Report

of the

Examination of

Managed Health Services Insurance Corp.

St. Louis, Missouri

As of December 31, 2017

TABLE OF CONTENTS

Page

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Tony Evers, *Governor*
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April 17, 2019

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:

MANAGED HEALTH SERVICES INSURANCE CORP.
Milwaukee, Wisconsin

and this report is respectfully submitted.

I. INTRODUCTION

The previous examination of Managed Health Services Insurance Corp. (MHSIC or the company) was conducted in 2013 as of December 31, 2012. The current examination covered the intervening period ending December 31, 2017, and included a review of such 2018 and 2019 transactions as deemed necessary to complete the examination.

The examination of the company was conducted concurrently with the examination of Superior HealthPlan, Inc. Representatives of the Texas Department of Insurance acted in the capacity as the lead state for the coordinated examinations. Work performed by the Texas Department of Insurance was reviewed and relied on where deemed appropriate.

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.

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

Managed Health Services Insurance Corp., is 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 clinics and/or independent contracting physicians operating out of their separate offices. HMOs compete with traditional fee-for-service health care delivery.

MHSIC was incorporated August 31, 1990, as a wholly owned stock insurer subsidiary of Managed Health Services, Inc. (MHSI), a Wisconsin non-stock, not-for-profit corporation. The HMO commenced business on December 17, 1990. On September 8, 1993, Coordinated Care Corporation (CCC), a Wisconsin stock corporation, acquired 100% of the outstanding common stock of MHSIC from MHSI. On November 20, 1996, the name of Coordinated Care Corporation was changed to Centene Corporation (CC).

The company has had several acquisitions/mergers since its acquisition by Coordinated Care Corporation.

- MHSIC purchased Genesis Health Plan Insurance Corporation (GHPIC) on September 1, 1997. MHSIC and GHPIC were merged with MHSIC as the surviving company.
- On October 1, 1998, MHSIC acquired Maxicare Health Insurance Company (Maxicare). Maxicare continued to exist as a separate company until December 31, 1999, when it was merged into the company with MHSIC being the surviving entity.
- On February 1, 2001, MHSIC purchased the Medicaid/BadgerCare line of business from Humana Wisconsin Health Organization Insurance Corporation. Approximately 35,000 Medicaid enrollees were transferred to MHSIC.

MHSIC derives all of its revenue from the Wisconsin Title XIX Medical Assistance BadgerCare (BC+) and Supplemental Security Income (SSI) Programs and from Medicare as a Medicare Advantage Special Needs Plan. The HMO contracts directly with the Wisconsin Department

of Health Services (DHS) to provide health care benefits to eligible Medical Assistance (Medicaid) recipients. In addition, the HMO provides benefits to the Medicaid enrollees of another HMO, Network Health Plan (NHP), through a subcontract under which MHSIC accepts all financial risk in exchange for a percentage of the capitation payments received by NHP from DHS. See the table below for a revenue and enrollment breakout.

	Revenue	Enrollment
Managed Health Services BC+	$ 60,849,352	30,881
Managed Health Services SSI	18,711,990	3,920
Managed Health Services HIM**	142,374	
Medicare	12,438,127	955
Network Health Plan BC+	61,169,207	32,164*
Network Health Plan SSI	10,026,603	2,255*
Total	$163,337,653	433,774

*NHP enrollment is not reported on MHSIC's annual statement.
** Health Insurance Marketplace

The HMO provides primary and specialty health services to Medicaid/BadgerCare and Medicare enrollees through contractual arrangements with physicians, independent practice associations (IPAs), group practices, physician-hospital organizations (PHOs), and clinics. Physician services are reimbursed on either a capitated or fee schedule basis. There are 1,849 clinics that serve the Medicaid/BadgerCare and Medicare enrollees.

