Report of the Examination of

Independent Care Health Plan

Milwaukee, Wisconsin

As of December 31, 2018

TABLE OF CONTENTS

Page

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Tony Evers, *Governor*
Mark V. Afable*, Commissioner*

Wisconsin.gov

125 South Webster Street • P.O. Box 7873
Madison, Wisconsin 53707-7873
Phone: (608) 266-3585 • Fax: (608) 266-9935
ociinformation@wisconsin.gov
oci.wi.gov

January 27, 2020

Honorable Mark V. Afable
Commissioner of Insurance
State of Wisconsin
125 South Webster Street
Madison, Wisconsin 53703

Commissioner:

In accordance with your instructions, a compliance examination has been made of the affairs and financial condition of:

INDEPENDENT CARE HEALTH PLAN
Milwaukee, Wisconsin

and this report is respectfully submitted.

I. INTRODUCTION

The previous examination of Independent Care Health Plan (iCare or the company) was conducted in 2014 as of December 31, 2013. The current examination covered the intervening period ending December 31, 2018, and included a review of such 2019 transactions as deemed necessary to complete the examination.

The examination was conducted using a risk-focused approach in accordance with the National Association of Insurance Commissioners (NAIC) *Financial Condition Examiners Handbook*. This approach sets forth guidance for planning and performing the examination of an insurer to evaluate the financial condition, assess corporate governance, identify current and prospective risks (including those that might materially affect the financial condition, either currently or prospectively), and evaluate system controls and procedures used to mitigate those risks.

All accounts and activities of the company were considered in accordance with the risk-focused examination process. This may include assessing significant estimates made by

management and evaluating management’s compliance with statutory accounting principles, annual statement instructions, and Wisconsin laws and regulations. The examination does not attest to the fair presentation of the financial statements included herein. If during the course of the examination an adjustment is identified, the impact of such adjustment will be documented separately at the end of the “Financial Data” section in the area captioned "Reconciliation of Surplus per Examination."

Emphasis was placed on those areas of the company's operations accorded a high priority by the examiner-in-charge when planning the examination. Special attention was given to the action taken by the company to satisfy the recommendations and comments made in the previous examination report.

The company is annually audited by an independent public accounting firm as prescribed by s. Ins 50.05, Wis. Adm. Code. An integral part of this compliance examination was the review of the independent accountant's work papers. Based on the results of the review of these work papers, alternative or additional examination steps deemed necessary for the completion of this examination were performed. The examination work papers contain documentation with respect to the alternative or additional examination steps performed during the course of the examination.

II. HISTORY AND PLAN OF OPERATION

Independent Care Health Plan is described as a for-profit mixed-model health maintenance organization (HMO) insurer. An HMO insurer is defined by s. 609.01 (2), Wis. Stat., as a health care plan offered by an organization established under ch. 185, 611, 613, or 614 or issued a certificate of authority under ch. 618 that makes available to its enrolled participants, in consideration for predetermined fixed payments, comprehensive health care services performed by providers selected by the organization. Under the mixed model, the company has a delivery system consisting of a combination of staff physicians and/or one or more clinics and/or independent contracting physicians operating out of their separate offices.

The company was incorporated on April 22, 2003, and commenced business on June 18, 2003. The company is a joint venture equally owned by CareNetwork, Inc. (a Humana Inc. subsidiary), and the Centers for Independence, Inc. (CFI). Humana is an insurance holding company that provides indemnity insurance, managed health care insurance and specialty service products through the operations of its subsidiary companies. Humana is incorporated in the state of Delaware and based in Louisville, Kentucky. CFI is a not-for-profit corporation based in Milwaukee, Wisconsin that provides programs and services to children and adults with disabilities and special needs.

The company operates solely in the Medicare and Medicaid markets with a focus on the special needs population that is considered dually eligible for Medicare and Medicaid. The company's products/programs include:

- Medicare Supplemental Security Income (SSI)
- Medicare Advantage – Special Needs Plan (MA-SNP) - This plan covers the major medical and pharmacy costs of people who dually qualify for Medicare and Medicaid. Dual-eligible individuals receive Medicare coverage, subsidies to cover Medicare Part D costs and Medicaid coverage including coverage of Medicare coinsurance and deductible amounts
- Medicaid BadgerCare contract with the Wisconsin Department of Health Services (DHS) to provide services to individuals and/or families that meet certain income and access requirements as determined by the state of Wisconsin.

- Family Care Partnership (FCP) - This plan is an integrated Medicaid and Medicare managed care program that provides long-term care support services in addition to the primary and acute managed health care benefits provided under the MA-SNP and/or Medicaid SSI coverage.

The company contracts with Wisconsin Department of Health Services to provide coverage to recipients eligible for Medicaid-BadgerCare Plus or SSI benefits enrolled under the State of Wisconsin Medicaid Program. The company's service area for Medicaid SSI initially consisted of Milwaukee County, and in 2006 through a business plan amendment expanded into Racine, Kenosha, Waukesha, Washington, Ozaukee, and Sheboygan Counties. Through a Business Plan Amendment in 2008, the company expanded into offering the BadgerCare Plus program in Milwaukee, Racine, Kenosha, Waukesha, Washington, Ozaukee, and Sheboygan counties.

