

Exhibit 11

Report on the Examination
of
Consumer Health Coalition of Vermont, Inc.
by the
Vermont Department of Financial Regulation
Division of Insurance



**Consumer Health Coalition of Vermont, Inc.
Examination Report**

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Department of Financial Regulation
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For consumer assistance
[All Insurance] 800-964-1784
[Securities] 877-550-3907
[Banking] 888-568-4547

April 01, 2013

Susan L. Donegan, Commissioner
Department of Financial Regulation
89 Main Street
Montpelier, VT 05620-3101

Dear Commissioner Donegan:

Pursuant to the November 20, 2012 examination order, the Insurance Division's financial examination team has conducted an examination of:

Consumer Health Coalition of Vermont, Inc.

with their offices located at
120 Kimball Avenue, Box 2
South Burlington, Vermont 05403

The examination was performed pursuant to Title 8 V.S.A. §3563, in order to investigate and examine the proposed application, activities, and transactions related to Docket # 12-041-I: Petition for a Title 8 §3305 Hearing.

Sincerely,

A handwritten signature in black ink, appearing to read "Kaj Samsom".

Kaj Samsom, Chief Examiner



Banking
802-828-3307

Insurance
802-828-3301

Captive Insurance
802-828-3304

Securities
802-828-3420

Health Care Admin
802-828-2900

SCOPE OF EXAMINATION

On October 15, 2012 the Department of Financial Regulation (Department) received an application dated October 12, 2012 for a Certificate of Authority as a mutual health insurer from Consumer Health Coalition of Vermont, Inc. (CHCVT or Applicant). On November 20, 2012 Commissioner Kimbell ordered an examination of the Applicant to “investigate and examine the proposed application, activities, and transactions related to Docket # 12-041-I: Petition for a Title 8 §3305 Hearing.” There were no prior examinations performed by the Department of the applicant.

This examination was conducted pursuant to Title 8 V.S.A. §3563 and §3573, and guidance provided by the National Association of Insurance Commissioners (NAIC). As detailed in this report’s Background and History section, there are certain unique factors that precluded the Department from performing a “full-scope examination” as defined in the NAIC *Financial Condition Examiners Handbook* (Handbook), mainly that the entity is not currently an operating insurance company or issuing statutory basis financial statements. The examiners conducted the examination using the guidance on “limited-scope examinations” provided in the Handbook. A limited-scope examination is not intended to communicate all matters of importance for an understanding of the company’s financial condition, but rather to communicate findings of specific areas reviewed. The specific areas reviewed were determined based on the goal of assessing the operational and financial feasibility of the proposed health insurer and identifying any significant risks in the applicant’s plan in the context of the Commissioner’s authority to grant a Certificate of Public Good (CPG) and a Certificate of Authority (COA or License) per Title 8 V.S.A. § 3305 and § 3309. This report is intended to summarize these findings.

Title 8 V.S.A. § 3305 states that in determining “public good” the Commissioner shall consider the following:

(1) The character, reputation, financial standing and purposes of the organizers, incorporators, and subscribers organizing the proposed insurer or organization.

(2) The character, reputation, financial responsibility, insurance experience, and business qualifications of its proposed officers and directors.

(3) Such other aspects of the proposed insurer or financing as he or she may deem advisable.

Furthermore, 8 V.S.A. § 3309 requires that prior to obtaining a Certificate of Authority, an applicant show *“an adequate amount of subscriptions of insurance and possesses and thereafter maintains unimpaired basic surplus of not less than \$2,000,000.00 and, when first so authorized, shall possess free surplus of not less than \$3,000,000.00.”*

Specific areas reviewed and considered in applying the statutory standards above included the Applicant's:

- Compliance with applicable statutes related to the organization of a domestic health insurance company in Vermont;
- business, operating and marketing plans;
- financial feasibility; and
- the insurance experience, character, reputation and financial responsibility of key personnel.

