6,859,787	$0	$6,859,787
Investment income due and accrued	99		99
Uncollected premiums and agents' balances in the course of collection	10,733		10,733
Amounts receivable relating to uninsured plans	13,451		13,451
Electronic data processing equipment and software	28,605		28,605
Furniture and equipment	165,748	165,748	0
Receivables from parent, subsidiaries, and affiliates	4,000,000		4,000,000
Health care and other amounts receivable	52,892	32,452	20,440
Aggregate write-ins for other than invested assets	161,585	161,585	0
Total assets	$11,292,900	$359,785	$10,933,115

LIABILITIES, CAPITAL AND SURPLUS

	Covered	Uncovered	Total
Claims unpaid	$330,943		$330,943
Unpaid claims adjustment expenses	68,742		68,742
Aggregate health policy reserves	4,154,029		4,154,029
Premiums received in advance	3,339		3,339
General expenses due or accrued		655,796	655,796
Amounts due to parent, subsidiaries and affiliates		23,124	23,124
Liability for amounts held under uninsured groups	6,845		6,845
Aggregate write-ins for other liabilities		1,665	1,665
Total liabilities	$4,563,898	$680,585	$5,244,483
Gross paid in and contributed surplus			$90,000
Surplus notes			23,000,000
Unassigned funds (surplus)			(17,401,368)
Total capital and surplus			$5,688,632
Total liabilities, capital and surplus			$10,933,115

STATEMENT OF REVENUE AND EXPENSES

	Uncovered	Total
Net premium income	XXX	$1,937,109
Total revenues	XXX	$1,937,109
Hospital and Medical		
Hospital/medical benefits		$1,118,197
Other professional services		82,254
Outside referrals	23,921	23,921
Emergency room and out-of-area	35,869	281,340
Prescription drugs		212,698
Total hospital and medical	$59,790	$1,718,410
Claims adjustment expenses	254,701	254,701
General administrative expenses	5,886,158	5,886,158
Increase in reserves for life and accident and health contracts	4,154,029	4,154,029
Total underwriting deductions	$10,354,678	$12,013,298
Net underwriting gain	XXX	($10,076,189)
Net investment income earned	XXX	$17,220
Net investment gains	XXX	$17,220
Net gain (loss) from agents' or premium balances charged off	XXX	($1,977)
Net income before federal income taxes	XXX	($10,060,946)
Federal income taxes incurred	XXX	0
Net loss	XXX	($10,060,946)

RECONCILIATION OF CAPITAL AND SURPLUS

	2009	2010
Capital and surplus prior reporting year	$0	($2,802,875)
GAINS AND LOSSES TO CAPITAL AND SURPLUS		
Net loss	($6,452,598)	($10,060,946)
Change in net unrealized capital gains and (losses)	14,278	(14,278)
Change in nonadmitted assets	(8,454,555)	8,094,769
Change in surplus notes	12,000,000	11,000,000
Capital changes:		
Paid in	90,000	
Aggregate write-ins for gains or (losses) in surplus		(528,038)
Net change in capital and surplus	($2,802,875)	$8,491,507
Capital and surplus end of reporting year	($2,802,875)	$5,688,632

CASH FLOW

Cash from Operations

Premiums collected net of reinsurance	$1,929,715
Net investment income	8,565
Total	$1,938,280
Benefit and loss related payments	$1,387,467
Commissions, expenses paid and aggregate write-ins for deductions	6,237,901
Total	$7,625,368
Net cash from operations	($5,687,088)

Cash from Financing and Miscellaneous Sources

Cash provided (applied):	
Surplus notes	$11,000,000
Other cash applied	(10,559,823)
Net cash from financing and miscellaneous sources	$440,177

RECONCILIATION OF CASH AND SHORT-TERM INVESTMENTS

Net change in cash and short-term investments	($5,246,911)
Cash and short-term investments:	
Beginning of the year	12,106,698
End of the year	$6,859,787

RECOMMENDATION FOR CORRECTIVE ACTION

Management and Control

1. The Company reported a loss of $10,060,946 in 2010. Contributing greatly to its loss in 2010 were general and administrative expenses of $6,140,859, representing an administrative cost ratio of 317%. The Company's general and administrative expenses are disproportionate when compared to premiums earned in 2010. In addition to its loss in 2010, the Company reported a pre-operational loss of $6,452,598 in 2009. Through December 31, 2010, the Company received $23,000,000 in capital contributions, in the form of subordinated surplus notes, to fund its initial capitalization and its losses in 2009 and 2010. At December 31, 2010, the Company's Capital and surplus was $5,688,632, which was $1,688,632 above its $4,000,000 minimum capital and surplus requirement. At its continued rate of losses and without additional capital infusion from its parent, the Company's capital and surplus could potentially approach its minimum capital and surplus requirement in the future. Based on this information, the Company's continued existence appears to depend, at least in the foreseeable future, on the willingness of its parent to fund the Company's losses. It is imperative that management develop a plan through which dependency on its parent will cease and that brings the Company to profitability through a combination of membership expansion and revenue increases and, most importantly, a reduction in general and administrative expenses.