Subsequently, in 2012 and 2013, the company expanded its BadgerCare Plus and SSI Managed Care business into Brown, Dane, Dodge, Door, Fond du Lac, Jefferson, Kewaunee, Manitowoc, Marinette, Outagamie, Walworth, Waupaca, and Winnebago counties.

Through multiple business plan amendments between 2016 and 2018, the company further expanded its BadgerCare Plus and SSI Managed Care business into Adams, Calumet, Crawford, Grant, Green, Jackson, Juneau, La Crosse, Marathon, Monroe, Sauk, Shawano, Trempealeau, and Vernon counties.

In 2007, the company entered into a risk contract with Centers for Medicare and Medicaid Services (CMS) to offer a Medicare Advantage Special Needs Plan (MA-SNP) for dual eligible individuals in Milwaukee, Racine, Kenosha, Waukesha, Washington, Ozaukee, and Sheboygan counties.

In 2011, the company contracted with CMS to expand the MA-SNP into Brown, Manitowoc, Outagamie, Winnebago, Waupaca and Walworth counties. The company further expanded the plan service area in 2013 to Dane, Shawano, and Oconto counties and again in 2015 to Kewaunee, Calumet, Sauk, Marinette, and Menominee counties. During 2017 and 2018, business amendments were filed to expand the service area to Adams, Columbia, Green, Green Lake, Iowa, Jackson, Juneau, Lafayette, Monroe, Richland, Trempealeau, and Vernon counties. For plan year

2020, the MA-SNP was approved for expansion into Dodge, Jefferson, Langlade, Marathon and Taylor counties.

In 2010, the company added a Family Care Partnership HMO SNP plan in Milwaukee County. In 2012, a business plan amendment was filed to expand the FCP service area into Racine and Kenosha counties. In 2015, the FCP plan expanded into Dane County and in 2019 it expanded into Sauk County.

In 2014, the company received a license to operate in Illinois to grow existing markets on the Illinois border and to allow for expansion into the Chicago market. In 2019, the company filed a business plan amendment to expand its Medicare Advantage Dual Eligible Special Needs Plan in Wisconsin, Indiana, and Missouri in 2021, and to launch in 2020 a Medicare Advantage-Prescription Drug (MAPD) plan in two Illinois counties.

The company provides primary and specialty health care services by contracting with primary care physicians, specialty care physicians, ancillary providers, and hospitals. The company utilizes over 6,000 contracted physicians. Physician services are reimbursed on a contractual fee-for-service basis.

The company's primary and specialty care provider contracts cover all medically necessary covered Medicare and Medicaid services as outlined in the company's contracts with the Wisconsin Department of Health Services and the Centers for Medicare and Medicaid Services. Providers are required to be available to provide services to enrollees on a readily available and accessible basis, including, but not limited to, the provider's normal business hours. The contracts require that services shall be available and accessible to enrollees on an emergency basis 24 hours per day, seven days per week.

The provider contracts contain hold-harmless provisions that prohibit the provider from seeking to recover health care costs from an enrollee. Providers are not allowed to bill, charge, collect a deposit from, seek remuneration or compensation from, file or threaten to file with a credit reporting agency, or have any recourse against an enrollee. This provision also remains in effect if the company becomes insolvent, breaches the agreement or no payment is received from DHS or CMS. Providers

are allowed to recover amounts due that are a result of any deductibles or copayments, or for premiums owed under the policy issued by the company.

Currently, the company contracts with the following independent practice associations (IPAs):

ProHealth Solutions	StaffCorp Inc.
Premium Healthcare	Independent Physicians Network, Inc.
Columbia St. Mary's Physician Network	Waukesha Elmbrook Health Care

The company also contracts with 78 hospitals to provide inpatient services. Hospitals are reimbursed on a diagnosis-related group (DRG) or a discounted fee-for-service basis. The contracts include hold-harmless provisions for the protection of policyholders.

At the time of the report, the company's service area is comprised of the following 45 Wisconsin counties:

Adams	Fond du Lac	Kenosha	Menominee	Rock	Washington
Brown	Grant	Kewaunee	Milwaukee	Sauk	Waukesha
Calumet	Green	La Crosse	Monroe	Shawano	Waupaca
Columbia	Green Lake	Lafayette	Oconto	Sheboygan	Waushara
Crawford	Iowa	Langlade*	Outagamie	Taylor*	Winnebago
Dane	Jackson	Manitowoc	Ozaukee	Trempealeau	
Dodge*	Jefferson*	Marathon*	Racine	Vernon	
Door	Juneau	Marinette	Richland	Walworth	

*Note: These counties were added to the company's service area for the MA-SNP plan after December 31, 2018.