The Department engaged two independent firms to assist with the examination. Oliver Wyman, an actuarial consulting firm, was engaged to review the financial and actuarial assumptions and projections provided by the applicant. Bostick Crawford Consulting Group (BCCG) was engaged to review the insurance expertise and business qualifications of management and provide input to the Department regarding the assessment of operational risks. Both firms are subject matter experts in the respective areas of involvement. The findings of Oliver Wyman and BCCG were relied upon and are incorporated into this report and an associated management letter.

This examination report addresses the application for a Certificate of Public Good and a Certificate of Authority, as referenced above. The examination did not address the applicant's compliance with several other requirements for selling health insurance in Vermont and on the Vermont Health Connect (Exchange). Those requirements include:

- Obtaining a Mental Health Review Agent License per Department of Financial Regulation Rule H-2011-01;

- Undergoing a “Baseline Review” per Department of Financial Regulation Rule H-2009-03;
- Certification as a Qualified Health Plan for purposes of selling on the Vermont Health Benefit Exchange; and
- Approval of rates by the Green Mountain Care Board.

Obtaining a license as a health insurer is required prior to completing the above.

SUMMARY OF SIGNIFICANT FINDINGS & RISKS

We found that the applicant has access to an appropriate capital level to begin operations as a health insurer, and is currently implementing a comprehensive plan for the major operational functions of a health insurer. However, there are several significant operational and financial risks identified in this report. We reported concerns related to management experience, variability in financial and enrollment projections, access to capital and the ability to execute the business plan. Many of these concerns are inherent in any start-up insurance company. The presence of these risks does not preclude the Applicant from becoming a viable health insurer in Vermont. However, taken as a whole, these risks may present significant challenges to the applicant’s ability to successfully establish and maintain a financially viable health insurance company.

BACKGROUND & HISTORY

The Applicant was incorporated by Mitchell R. Fleischer on November 18, 2011 and seeks to operate on the Vermont Health Benefit Exchange as a Consumer Operated and Oriented Plan. Consumer Operated and Oriented Plans are nonprofit health insurance issuers authorized by the Patient Protection and Affordable Care Act of 2010. They must obtain all approvals necessary in the states where they wish to operate; and are eligible for both federal “Start-up” loans, and if licensed, “Solvency” loan funding. The Applicant applied to Centers for Medicare and Medicaid Services (“CMS”) for funding under these loan programs in December of 2011.

The CMS Solvency loan program is designed to satisfy state minimum capital and solvency requirements. The loan must be structured as a surplus note per statutory accounting guidance and relevant state law in order to be counted as capital rather than debt for statutory accounting purposes. A key characteristic of a surplus note is the Commissioner's ability to disapprove any principal or interest payment to the lender in the interest of solvency or policyholder protection.

In a February 22, 2012 response to an inquiry from the Applicant, the Deputy Commissioner of Insurance affirmed that surplus note funds were eligible for the purposes of meeting the minimum capital & surplus requirements in Vermont insurance law. After review of the proposed promissory note between the Applicant and CMS, the Department wrote to CMS on June 11, 2012 confirming that funds received through the Solvency loan would be acceptable as regulatory capital in Vermont.

CMS awarded CHCVT federal funding to create a Consumer Operated and Oriented Plan on June 19, 2012. The Applicant received Start-Up Loan disbursements of approximately \$1.7 million on June 26, 2012. To date the Applicant has received approximately \$4.5 million in Start-up loan funds.

CHCVT submitted its original application to the Department dated October 12, 2012, at which point Docket # 12-036-I was opened. This initial application proved problematic because Title 8 V.S.A. § 3305 requires a public hearing and Commissioner approval prior to incorporation of a proposed insurer. Furthermore, the requirement for 15 incorporators per Title 8 V.S.A. § 3302 was not met. The original application and hearing request was ultimately superseded by a new application for a proposed corporation, with the intent to transfer the substance (including the CMS Loan Award) of the original CHCVT and its application to a new company, if approved for formation by the Commissioner. Docket # 12-041-I was opened upon receipt of a November 9, 2012 petition for a Title 8 V.S.A. § 3305 public hearing of a proposed insurance company. That hearing was held on March 1, 2013, with Commissioner Susan L. Donegan presiding, to hear from the petitioners and to take public comment on whether creation and licensing of the Applicant was in the public good.