The contracts include hold-harmless provisions for the protection of policyholders, have a one-year term, and automatically renew unless terminated by either party giving written notice to the other party at least 90 days prior to the end of the initial or renewed term. In addition, the contracts require physicians to participate in and contribute information for the company's quality improvement and utilization management programs and abide by applicable provisions of the contract with DHS and the Centers for Medicare & Medicaid Services (CMS).

Inpatient services to Medicaid enrollees are provided through contracts with 126 hospitals. The hospitals are paid on a DRG or per diem basis. The contracts include hold-harmless provisions for the protection of policyholders, automatically renew for one-year terms, and may be terminated by either party upon 120-days' written notice prior to the next termination date of the contract between the HMO and DHS or CMS.

The HMO's service area for BadgerCare Plus and Medicaid SSI population is comprised of the following 52 counties:

Adams	Eau Claire	Marinette	Sauk
Ashland	Florence	Marquette	Sawyer
Barron	Fond du Lac	Menominee	Shawano
Bayfield	Forest	Milwaukee	Sheboygan
Brown	Grant	Monroe	Taylor
Burnett	Green Lake	Oconto	Trempealeau
Calumet	Iowa	Oneida	Vernon
Chippewa	Jackson	Outagamie	Vilas
Clark	Jefferson	Ozaukee	Walworth
Columbia	Kenosha	Pierce	Washburn
Crawford	Kewaunee	Polk	Washington
Dane	La Crosse	Portage	Waukesha
Dodge	Langlade	Price	Waupaca
Door	Lincoln	Racine	Waushara
Douglas	Manitowoc	Rock	Winnebago
Dunn	Marathon	Rusk	Wood

Benefits for its BadgerCare/Medicaid SSI members are provided for in the contract between MHSIC and DHS. Coverage must be consistent with coverage specified in the State Plan; however, the HMO retains the right to determine the medical necessity of a covered service and to require prior authorization of certain services that it identifies.

The HMO's service area for the Medicare Advantage Special Needs Plan is comprised of the following 25 counties:

Adams	Marquette	Shawano
Brown	Menominee	Sheboygan
Calumet	Milwaukee	Taylor
Kenosha	Oconto	Washington
Kewaunee	Outagamie	Waukesha
Langlade	Ozaukee	Waupaca
Lincoln	Portage	Waushara
Marathon	Racine	Wood
Marinette		

Benefits for its Medicare members are provided for in the contract between MHSIC and CMS. Coverage must be consistent with coverage specified in the Medicare coverage rules; however, the HMO retains the right to determine the medical necessity of a covered service and to require prior authorization of certain services that it identifies.

III. MANAGEMENT AND CONTROL

Board of Directors

The board of directors consists of 10 members. All directors are elected annually to serve a one-year term. Officers are elected 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 HMO group. The board members currently receive $500 per meeting for serving on the board.

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

Name and Residence	Principal Occupation	Term Expires
John Finerty, Jr., Chair Milwaukee, WI	Attorney Michael Best & Friedrich, LLP	2018
John Bartkowski, PhD Glendale, WI	Retired Health Administrator	2018
Keith Williamson St. Louis, MO	Executive Vice President, Secretary/General Counsel Centene Corporation	2018
Corey Hoze Milwaukee, WI	Senior Vice President Associated Bank Corp.	2018
Sherry Husa Plainfield, IL	President, Chief Executive Officer Managed Health Services Ins. Corp.	2018
Antonio, Perez Milwaukee, WI	Executive Director Housing Authority, city of Milwaukee	2018
Joan Prince, PhD Glendale, WI	Vice Chancellor University of WI - Milwaukee	2018
James Villa Milwaukee, WI	Chief Executive Officer NAIOP Commercial Real Estate Dev Assoc.	2018
John Waeltz, MD Glendale, WI	OB/GYN Glen Point OB/GYN	2018
Sheldon Wasserman Glendale, WI	OB/GYN Milwaukee	2018

Officers of the Company

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

Name	Office	2017 Compensation
Sherry B. Husa	President/CEO	$1,215,969
Keith H. Williamson	Secretary	67,387
Jeffrey A. Schwaneke	Treasurer	72,409
Sandra S. Tunis	SVP Compliance	358,179
Robert K. Lyon	Chief Medical Director	470,726

*The officers' salaries are paid by Centene Management Company LLC, a wholly owned subsidiary of Centene Corporation, through a management agreement with MHSIC. The salaries shown above are the amounts allocated to MSHIC through the management agreement.