The company offers comprehensive health care coverage which may include deductibles and copayments depending on the product line. The following basic health care coverages are provided:

Physician services
Inpatient services
Outpatient services
Mental health, drug, and alcohol abuse services
Ambulance services
Special dental procedures (oral surgery)
Prosthetic devices and durable medical equipment
Newborn services
Home health care
Preventive health services
Family planning
Hearing exams and hearing aids
Diabetes treatment
Routine eye examinations
Convalescent nursing home service

Prescription drugs
Cardiac rehabilitation, physical, speech, and/or occupational therapy
Physical fitness or health education
Kidney disease treatment
Certain transplants (Medicare)
Chiropractic services
Personal care worker service (Medicaid)
Routine transportation to/from medical appointments (Medicaid)
Over-the-counter drugs (Medicare only)

The company had two major third party agreements (TPA) in place during the period under examination. The claims processing agreement with The TriZetto Group (now known as Cognizant, Inc.) covers primarily medical and long-term care claims processing functions. This includes the claims processing software, hosting the software and staffing for a significant part of the claims processing activities. The claims processing agreement also includes claims front-end functions such as claims receipts and claims data entry, as well as back-end functions such as printing and mailing of checks, Explanation of Payment and Explanation of Benefit forms. The TriZetto Group also issues ID cards and other necessary member materials. The agreement with The TriZetto Group was effective September 30, 2010, and remained in effect for the period under examination.

The company also had a TPA agreement with MedImpact which administered all pharmacy benefits on behalf of the company. This included obtaining contracts with pharmacies, adjudicating pharmacy claims and issuing pharmacy claims payments. The agreement was effective January 1, 2010, for a three-year term and has been amended several times. The last amendment was the seventh amendment effective January 1, 2018, and shall continue through December 31, 2023 (initial term). After the initial term, the agreement will automatically renew for successive one-year terms, unless terminated by either party by giving a notice of non-renewal by certified or registered mail at least 180 days prior to expiration of the then-current term.

III. MANAGEMENT AND CONTROL

Board of Directors

The board of directors consists of nine members. All directors are elected for annual terms at the annual shareholders meeting. Officers are appointed by the board of directors. Members of the company's board of directors may also be members of other boards of directors in the holding company group. Board members currently do not receive compensation for serving on the board.

Currently, the board of directors consists of the following persons:

Name and Residence	Principal Occupation	Term Expires
Daniel Neely Bayside, Wisconsin	Associate Professor of Accounting University of Wisconsin-Milwaukee	2019
Patrick Nicholas Judd Louisville, Kentucky	Associate Vice President of Finance Humana, Inc.	2019
Timothy Voightman Glendale, Wisconsin	Partner Foley & Lardner LLC	2019
Teri Zywicki Pewaukee, Wisconsin	President/CEO Centers for Independence, Inc.	2019
Anita Holloway Milwaukee, Wisconsin	Market VP and Medical Officer Humana, Inc.	2019
Cheri Greenfield-LaTour DePere, Wisconsin	Senior Vice President – Home Care Operations Humana, Inc.	2019
Mark Matzke De Pere, Wisconsin	Senior Vice President – Employer Group & Specialty Humana, Inc.	2019
Rebecca Goldman Milwaukee, Wisconsin	General Counsel Optimas Solutions	2019
Elwood Kleaver, Jr.* Boise, Idaho	Independent Board Member	2019

*Note: This position was left vacant in 2019. The company was expecting a replacement in January 2020.

Officers of the Company

The officers serving at the time of this examination are as follows:

Name	Office	2018 Compensation
Thomas Lutzow	President/Chief Executive Officer	$453,035
Craig Steffes	Vice President and Chief Financial Officer	289,773
William Jensen	Vice President – Marketing & Sales	217,075
Elizabeth Bartlett	Vice President and General Counsel	243,967
Vinay Pandey	Vice President, Chief Information Officer and Chief Quality Officer	215,079
Margaret Kristan	Vice President – Long-Term Care and Community Inclusion	156,625
Donald Slowik	Vice President – Analytics	212,443
Lisa Holden	Vice President – Accountable Care	210,808

Committees of the Board

The company's bylaws allow for the formation of certain committees by the board of directors. The committees at the time of the examination are listed below:

Finance Committee
Mark Matzke, Chair
Daniel Neely
Elwood Kleaver, Jr.*

Audit & Compliance Committee
Daniel Neely, Chair
Tim Voigtman
Patrick Nicholas Judd
Elwood Kleaver, Jr.*

Systems & Quality Committee
Cheri Greenfield-La Tour, Chair
Anita Holloway
Rebecca Goldman
Patrick Nicholas Judd

Enrollee Advisory Committee
Anita Holloway, Chair
Rebecca Goldman

Stakeholder Planning Advisory Committee
Anita Holloway, Chair
Rebecca Goldman

*Note: This position was vacant in 2019.

Organizational Structure

The company organizes its employees into several departments run by senior management under the direction of the president/chief executive officer, as follows:

- Vice President/Chief Financial Officer – Finance and Operations
- Vice President - Analytics – Data Analytics
- Vice President and General Counsel – Legal, Network Development, and Credentialing
- Office/Facility Manager – Administrative Services/Facilities
- Vice President - Accountable Care – Care Management, Specialty Services, BadgerCare Plus (BC+), and Follow to Home

- Medical Director – Prior Authorization and Pharmacy
- Human Resources Director – Human Resources and Facilities
- Vice President, Chief Information Officer, and Chief Quality Officer – Information Systems, Business Systems, Project Management, and Quality Improvement
- Director of Compliance – Compliance
- Vice President - Marketing & Sales – Public Relations/Marketing, Product Development, and Sales
- Vice President – Long-Term Care and Community Inclusion – Family Care Partnership Plan