SUBSEQUENT EVENTS

Effective April 19, 2011, the Company entered into a Support and Commitment Agreement with Carilion Clinic. According to the agreement, Carilion Clinic confirms its intent to continue to fund the Company at a level necessary to ensure regulatory and statutory compliance and its continued commitment to cover any future cash flow needs of the Company.

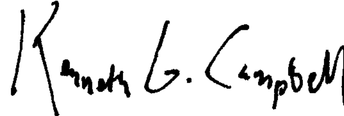
On May 31, 2011, CSI issued a $7,000,000 subordinated surplus note to the Company. On June 29, 2011, the Company drew $6,000,000 from the surplus note. Interest on the note is stated at six percent.

CONCLUSION

The courteous cooperation extended by the Company's officers and employees during the course of the examination is gratefully acknowledged.

In addition to the undersigned, Darrin Bailey, CFE, participated in the work of the examination.

Respectfully submitted,



Kenneth G. Campbell, CFE
Assistant Chief Examiner

November 15, 2011

David H. Smith, CFE, CPA, CPCU
Chief Examiner
State Corporation Commission
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218

RE: Carilion Clinic Medicare Resources, LLC
Examination Report as of December 31, 2010

Dear Mr. Smith,

We respectfully acknowledge receipt of the Examination Report as of December 31, 2010. Thank you for the opportunity to respond to the recommendation for corrective action included in the report.

The Company wishes to thank the Commission and the examination staff for the courtesy extended and we appreciate the cooperation extended to us during the exam. Should you have any further questions or concerns, please do not hesitate to contact us.

In addition, CCMR would like to request an electronic copy, plus five (5) printed copies of the report. However, if an electronic copy is not possible, please provide twenty (20) printed copies of the report for our internal use.

Sincerely,

Donald E. Lorton
President and Treasurer
Carilion Clinic Medicare Resources, LLC

cc. Kerri Thornton, Vice President, Carilion Clinic

213 S. Jefferson St. Suite 1409 Roanoke, VA 24011 P.O. Box 40032 Roanoke, VA 24022
877-335-0202 FAX: 540-224-5330 www.CarilionMedicare.com

Carilion Clinic Medicare Resources
December 31, 2010 Examination
Recommendations of Corrective Action

The recommended corrective action stated:

Management and Control

1. The Company reported a loss of $10,060,946 in 2010. Contributing greatly to its loss in 2010 were general and administrative expenses of $6,140,859 representing an administrative cost ratio of 317%. The Company's general and administrative expenses are disproportionate when compared to premiums earned in 2010. In addition to its loss in 2010, the Company reported a pre-operational loss of $6,452,598 in 2009. Through December 31, 2010, the Company received $23,000,000 in capital contributions, in the form of subordinated surplus notes, to fund its initial capitalization and its losses in 2009 and 2010. At December 31, 2010, the Company's Capital and surplus was $5,688,632 which was $1,688,632 above its $4,000,000 minimum capital and surplus requirement. At its continued rate of losses and without additional capital infusion from its parent the Company's capital and surplus could potentially approach its minimum capital and surplus requirement in the future. Based on this information, the Company's continued existence appears to depend, at least in the foreseeable future, on the willingness of its parent to fund the Company's losses. It is imperative that management develop a plan through which dependency on its parent will cease and that brings the Company to profitability through a combination of membership expansion and revenue increases and, most importantly, a reduction in general and administrative expenses.

The Company feels it is important to point out that the losses noted in the recommendation include an amount recorded as a Premium Deficiency Reserve (PDR). The PDR essentially moves the estimated loss for the 2011 plan year to 2010 and increased the required capital and surplus that was needed, which lowered the amount of excess over and above the minimum required capital and surplus.

The company has taken the following actions to address the noted concerns in the examination report's recommendation for corrective action:

1. The company has enhanced the Medicare Advantage plans currently being marketed for the 2012 plan year in an attempt to make the plans more attractive to the consumers of Southwest Virginia. These enhancements include extending the network of facilities and physicians available to plan members.

2. The Company has taken actions to increase its market presence and increase revenue. CCMR was recently awarded a contract by the Virginia Department of Medical Assistance Services to provide Medicaid benefits beginning with the 2012 plan year. In addition, the Company has reinforced efforts to increase membership of the Medicare Advantage plan by expanding the broker base and taking advantage of the plan's greater recognition in the marketplace over the last two years.

3. In an attempt to lower the general administration expenses, the Company has entered into a management agreement and partnership with Aetna. This will lower the amount of expenses being paid per member each month. Previous

contracts were based on a fixed membership amount that was much higher than actual members. The new plan administration contracts will not be linked to a minimum membership, but will be based on actual members and/or a flat fee. This new contract will also bring the costs more in line with the market average.