Committees of the Board

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

Strategic Planning Committee
John D. Finerty, Jr., Chair*
Sherry B. Husa*
Corey Hoze*
Antonio Perez*

* Indicates committee member is on the board of directors

The company has no employees. Necessary staff is provided through a management agreement with Centene Management Company LLC, (CMC), a wholly owned subsidiary of Centene Corporation. Under the agreement, effective January 1, 1997, CMC agrees to provide the company with administrative and financial services necessary to manage its business operations and agrees to assume responsibility for all costs associated therewith. Areas/systems for which CMC assumes responsibility, under the terms of the agreement, include the following: program planning and development, management information systems, financial systems and services, claims administration, provider and enrollee services and records, utilization review, quality assurance/quality improvement, and marketing services. CMC receives a management fee of 12% of gross monthly revenues (payable on the first day of the month based on estimated gross revenue). The term of the agreement is five years and shall automatically renew for additional five-year terms. The company may terminate the agreement upon 30-days' written notice if the default of standards of performance continues 60 days after notice of such default.

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

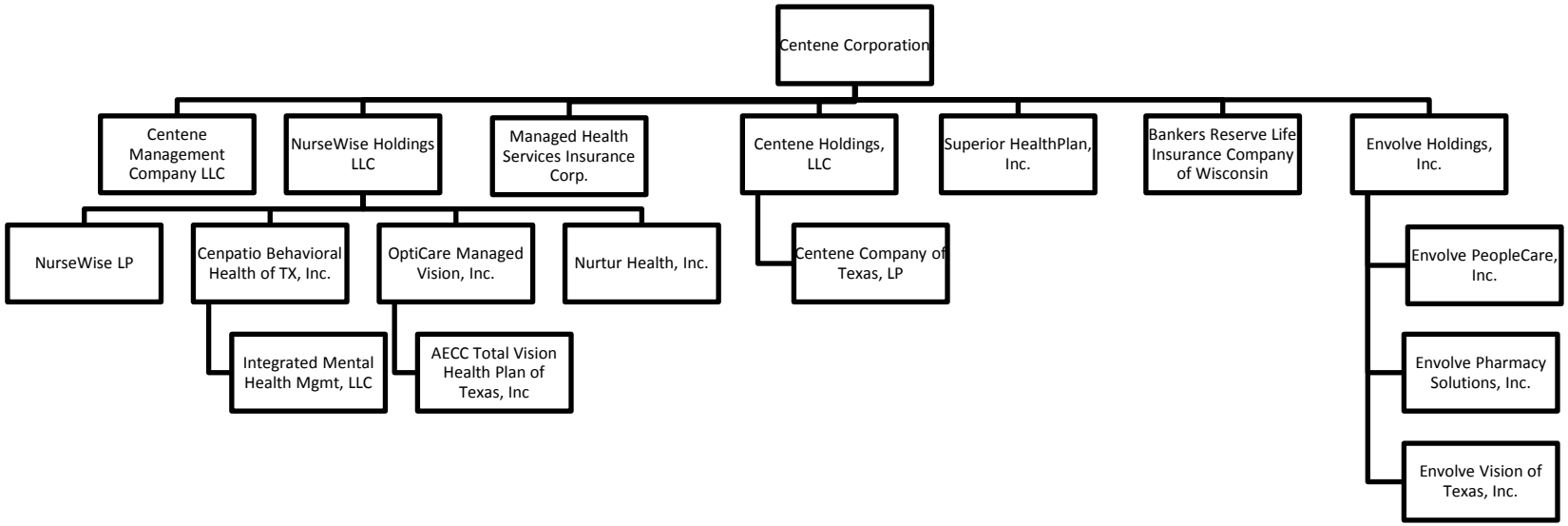
2. Enrollees will be entitled to similar, alternate coverage which does not contain any medical underwriting or preexisting limitation requirements.