Insolvency Protection for Policyholders

Under s. Ins 9.04 (6), Wis. Adm. Code, HMOs are required to either maintain compulsory surplus at the level required by s. Ins 51.80, Wis. Adm. Code, or provide for the following in the event of the company's insolvency:

1. Enrollees hospitalized on the date of insolvency will be covered until discharged; and

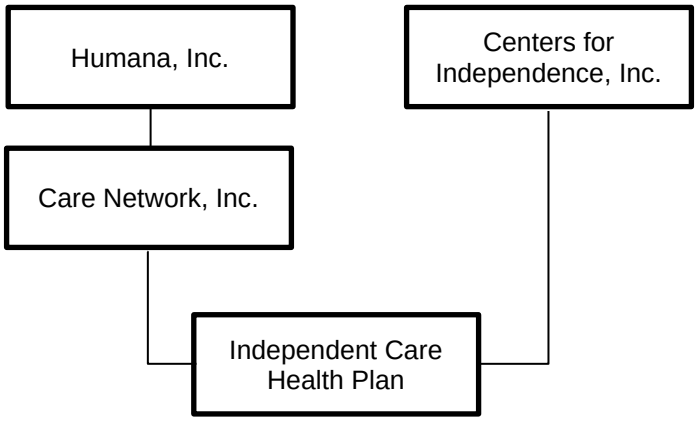
2. Enrollees will be entitled to similar, alternate coverage which does not contain any medical underwriting or preexisting limitation requirements.

The company has met this requirement through its reinsurance contract, as discussed in the Reinsurance section of this report.

IV. AFFILIATED COMPANIES

The company is a member of a holding company system. The ultimate parent companies are Humana, Inc. and Centers for Independence. Each company owns 50% of iCare. The organizational chart below depicts the relationships among the affiliates in the group. A brief description of the significant affiliates of the company follows the organizational chart.

Holding Company Chart
As of December 31, 2018



Humana, Inc.

Humana, Inc., (Humana) is an insurance holding company that provides indemnity insurance, managed health care insurance, and specialty service products through the operations of its subsidiary companies. The company is incorporated in the state of Delaware and based in Louisville, Kentucky. As of December 31, 2018, the company's consolidated audited financial statement reported assets of $25.4 billion, liabilities of $15.2 billion, and shareholder equity of $10.2 billion. Operations for 2018 produced a net income of $1.7 billion on revenues of $56.9 billion. Humana owns Care Network, Inc. (CNI), an intermediate holding company of iCare.

Centers for Independence, Inc.

Centers for Independence, Inc. is a non-profit organization operating to govern and carry out the missions of Related Corporations (collectively referred to as the Center). The Center consists of the following non-profit organizations and companies: Milwaukee Center for Independence (MCFI), School for Early Development and Achievement (SEDA), New Health Services, Inc. (NHS), iLife, LLC

(iLIFE), MCFI Home Care, LLC (Home Care), Milwaukee Center for Independence Foundation, Inc. (the Foundation), MCFI Health Clinic, LLC (the Clinic), First Person Care Consultants, LLC (FPCC), and Whole Health Clinical Group, Inc. (WHCG). CFI is located in Milwaukee, Wisconsin. As of December 31, 2018, the company's consolidated audited financial statement reported assets of $53.0 million, liabilities of $17.5 million, and total net assets of $35.5 million. Operations for 2018 produced an increase in net assets of $3.4 million on revenues of $70.3 million.

Affiliated Agreements

The company entered into a Long-Term Care (LTC) Services Agreement with Milwaukee Center for Independence (MCFI) on August 17, 2009, which became effective January 1, 2010, in which MCFI provides procedures, services, supplies, equipment or other goods or services which are covered Long-Term Care benefits under Family Care, Family Care Partnership or other Medicaid, Medicare, individual or group insurance plan offered by iCare. MCFI was contracting with iCare to participate in iCare's network of participating providers and to provide covered LTC services to enrollees in iCare's Family Care or Family Care partnership plan. The agreement was changed as follows:

- Terminated and replaced by LTC Services Agreement with MCFI effective July 1, 2015, and was amended on the same date to include adult daycare, day services and treatment, financial management services, and prevocational services.
- The second amendment was made effective on August 6, 2018, to reflect the rate per day for day habilitation and day service of a particular member.
- The third amendment was made effective on October 15, 2018, to add supported employment to the procedures covered.

This agreement continues in effect until terminated by either party.

The company entered into a Long-Term Care Services Agreement with MCFI Home Health Care, LLC (Home Care) effective January 1, 2014, in which Home Care provides procedures, services, supplies, equipment or other goods or services which are covered LTC benefits under Family Care, Family Care Partnership or other Medicaid, Medicare, individual or group insurance plan offered by iCare. Home Care was contracting with iCare to participate in the network of participating providers

and to provide covered long-term care services to enrollees in iCare FCP plan. This agreement was changed as follows.

- Amended effective December 1, 2016, to add consultative clinical and therapeutic services for caregivers.
- The second amendment to the LTC agreement was made effective March 1, 2017, to add training service for unpaid caregivers and to add Milwaukee, Kenosha, Racine and Dane counties to the service area covered.
- The third amendment to this agreement was made effective January 1, 2018, to reflect updated rates for supportive home care services as well as to add daily living skills training service to the LTC agreement.

This agreement shall continue in effect until terminated by either party.