PLAN OF ORGANIZATION

The Applicant's list of incorporators was reviewed and no concerns were noted related to Title 8 V.S.A. § 3302 which requires at least 15 incorporators with no less than two thirds being Vermont residents. We reviewed the proposed articles of incorporation and by-laws and noted no concerns related to Title 8 V.S.A. § 3303, which requires that they set forth the manner in which the board of directors shall be elected, and in which meetings of policyholders shall be called, held and conducted. As the applicant has not yet formed an insurance company, the examination did not include a review of the minutes of the Board of Directors as is typical in a Full Scope Examination.

MANAGEMENT AND CONTROL

Board of Directors

The Applicant is a proposed member owned and member governed mutual insurer. The proposed by-laws define a member as "any individual of legal age covered under the health insurance policies issued by the CO-OP". Until such time as the applicant obtains a license and enrolls members (sells health insurance) it will not have members. As such, the by-laws contemplate a transition to a member elected board over time. They state that an initial Board (the "Formation Board") shall consist of no less than three (3) directors or more than nine (9), including ex officio directors. The by-laws require that no more than forty-nine (49%) percent of the individuals serving on the Formation Board may be financially interested persons within the meaning of 11B V.S.A. §8.13 of the Vermont Nonprofit Corporations Act.

Once the entity begins accepting enrollment and has members, it will begin a multi-year transition to an "Operational Board". Per the proposed by-laws, the first Member election shall take place no later than one year following the date the Applicant begins providing coverage to its first Member, resulting in a board that is comprised of fifty percent (50%) or more directors elected by the Members. Thereafter, all directors must be elected by a majority vote of a quorum of the Members. The Formation Board shall be replaced by the Operational Board within two years after providing coverage to its first member.

The proposed by-laws state that the Operational Board shall consist of no less than nine (9) and no more than thirteen (13) directors. The term "Operational Board" shall mean the Board of Directors elected by the Members of the Applicant. All Members will be eligible to vote for each director on the Operational Board. The majority of directors on the Operational Board must be Members of the organization. Each director has one vote unless he or she is a non-voting director. While all directors of the Operational Board must be elected by the Members, the Applicant may designate some Operational Board positions for directors with certain types of expertise that are essential to the governance of the Applicant. Positions on the Operational Board designated for individuals with specialized expertise, experience or affiliation cannot constitute a majority of the Operational Board. This provision does not prevent any individual from seeking election to the Operational Board based on being a Member. No more than forty-nine (49%) percent of the individuals serving on the Operational Board may be financially interested persons.

The following are proposed Directors of the Formation Board:

<u>Name</u>	<u>Principal Business Affiliation</u>
Mitchell R. Fleischer	President & CEO, Fleischer Jacobs Group
David A. Jillson, PhD	Retired Business Manager, Associates in Orthopedic Surgery
James S. Lampman	Entrepreneur/Restaurateur; President, Lake Champlain Chocolates
Douglas C. Nedde	Managing Partner Bolton Valley Resort; Principal, Redstone Group
Mark A. Pitcher, M.D., F.A.C.P.	Doctor of Internal Medicine
Christine M. Oliver (<i>ex officio</i>)	Chief Executive Officer, CHCVT

Officers

The Officers proposed for the Applicant are as follows:

<u>Name</u>	<u>Title</u>
Christine M. Oliver	Chief Executive Officer (CEO)
Thomas M. McKeown	Chief Operating Officer (COO)
Tara D. Banks, CPA	Chief Financial Officer (CFO)
Margaret C. Platzner	General Counsel
Chad E. Somerset	Chief Information Officer (CIO)
Jaskanwar S. Batra	Chief Medical Officer

TERRITORY AND PLAN OF OPERATIONS

The Applicant intends to offer health insurance in Vermont only and has not applied for a license in any other states.