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. Its ultimate parent is Centene Corporation. The abbreviated organizational chart on the next page depicts the relationships among the company and certain 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, 2017



Note: Not all of the subsidiaries of Centene Corporation have been included in this organizational chart as there were 235 companies in the group as of December 31 2017.

Centene Corporation

Centene Corporation, originally incorporated in 1993 as Coordinated Care Corporation, is a publicly held, for-profit company, headquartered in St. Louis, Missouri. It is the ultimate controlling person in the holding company system. It is a multi-line health care enterprise operating in two segments: Medicaid managed care and specialty services. Centene's Medicaid managed care segment provides Medicaid and Medicaid-related health plan coverage to individuals through government subsidized programs, including Medicaid, the State Children's Health Insurance Program, or CHIP, foster care, long-term care, Medicare special needs plans, and the Supplemental Security Income Program, also known as the Aged, Blind or Disabled Program, or collectively ABD.

As of December 31, 2017, the audited financial statements of Centene Corporation reported assets of $21.9 billion, liabilities of $15.0 billion, and stockholders' equity of $6.9 billion. Operations for 2017 produced net earnings of $828 million.

Centene Management Company LLC

Centene Management Company LLC (CMC), originally incorporated in 1996 as Coordinated Care Medicaid Management Corporation, was created to provide management and administrative services to Centene Corporation's HMO subsidiaries. CMC, a wholly owned subsidiary of Centene Corporation, is a for-profit corporation that holds management agreements with Centene's subsidiaries and employs all staff, both at corporate headquarters and at the health plans. Licenses and certifications as required by individual state regulations are current. Specifically, in Wisconsin, CMC holds a license as an Employee Benefit Plan Administrator. The unaudited financial results reported assets of $13.1 million, liabilities of $12.0 million, and stockholders' equity of $0.8 million. Operations for 2017 resulted in net earnings of $0.1 million on revenues of $2.2 million.

Bankers Reserve Life Insurance Company of Wisconsin

Bankers Reserve Life Insurance Company of Wisconsin is licensed in 42 states and only directly writes business in the State of Texas. The company was incorporated under the laws of Wisconsin on January 5, 1961, and commenced business on July 29, 1964. The company became a member of the holding group on March 1, 2002, when it was purchased by the Centene Corporation. The company primarily provides managed care services to individuals receiving benefits under the

State of Texas Children's Health Insurance Program (CHIP) and Foster Care Program. The company provides these services under separate contracts with the Texas Health and Human Services Commission. The company assumes reinsurance from eight Centene affiliates, including MHSIC, and retrocedes a portion of the risk to an external reinsurer.

As of December 31, 2017, the company's audited financial statements reported assets of $410 million, liabilities of $219 million, and capital and surplus of $191 million. Operations for 2017 produced a net loss of $66 million on revenues of $1.9 billion.

Sunshine State Health Plan, Inc.

Sunshine State Health Plan, Inc., is a wholly owned subsidiary of Centene Corporation. The company was incorporated under the laws of Florida on April 3, 2007, as a health maintenance organization (HMO) for the purpose of providing comprehensive managed health care services to low-income (primarily Medicaid-eligible) residents of Florida. As of December 31, 2017, the company's audited financial statements reported assets of $736 million, liabilities of $367 million, and capital and surplus of $369 million. Operations for 2017 produced a net income of $5.9 million on revenues of $3.8 billion.

Superior HealthPlan, Inc.