The company entered into a Direct Care Workforce Addendum to the LTC Provider Services Agreement with Home Care effective January 1, 2018, in which Home Care provides adult day care services, daily living skills training, habilitation services, residential care (adult family homes of 1-2 beds, adult family homes of 3-4 beds, community-based residential facilities, residential care apartment complexes), respite care services provided outside of a nursing home, supportive home care, and other services that require direct interaction with members. This agreement shall continue in effect until terminated by either party.

The company entered into a Provider Service Agreement with Home Care effective January 1, 2014, in which Home Care provides those services which are covered benefits under Medicaid, Medicare or any other individual or group health insurance plan covered by iCare. This agreement shall automatically renew for successive one-year terms until or unless terminated by either party.

The company entered into a Provider Service Agreement with MCFI, d/b/a Transitional Living Services Behavioral Health (TLS Behavioral Health) effective March 1, 2014, in which TLS Behavioral Health provides those services which are covered benefits under the Medicaid, Medicare or any other individual or group health insurance plan offered by iCare. This contract was terminated and replaced with Provider Service Agreement with MCFI d/b/a Whole Health Clinical Group effective

February 15, 2019. MCFI changed the name of their d/b/a from TLS Behavioral Health to Whole Health Clinical Group. Rather than amending the existing contract, a new contract was executed to reflect the new d/b/a name. This agreement shall automatically renew for successive one-year terms until or unless terminated by either party.

Effective August 26, 2011, the company entered into an Independent Agent/Agency/ Broker Agreement with Humana MarketPoint. The agreement allows Humana MarketPoint to act as an agent for the company's Medicare Advantage products. This agreement was terminated and replaced with a new agreement of the same title effective April 3, 2015. The only changes were formatting and the addition of HIPAA Business Associate Agreement. This agreement shall continue in effect unless terminated by either party.

V. REINSURANCE

The company has reinsurance coverage under the contract outlined below:

Reinsurer:	HM Life Insurance Company
Type:	Specific Excess of Loss Reinsurance
Effective date:	January 1, 2018
Retention:	$235,000 per member per agreement year
Coverage:	90% of services other than transplant services, 90% of approved transplants, and 50% of non-approved transplants.
Termination:	December 31, 2018

The reinsurance policy has an endorsement containing the following insolvency provisions:

1. Reinsurer will continue plan benefits for members who are confined in an acute-care hospital on i) the date of insolvency until their discharge or ii) the date the member becomes covered for health coverage or benefits under another group or blanket policy or plan or any federal, state, or local governmental plan or program or iii) 365 days from the date in which the company's insolvency occurs.

2. The reinsurer will continue plan benefits for any member insured plan until the end of the contract period for which premiums have been paid to plan by that member or on his behalf.

3. In the event the company shall become insolvent while the agreement is in force, the aggregate maximum liability of the reinsurer pursuant to this insolvency provision shall be $5,000,000.

VI. FINANCIAL DATA

The following financial statements reflect the financial condition of the company as reported to the Commissioner of Insurance in the December 31, 2018, annual statement. Adjustments made as a result of the examination are noted at the end of this section in the area captioned "Reconciliation of Capital and Surplus per Examination." Also included in this section are schedules that reflect the growth of the company and the compulsory and security surplus calculation.

Independent Care Health Plan
Assets
As of December 31, 2018

	Assets	Nonadmitted Assets	Net Admitted Assets
Bonds	$50,459,568	$	$50,459,568
Cash, cash equivalents and short-term investments	20,356,088		20,356,088
Receivable for securities	7,418		7,418
Investment income due and accrued	224,847		224,847
Uncollected premiums and agents' balances in the course of collection	1,086,971	74,709	1,012,262
Accrued retrospective premiums and contracts subject to redetermination	6,393,914		6,393,914
Other amounts receivable under reinsurance contracts	91,972		91,972
Net deferred tax asset	1,833,542		1,833,542
Electronic data processing equipment and software	1,467,569	1,225,884	241,685
Furniture and equipment, including health care delivery assets	1,702,594	1,702,594	
Health care and other amounts receivable	10,141,416	3,562,173	6,579,243
Write-ins for other than invested assets:			
Other Assets Nonadmitted - Prepaids	338,251	338,251	
Corporate Owned Life Insurance	77,650		77,650
Total Assets	$94,181,800	$6,903,611	$87,278,189

Independent Care Health Plan
Liabilities and Net Worth
As of December 31, 2018

Claims unpaid		$39,483,448
Unpaid claims adjustment expenses		476,206
Aggregate health policy reserves		3,235,175
General expenses due or accrued		5,464,400
Current federal and foreign income tax payable and interest thereon		212,748
Amounts withheld or retained for the account of others		23,628
Payable for securities		516,157
Liability for amounts held under uninsured accident and health plans		5,186,852
Aggregate write-ins for other liabilities (including $(0) current)		172,636
Total Liabilities		54,771,250
Common capital stock	$ 2	
Gross paid in and contributed surplus	4,271,027	
Unassigned funds (surplus)	28,235,910	
Total Capital and Surplus		32,506,939
Total Liabilities, Capital and Surplus		$87,278,189