REINSURANCE

The Applicant is considering several reinsurance offers and has presented the Examiners with a plan for obtaining specific reinsurance with retentions between \$250,000 and \$350,000. The Applicant is also considering additional coverage for transplant related claims. The Examiners reviewed evidence that quotes have been received and that coverage is obtainable. It is essential that coverage is in place prior to writing the first insurance policy.

FINDINGS AND IDENTIFIED RISKS

In reviewing criteria for issuance of a CPG and COA, we identified the following risks we feel are significant. It is important to note that many of these risks would exist for any start-up entity in this environment; in the following section we have identified and discussed the risks judged to be relevant and significant to this application.

In determining the following risks we considered the Applicant's risk mitigation strategies and responses to findings communicated and requests made during the examination; either by Department examiners, Oliver Wyman or BCCG. When stating a risk, we are identifying the

possibility of an adverse outcome that we feel is significant. The outcomes discussed as a result of each risk are not certainties, but possibilities the Examiners feel are noteworthy.

MINIMUM CAPITAL AND SURPLUS

We have reviewed the loan agreements with CMS. We also reviewed a letter from CMS affirming that the loans originally awarded to CHCVT can be transferred to the proposed new entity. The Applicant is currently funding operations with CMS start-up loan funds, with approximately \$4.5 million received to date. Approximately \$6.3 million in total Start-up funds are available to the Applicant. Repayment of the start-up loan disbursements begin in 2017. A lump sum repayment of each installment is due 5 years after the disbursement.

Finding #1: We found that the Start-up loan funds appear reasonable to adequately fund the entity in the pre-enrollment phase.

We reviewed the Solvency Loan agreement and noted that \$27.6 million is approved and available to the Applicant, but is not awarded in one sum. On March 28, 2013 the Applicant reported receipt of its first installment of \$9.8 million. Per the terms of the loan agreement, additional disbursements can be requested to meet solvency criteria. Interest payments on these loans (0.25%) begin in 2019. Repayment of principal on the first installment begins in 2021 and is based on a 7 year amortization.

Finding #2: We found that the Solvency Loan agreement provides for access to adequate funding to meet the statutory minimum starting surplus of \$5,000,000, although we are reporting a risk related to maintaining adequate capital once operations commence.

The terms of the loan agreement include broad authority for CMS to terminate the loan or cease further disbursements due to compliance or solvency issues. We identified a risk related to the Applicant's access to capital, both through this loan program and related to its proposed status as a non-profit mutual.

Risk #1: Access to Capital

There is a risk that the applicant is unable to access the available funding and necessary capital to maintain the Vermont minimum regulatory requirements, threatening its ability to continue as a going concern.

ACTUARIAL DATA PROVIDED BY THE APPLICANT

Oliver Wyman performed an analysis of the Application with emphasis on the financial feasibility study and pro-forma financial statements provided. The Applicant's revenue and premium assumptions in the pro-formas were developed by its actuarial firm but did not use actual premium rates to be offered in the market. It is the nature of pro-formas to be heavily reliant on assumptions, particularly for a new entity with no specific underwriting experience to draw from. The Applicant submitted pro-formas and data asserting that they are adequately capitalized and can be profitable through many scenarios (low - high enrollment, base case - adverse claim experience). However, the reliance on assumptions and the sensitivity of the pro-formas to changes in the assumptions present significant risk as described below.

Risk #2.1: Assumption of Allowable Costs

Oliver Wyman developed independent estimates of allowable costs based on analysis of the Vermont rate filings of two major carriers. Substituting the Applicants projections with the Oliver Wyman estimated allowable costs produce a materially different result in all scenarios related to profitability. There is a risk that the allowable costs assumptions made by the applicant are materially different from the actual costs it will encounter in the Vermont market, resulting in operating losses rather than gains at the Applicant's enrollment target.

Risk #2.2: Enrollment Assumptions

As with any insurers entry into a new market, there is a risk that enrollment targets are not met, resulting in an inadequate volume of business for profitability. As a start-up entity in a brand new market (Exchange), this risk is particularly acute.