Superior HealthPlan, Inc., is a wholly owned subsidiary of Centene Corporation. The company was incorporated under the laws of Texas on February 14, 2007, as a network model health maintenance organization (HMO). The company holds a contract with Texas Health and Human Services to provide Medicaid, State Children's Health Insurance Program, and Supplemental Security Income Program managed care services. The company also holds a contract with the Centers for Medicare and Medicaid Services to participate in the Medicare Advantage Program. As of December 31, 2017, the company's audited financial statements reported assets of $754 million, liabilities of $384 million, and capital and surplus of $369 million. Operations for 2017 produced net income of $64 million on revenues of $3,957 million.

Agreements with Affiliates

The company has entered into numerous affiliated agreements. These agreements are described below:

- Effective December 31, 2002, the company entered into a tax-sharing agreement with Centene Corporation (Centene). Under this agreement, Centene will file a consolidated tax return for member companies; member companies, in turn, agree to make quarterly payments to Centene in an amount equal to the full separate federal, state, and local income tax liability attributable to the net taxable income of each member that would have been paid if such member had filed separate federal, state, and local tax returns.
- Effective January 1, 1997, (last amended January 1, 2015), the company entered into an administrative service agreement with Centene Management Company LLC (CMC). This agreement is discussed in the section of the report captioned "Management and Control."
- Effective March 1, 2006 (last amended October 1, 2010), the company entered into a pharmacy benefit management agreement with US Script, Inc. Under the agreement, US Script, Inc., provides the company's members with access to their pharmacy network. This agreement automatically renews in one-year periods, unless either party gives 90-days' written notice.
- Effective January 1, 2008 (last amended February 17, 2010), the company entered into a service agreement with NurseWise, LP. Under this agreement, NurseWise, LP has established a toll-free bilingual care line. Professional nurses employed by NurseWise, LP respond to inquiries on matters for eligible individuals and their eligible dependents that are enrolled in MHSIC's covered plans.
- Effective July 1, 2007 (last amended January 1, 2010), the company entered into an agreement with OptiCare Vision Company d/b/a/ OptiCare Managed Vision (Vision Network). MHSIC is responsible for administrative activities necessary to fulfill the obligations such as quality-improvement process, utilization management, marketing, customer service, claims processing, benefits and eligibility verification, accounts receivable collection, maintenance of provider directory and records, and development of contracts with providers of covered services. Vision Network is responsible for ongoing network development and network maintenance, including provision for covered services, credentialing criteria, determination of covered person eligibility, emergency care, compliance with policies, acceptance of new

patients, referrals, drug formulary, network provider responsibilities, non-discrimination, medical records, advance directives, quality improvement, utilization management program, grievance and appeals procedures, encounter data, financial records, non-solicitation, new or modified product attachments, provider listings, compliance with laws, and information systems. This agreement shall automatically renew for successive one-year periods unless either party gives 180-days' written notice.

- Effective January 1, 2008 (last amended January 1, 2011), the company entered into a behavioral health services agreement with Cenpatico Behavioral Health LLC (Behavior Network). The Behavior Network is engaged in the business of arranging for the provision of covered behavioral health services. Behavior Network shall be responsible for ongoing network development and network maintenance, including provision for covered services, credentialing criteria, determination of covered person eligibility, emergency care, compliance with policies, acceptance of new patients, referrals, drug formulary, network provider responsibilities, non-discrimination, medical records, advance directives, quality improvement, utilization management program, grievance and appeals procedures, encounter data, financial records, non-solicitation, new or modified product attachments, provider listings, compliance with laws, and information systems. This agreement shall automatically renew for successive one-year periods unless either party gives 180-days' written notice.
- Effective February 1, 2008 (last amended November 1, 2009), the company entered into a disease management program services agreement with Nurtur Health, Inc. MHSIC arranges for provisions of health care services, including disease prevention services and chronic disease management services to members. Nurtur Health, Inc., also entered into a disease management program services agreement with MHSIC to provide disease management services to members enrolled in the BadgerCare, BadgerCare Plus, and SSI program. This agreement shall automatically renew in one-year periods unless either party gives 90-days' written notice.
- Effective January 1, 2014, (last amended January 1, 2016), the company entered into a pharmacy benefit management agreement with Envolve Pharmacy Solutions. Under the

agreement, Envolve Pharmacy Solutions provides the company's members under the commercial exchange/Marketplace product with access to their pharmacy network. This agreement automatically renews in one-year periods, unless either party gives 90-days' written notice.