Independent Care Health Plan
Statement of Revenue and Expenses
For the Year 2018

Net premium income		$285,705,729
Change in unearned premium reserves and reserve for rate credits		(584,497)
Total revenues		285,121,232
Medical and Hospital:		
Hospital/medical benefits	$206,060,559	
Other professional services	7,285,934	
Prescription drugs	15,931,486	
Subtotal	229,277,979	
Less		
Net reinsurance recoveries	258,084	
Total medical and hospital	229,019,895	
Claims adjustment expenses	23,538,834	
General administrative expenses	23,501,087	
Increase in reserves for Life and Accident and Health contracts	2,650,678	
Total underwriting deductions		278,710,494
Net underwriting gain or (loss)		6,410,738
Net investment income earned	962,771	
Net realized capital gains or (losses)	(196,032)	
Net investment gains or (losses)		766,739
Net income or (loss) before federal income taxes		7,177,477
Federal and foreign income taxes incurred		2,605,331
Net Income (Loss)		$4,572,146

Independent Care Health Plan
Capital and Surplus Account
For the Five-Year Period Ending December 31, 2018

	2018	2017	2016	2015	2014
Capital and surplus, beginning of year	$29,281,044	$27,397,493	$27,526,671	$22,189,188	$20,834,015
Net income (loss)	4,572,146	2,801,652	(515,371)	5,291,577	1,796,022
Change in net deferred income tax	806,621	(474,307)	241,284	264,189	13,662
Change in nonadmitted assets	(2,152,872)	(443,794)	394,909	(218,283)	(454,511)
Dividends to stockholders			(250,000)		
Surplus, End of Year	$32,506,939	$29,281,044	$27,397,493	$27,526,671	$22,189,188

Independent Care Health Plan
Statement of Cash Flow
For the Year 2018

Premiums collected net of reinsurance			$282,346,479
Net investment income			1,128,608
Total			283,475,087
Less:			
Benefit- and loss-related payments		$232,266,867	
Commissions, expenses paid and aggregate write-ins for deductions		46,409,316	
Federal and foreign income taxes paid (recovered) $0 net tax on capital gains (losses)		1,724,999	
Total			280,401,182
Net cash from operations			3,073,905
Proceeds from Investments Sold, Matured or Repaid:			
Bonds	$12,995,499		
Net gains (losses) on cash, cash equivalents, and short-term investments	(167)		
Miscellaneous proceeds	528,468		
Total investment proceeds		13,523,800	
Cost of Investments Acquired—Long-term Only:			
Bonds		23,882,971	
Net cash from investments			(10,359,171)
Cash Provided/Applied:			
Other cash provided (applied)			(458,927)
Net Change in Cash, Cash Equivalents, and Short-Term Investments			(7,744,193)
Cash, cash equivalents, and short-term investments:			
Beginning of year			28,100,281
End of Year			$20,356,088

Growth of Independent Care Health Plan

Year	Assets	Liabilities	Capital and Surplus	Premium Earned	Medical Expenses Incurred	Net Income
2018	$87,278,189	$54,771,250	$32,506,939	$285,121,232	$229,019,895	$4,572,146
2017	78,481,658	49,200,614	29,281,044	227,977,127	190,108,402	2,801,652
2016	71,162,030	43,764,537	27,397,493	215,084,950	180,940,174	(515,371)
2015	68,248,215	40,721,544	27,526,671	210,927,248	169,085,113	5,291,577
2014	55,436,938	33,247,750	22,189,188	175,467,752	144,366,717	1,796,022

Year	Profit Margin	Medical Expense Ratio	Administrative Expense Ratio	Change in Enrollment
2018	1.6%	80.3%	16.5%	17.1%
2017	1.2	83.4	15.1	10.2
2016	-.2	84.1	15.7	4.8
2015	2.5	80.2	15.5	8.4
2014	1.0	82.3	16.0	60.0

Enrollment and Utilization

Year	Enrollment	Hospital Days/1,000	Average Length of Stay
2018	35,304	1,773.9	5.8
2017	30,149	1,834.7	6.0
2016	27,360	1,899.5	6.2
2015	26,106	1,838.8	5.7
2014	24,080	2,345.5	6.1

Per Member Per Month Information

	2018	2017	Percentage Change
Premiums:			
Medicare	$1,495.68	$1,409.18	6.1%
Medicaid	466.13	414.52	12.4
Expenses:			
Hospital/medical benefits	508.78	491.40	3.5
Other professional services	17.99	13.16	36.7
Prescription drugs	39.34	44.80	-12.2
Less: Net reinsurance recoveries	.64	.71	-10.1
Total medical and hospital	565.47	548.64	3.1
Claims adjustment expenses	58.12	48.15	20.7
General administrative expenses	58.03	51.15	13.4
Total underwriting deductions	$681.61	$647.93	5.2

Assets increased from $55.4 million in 2014 to $87.3 million in 2018, primarily due to favorable results from operations over the last five years, consistent with the growth in business. Liabilities increased from $33.2 million in 2014 to $54.8 million in 2018, primarily due to the increase in claims unpaid from $27.7 million in 2014 to $39.5 million in 2018. Surplus increased from $22.2 million in 2014 to $32.5 million in 2018, primarily due to favorable net income results over the five-year period, except in 2016 when there was a net loss of $515,371 due to underwriting and investment results.