Risk #2.3 Actual Premiums Inconsistent with Pro-formas

There is a risk that the rates filed and ultimately approved by the Green Mountain Care Board in accordance with Vermont law are materially different from the rates assumed in the Applicant's pro-formas, resulting in unanticipated results, such as the inability to operate profitably in scenarios previously assumed to be profitable per the original pro-formas.

RELIANCE ON VENDORS

In the application for a Certificate of Authority, CHCVT states that the following functions will be outsourced to third party contractors:

- Provider Network Management
- Provider Management and Credentialing
- Underwriting
- Claim Administration
- Billing
- Coordination of Benefits
- Sales and Marketing
- Actuarial Services.

The Applicant proposes to retain the following functions in-house:

- Finance
- Information Technology
- Medical Management
- Provider and Member Services
- Compliance
- Grievances and Appeals
- Portions of Education & Outreach

The Applicant emphasizes that they "...have been very strategic in determining which services should be built internally and which would be more cost effective and efficient if purchased from

an outside vendor. We've retained in-house the services that very directly affect our members and providers including medical management, provider and member services, compliance, grievances and appeals, information technology, finance and portions of education and outreach." The applicant also states that "All vendors were vetted through a competitive bidding process where scoring was based, in part, on the vendor's demonstrated knowledge of and experience in the industry and their experience in the Vermont market. We also paid careful attention to each vendor's willingness and flexibility to alter their standard operating procedures to meet unique CO-OP needs."

Heavy reliance on third parties for core insurance functions provides advantages in terms of the scalability of the proposed entity and is not an inappropriate strategy for entering a very concentrated market dominated by a few large and well established insurers (as opposed to building the administrative capabilities all in-house). However, the Examiners considered the approach and strategy used by the Applicant and identified the following risks:

Risk #3.1 Oversight of Healthcare Vendors

There is a risk that the Applicant may not have requisite in-house knowledge or experience in the functions delegated to properly supervise and monitor the vendors, resulting in a failure to prevent or quickly address critical issues.

Risk #3.2 Vendor Performance

There is a risk that vendors may not perform as expected under their contracts, including allocating adequate resources to the Applicant's operations and execution of the necessary coordination between vendors required, resulting in customer service, compliance or other issues.

MANAGEMENT EXPERIENCE

With assistance from BCCG, Examiners reviewed the business plan of the Applicant as well as the resumes and biographical affidavits of senior management and the Chair of the Board. No concerns were noted related to the "character, reputation, financial responsibility" standards in Title 8 V.S.A. §3305.

Finding #3: Our review identified no concerns regarding the character, reputation and financial responsibility of the Applicant's proposed Officers and Directors.

Key personnel were interviewed to supplement our understanding of management's insurance experience and business qualifications related to the statutory requirement of 'insurance expertise and business qualifications'. The examination found that certain officers of the company did not have the specific insurance experience observed for similar positions at similar entities.

Risk #4: Experience of Management

There is a risk that the lack of insurance experience and business qualifications of certain key officers will result in problems with identification and resolution of strategic and operational issues, or results in less than optimal oversight of contractors (Risk #3.1).

SALES & MARKETING STRATEGY

The applicant has submitted a detailed plan for achieving sufficient enrollment to support financial projections and remain solvent. One feature of this plan, as expressed in both the application to CMS and the Department, and in subsequent communications with the Department is the use of a preferred broker network through a Managing General Agency agreement executed with Fleischer Jacobs Group (FJG) on December 4, 2012. The enrollment strategy includes a purported competitive advantage for CHCVT as being the only carrier offering commissions on the exchange. The payment of commissions on the exchange is in conflict with Title 8 VSA §4085 and therefore increases the risk that the applicant will not achieve its enrollment targets. The Applicant has indicated that they will modify the contract accordingly and will not pay commissions on the exchange.