V. REINSURANCE

The company has reinsurance coverage under the contract outlined below:

Affiliated Ceded Reinsurance

1. Reinsurer:	Bankers Reserve Life Insurance Company of Wisconsin
Type:	Specific Excess of Loss Reinsurance
Effective date:	January 1, 2017
Termination:	January 1, 2018
Retention:	Specific deductible per covered person per agreement term: $500,000
Maximum coverage:	The maximum payable per covered person: $4,600,000
Covered business:	TANF and SSI non-dual covered persons
Coverage:	90% of covered expenses incurred from January 1, 2017, to January 1, 2018, and 90% of covered expenses paid from January 1, 2017, to December 31, 2018. Organ transplant services: reimbursement percentage if performed at a non-approved transplant provider, 50%.
Limitations:	Hospital Inpatient Services: the lesser of • the amount paid • the contracted rate in effect at the time of admission or the applicable Medicaid fee schedule where contracted rates do not exist • billed charges; or • a $15,000 maximum average per diem per discharge Hospital Inpatient Services: the lesser of • the amount paid • the contracted rate • the applicable Medicaid fee schedule where a contracted rate does not exist; or • a $1,000 per diem and limited to 90 days in total for the combination of all categories The approved transplant provider limit is as agreed to in writing by PartnerRe on behalf of the company. Per diem limit is waived for an approved transplant provider case rate.
Insolvency Coverage	BRLIC agrees to provide the following coverage in the event that Managed Health Services Insurance Corp., becomes insolvent: 1. The reinsurer will continue to provide the benefits covered under the applicable membership services agreement with respect to each covered person who is confined in a hospital on the insolvency date for expenses incurred and payable by such covered person on or after such date until the earlier of:

a. the covered person's discharge from the hospital; or
b. the date the covered person becomes eligible for health insurance coverage or benefits under another group or blanket policy or plan or any federal, state, or local government plan or program.

2. The reinsurer will continue the benefits for any other covered person with respect to expenses incurred for medical services or treatment by providers received after the insolvency date until the end of the period for which applicable premium was received by the reinsured for that covered person, prior to the insolvency date, but in no event to extend beyond the end of the calendar month in which the insolvency date occurs.

This insolvency coverage is subject to a $4,600,000 maximum.

Nonaffiliated Ceding Contracts

2. Reinsurer:	PartnerRe America Insurance Company
Type:	HMO Specific Excess of Loss Reinsurance
Effective Date:	January 1, 2017
Expiration Date:	January 1, 2018
Retention:	Specific deductible per covered person per agreement term: $1,250,000 Maximum payable per covered person: $3,000,000
Covered business:	Medicare Advantage Special Needs Plan
Coverage:	Covered expenses in excess of $1,250,000 that are referred for audit services are subject to a reimbursement percentage of 90%. Covered expenses in excess of $1,250,000 that are not referred for audit services will be subject to a reimbursement percentage of 80% No coverage is provided if a complete claim is not received by March 1, 2019.
Limitations:	Hospital Inpatient Services: Acute Care Services the lesser of • the amount paid • the contracted rate • the applicable Medicaid fee schedule where a contracted rate does not exist; or • a $15,000 maximum average per diem per discharge Long Term Acute Care Hospital and Sub-Acute Care the lesser of • the amount paid • the contracted rate • the applicable Medicaid fee schedule where a contracted rate does not exist; or • a $1,000 per diem limited to 90 days in total

The per diem limit is waived for an approved transplant provider case rate.

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Insolvency Coverage: In the event of the insolvency of the reinsured, this agreement shall be payable directly to the reinsured or to its liquidator, receiver, conservator, or statutory successor on the basis of the liability of the reinsured without diminution because of the insolvency of the reinsured.