Medical expenses increased $38.9 million in 2018 from $190.1 million in 2017 due to higher enrollment, offset by the release of favorable prior year reserve development. The favorable reserve development included the impact of changes in the reserve policy in 2018 approved by the Audit Committee. It reduced the length of time that reserves for inpatient claims are held and reduced the explicit margin on reserves from 17% to 12%. The policy change resulted in a $6.8 million favorable impact to the net underwriting gain. General administrative expenses in 2018 were higher by 13.4% compared with 2017 due to staff additions, higher claim processing charges due to higher enrollment, as well as Affordable Care Act (ACA) Section 9010 Assessment expense for 2018 versus no expense in 2017 due to suspension.

Enrollment increased from 24,080 members in 2014 to 35,304 members in 2018, while the average length of hospital stays decreased from 6.1 days in 2014 to 5.8 days in 2018. In 2014, total enrollment increased by 60% compared with 2013. The increase was primarily due to program changes in 2014. Effective July 1, 2014, the Medicaid BadgerCare plan included childless adults as well as pregnant women and children who meet certain qualifications, which resulted in an increase in members under this plan from 978 in 2013 to 9,253 in 2014. Enrollment in the Medicaid BadgerCare plan continued to grow to 16,605 members in 2018.

In 2010, the company added the Family Care Partnership program to its product line. This is a capitated integrated Medicaid and Medicare managed care program that provides long-term care benefits in addition to the primary and acute managed health care benefits provided under the Medicare Advantage Special Needs Plan (MA-SNP) and/or Medicaid SSI programs. Enrollment in FCP grew from 794 members in 2014 to 1,014 members in 2018.

Premiums per member per month increased by 6.1% and 12.4% in Medicare and Medicaid, respectively, in 2018 compared with 2017. The increase was primarily due to higher premium rates in Medicaid SSI, MA-SNP and FCP, offset by lower rates in BadgerCare.

Financial Requirements

The financial requirements for an HMO under s. Ins 9.04, Wis. Adm. Code, are as follows:

		Amount Required
1.	Minimum capital or permanent surplus	Either: $750,000, if organized on or after July 1, 1989 or $200,000, if organized prior to July 1, 1989
2.	Compulsory surplus	the greater of $750,000 or: If the percentage of covered liabilities to total liabilities is less than 90%, 6% of the premium earned in the previous 12 months; If the percentage of covered liabilities to total liabilities is at least 90%, 3% of the premium earned in the previous 12 months
3.	Security surplus	the greater of: 140% of compulsory surplus reduced by 1% of compulsory surplus for each $33 million of additional premiums earned in excess of $10 million or 110% of compulsory surplus

Covered liabilities are those due to providers who are subject to statutory hold-harmless provisions.

The company's calculation as of December 31, 2018, is as follows:

Assets		$87,278,189
Less:		
Liabilities		54,771,250
Assets available to satisfy surplus requirements		32,506,939
Net premium earned		
HMO business	$285,121,232	
Factor	3%	
Compulsory surplus		8,553,636
Compulsory Surplus Excess (Deficit)		$23,953,303
Assets available to satisfy surplus requirements		$32,506,939

Compulsory surplus	$8,553,636	
Security factor	132%	
Security surplus		11,290,799
Security Surplus Excess (Deficit)		$21,216,140

Reconciliation of Capital and Surplus per Examination

No adjustments were made to surplus as a result of the examination. The amount of surplus reported by the company as of December 31, 2018, is accepted.

VII. SUMMARY OF EXAMINATION RESULTS

Compliance with Prior Examination Report Recommendations

There were four specific comments and recommendations in the previous examination report. Comments and recommendations contained in the last examination report and actions taken by the company are as follows:

1. Business Plan Reporting—It is recommended the company file a business plan amendment per s. Ins 9.06 (1), Wis, Adm. Code, when changes are made to the company geographic service area.

   Action—Compliance.

2. Conflict of Interest Statements—It is recommended the company complete conflict of interest statements for all board members upon appointment to the board and annually thereafter.

   Action—Compliance.

3. Affiliated Agreement Reporting—It is recommended that the company report all affiliated agreements in accordance with s. 617.21, Wis. Stat., and s. Ins 40.04 (2) (d), Wis. Adm. Code.

   Action—Noncompliance. Further comment is contained in the section of this report captioned, "Affiliated Agreements."

4. Premium Deficiency Reserves—It is recommended the company document the procedures performed to determine if a premium deficiency reserve shall be accrued in accordance with SSAP No. 54, par. 19, for each grouping where a premium deficiency exists.

   Action—Compliance.

Summary of Current Examination Results

This section contains comments and elaboration on those areas where adverse findings were noted or where unusual situations existed. Comment on the remaining areas of the company's operations is contained in the examination work papers.

Corporate Governance

The current examination included a review of biographical reports on newly elected or appointed officers and directors based on the names listed in the Annual Statement jurat pages for the years 2014 to 2018. Based on the review, it was noted the company did not submit the required biographical report for two officers during the years they were appointed and held office. According to s. Ins 6.52 (5), Wis. Adm. Code, a biographical report shall be provided by each domestic insurer to which this rule applies for any new director, trustee or officer elected or appointed within 15 days after such election or appointment. Such a report shall be prepared by the company in form and substance substantially in accordance with Form A, as provided by s. Ins 6.52, Wis. Adm. Code. It is recommended that the company submit a complete biographical report for each newly appointed or elected director, trustee, or officer in accordance with s. Ins 6.52 (5), Wis. Adm. Code.