Risk #5: Inability to Pay Commissions

To the extent that the MGA contract with FJG is a key component of the Applicant's enrollment strategy, significant changes in the nature of that

arrangement may have an adverse impact. There is a risk that the any necessary changes in the Applicant's plans will further exacerbate the risk related to achieving enrollment targets (Risk #2.2).

ADMINISTRATIVE COSTS AND OVERHEAD

The Department and Oliver Wyman each conducted reviews and inquiries of the administrative cost of the proposed entity. Administrative costs of Vermont's health insurers based on audited statutory annual statement filings are generally in the \$30-\$45 per member per month (pmpm) range. We noted and confirmed with the Applicants actuary that the pro-formas included administrative costs in excess of \$90 pmpm. Subsequent communications with the Applicant indicated they have revised their administrative cost projections to approximately \$76 pmpm.

Risk #6: Administrative Costs

There is a risk that administrative costs, observed to be significantly higher than the administrative costs of existing Vermont health insurers, will result in the Applicant being unable to effectively compete on price and will exacerbate the risk of missing enrollment targets (Risk #2.2), and/or affect the company's ability to maintain profitability, both of which could result in financial losses.

It can be challenging for any entity to successfully enter a new market and preserve initial capital through break-even or profitable operations. In this case, the Applicant is a start-up entering a highly concentrated and established market. There is the added burden of the required repayment of all of its initial capital per the terms of the loan agreement with CMS. Start-up loan borrowings of up to \$6.3 million are due for repayment beginning in 2017. Principal and interest payments for each Solvency loan draw begin 8 years after the disbursement. The first Solvency Loan disbursement of \$9.8 million was received in March of 2013. As such, Solvency loan repayment will begin in 2021. Planning for repayment of these loans may require the applicant to build greater profit margins into its rates than its anticipated competitors on the Exchange. Those competitors are two existing not for profit entities with significant existing capital not derived from loans. Any reliance on solvency loan proceeds to absorb losses or subsidize operations will have to be made up in subsequent periods in order to ensure repayment of the loans.

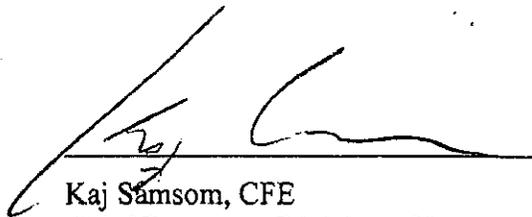
Risk #7: Repayment of Loans

There is a risk that the obligation to repay the Solvency and Start-up loans will adversely affect the Applicants ability to offer both profitable and competitive rates in 2014 and beyond. This may result in an inability to achieve its financial projections, affecting the viability of the Applicant.

CONCLUSION

This limited-scope examination report sets forth the risks identified in the review of the application. The presence of these risks does not preclude the Applicant from becoming a viable health insurer in Vermont. However, taken as a whole, these risks may present significant challenges to the applicant's ability to successfully establish and maintain a financially viable health insurance company.

Respectfully submitted,



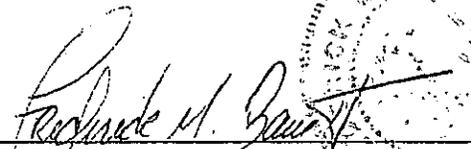
Kaj Samsom, CFE
Chief Examiner, Division of Insurance
Vermont Department of Financial Regulation

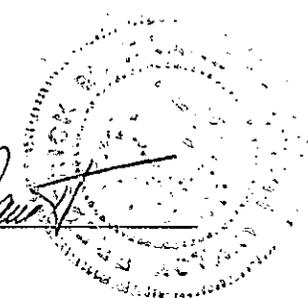
STATE OF VERMONT
COUNTY OF WASHINGTON

Kaj Samsom, being duly sworn, deposes and says that the foregoing report submitted by him is true to the best of his knowledge and belief.

Subscribed and sworn to before me

This 1 day of April, 2013


Notary Public



Frederick M. Barter
Notary Public, State of Vermont at Large
My Commission Expires February 13, 2016