Affiliated Agreements

The current examination included a review of affiliated contracts and amendments to affiliated contracts. Based on the review, several contracts and/or amendments were found not reported to the commissioner for non-disapproval before the company entered into the transactions. These were:

1. Long-Term Care (LTC) Services Agreement with Milwaukee Center for Independence (MCFI) effective July 1, 2015, and subsequent amendments. This contract replaced the original LTC Services Agreement with MCFI that was effective January 1, 2010. The amendments were related to additions/changes to services covered, change in rates, and procedures covered.

2. Several amendments and an addendum to LTC Services Agreement with MCFI Home Health Care, LLC (Home Care). The amendments were related to additions/changes to services covered, training service for unpaid caregivers, and updates or changes in rates.

3. Provider Service Agreement with MCFI d/b/a Whole Health Clinical Group effective February 15, 2019. This contract replaced the original provider services agreement with MCFI d/b/a Transitional Living Services Behavioral Health (TLS Behavioral Health) that was effective March 1, 2014. Rather than amending the original contract, a new contract was executed to reflect the new d/b/a name.

4. Agent/Agency/Broker Agreement with Humana MarketPoint effective April 3, 2015. This contract replaced the original agreement that was effective August 26, 2011. The changes were formatting and the addition of HIPAA Business Associate Agreement.

Note: The above contracts are discussed in detail under Section IV, "Affiliated Companies" of this examination report.

According to s. 617.21, Wis. Stat., and s. Ins. 40.04 (2) (d), Wis. Adm. Code, a domestic insurer must report all transactions, including amendments or modifications of transactions previously filed, to the commissioner in writing at least 30 days before the insurer enters into the transaction unless the commissioner in writing approves a shorter period. Furthermore, under s. Ins. 40.17, Wis. Adm. Code, an insurer required to give notice of a proposed transaction must furnish the required information on Form D. It is again recommended that the company report all affiliated agreements, including amendments, in accordance with s. Ins 40.04 (2) (d), Wis. Adm. Code, and s. 617.21 (2), Wis. Stat. The company shall use Form D in reporting these transactions in accordance with s. Ins. 40.17, Wis. Adm. Code.

VIII. CONCLUSION

Independent Care Health Plan is equally owned as a joint venture between Care Network, Inc. (a Humana subsidiary) and Centers for Independence, Inc., a Milwaukee-based social services agency. The company offers a comprehensive health and social services program for individuals ages 19 and over with special needs who receive both Medicaid and Supplemental Security Income (SSI) benefits.

Over the years, iCare expanded its product offering to include Medicaid BadgerCare, which covers childless adults and women and children who meet certain qualifications. The company added the Family Care Partnership program, which is a capitated integrated Medicaid and Medicare managed care program that provides long-term care benefits in addition to the primary and acute managed health care benefits provided under the Medicare Advantage Special Needs Plan and/or Medicaid SSI programs. With these expansions, enrollment increased from approximately 24,000 members in 2014 to more than 35,000 members in 2018.

Consistent with the growth in business, the company's assets, liabilities, and surplus also increased significantly over the last five years. Assets increased by 57%, liabilities increased by 65%, and surplus increased by 46% from 2014. The company reported positive net income in each of the last five years, except in 2016 when there was a net loss of $515 thousand due to underwriting and investment results. Overall, operations resulted in an average annual net income of $2.8 million over the last five years.

Currently, the company contracts with six IPAs, 78 hospitals and clinics, and over 6,000 physicians to provide primary and specialty health care services covered under the benefits of Medicare and Medicaid services as outlined in the contracts with the Wisconsin Department of Health Services and the Centers for Medicare and Medicaid Services.

The examination resulted in two recommendations, with one repeated from the previous examination. There were no adjustments to surplus or reclassifications required as a result of the examination.

IX. SUMMARY OF COMMENTS AND RECOMMENDATIONS

1. Page 28 Corporate Governance—It is recommended that the company submit a complete biographical report for each newly appointed or elected director, trustee, or officer in accordance with s. Ins 6.52 (5), Wis. Adm. Code.

2. Page 28 Affiliated Agreements—It is again recommended that the company report all affiliated agreements, including amendments, in accordance with s. Ins 40.04 (2) (d), Wis. Adm. Code, and s. 617.21 (2), Wis. Stat. The company shall use Form D in reporting these transactions in accordance with s. Ins. 40.17.

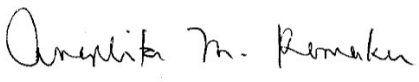
X. ACKNOWLEDGMENT

The courtesy and cooperation extended during the course of the examination by the officers and employees of the company are acknowledged.

In addition to the undersigned, the following representatives of the Office of the Commissioner of Insurance, State of Wisconsin, participated in the examination:

Name	Title
Gabriel Gorske	Insurance Financial Examiner
David Jensen, CFE	IT Specialist
Karl Albert, CFE	Workpaper Specialist
Jerry DeArmond, CFE	Reserve Specialist

Respectfully submitted,



Angelita Romaker
Examiner-in-Charge