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, 2017, 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 for the period under examination.

Managed Health Services Insurance Corporation
Assets
As of December 31, 2017

	Assets	Nonadmitted Assets	Net Admitted Assets
Bonds	$39,405,126	$	$39,405,126
Stocks:			
Common stocks	1,095,133		1,095,133
Cash, cash equivalents and short-term investments	9,729,920		9,729,920
Other invested assets	1,275,387		1,275,387
Investment income due and accrued	273,110		273,110
Uncollected premiums and agents' balances in the course of collection	8,537,503		8,537,503
Accrued retrospective premiums and contracts subject to redetermination	297,629		297,629
Amounts recoverable from reinsurers	155,458		155,458
Current federal and foreign income tax recoverable and interest thereon	4,682,787		4,682,787
Net deferred tax asset	523,804		523,804
Receivables from parent, subsidiaries and affiliates	892,516	892,516	
Health care and other amounts receivable	4,378,090	770,372	3,607,718
Write-ins for other than invested assets:	55,640		55,640
Total Assets	$71,302,102	$1,662,888	$69,639,214

Managed Health Services Insurance Corporation
Liabilities and Net Worth
As of December 31, 2017

Claims unpaid		$16,566,518
Accrued medical incentive pool and bonus payments		261,998
Unpaid claims adjustment expenses		273,000
Aggregate health policy reserves		242,245
Premiums received in advance		7,996
General expenses due or accrued		769,169
Amounts due to parent, subsidiaries, and affiliates		4,580
Liability for amounts held under uninsured accident and health plans		549,134
Aggregate write-ins for other liabilities (including $[1] current)		215,944
Total liabilities		18,890,584
Aggregate write-ins for special surplus funds	$ 1,795,267	
Common capital stocks	750,000	
Gross paid in and contributed surplus	1,250,000	
Unassigned funds (surplus)	46,953,363	
Total capital and surplus		50,748,630
Total liabilities, capital and surplus		$69,639,214

Managed Health Services Insurance Corporation
Statement of Revenue and Expenses
For the Year 2017

Net premium income		$ 92,141,843
Risk revenue		71,195,810
Total revenues		163,337,653
Medical and Hospital:		
Hospital/medical benefits	$104,204,888	
Other professional services	16,793,474	
Emergency room and out-of-area	13,762,401	
Prescription drugs	824,636	
Incentive pool and withhold adjustments	81,728	
Subtotal	135,667,127	
Less		
Net reinsurance recoveries	56,990	
Total medical and hospital	135,610,137	
Claims adjustment expenses	2,136,314	
General administrative expenses	12,304,720	
Total underwriting deductions		150,051,171
Net underwriting gain or (loss)		13,286,482
Net investment income earned	935,800	
Net realized capital gains or (losses)	9,867	
Net investment gains or (losses)		945,667
Net gain or (loss) from agents' or premium balances charged off		(5,729)
Net income or (loss) before federal income taxes		14,226,420
Federal and foreign income taxes incurred		4,981,443
Net Income (Loss)		$ 9,244,977

Managed Health Services Insurance Corporation
Capital and Surplus Account
For the Five-Year Period Ending December 31, 2017

	2017	2016	2015	2014	2013
Capital and surplus, beginning of year	$51,510,301	$46,591,044	$30,891,508	$26,490,850	$18,245,918
Net income (loss)	9,244,977	9,488,622	15,757,178	6,717,775	8,156,437
Change in net unrealized capital gains/losses	383,136	55,704	41,895	243,408	32,922
Change in net deferred income tax	(389,829)	(102,478)	(118,910)	646,311	(79,664)
Change in nonadmitted assets	44	(522,591)	19,373	(606,836)	135,237
Dividends to stockholders	(10,000,000)	(4,000,000)		(2,600,000)	
Write-ins for gains and (losses) in surplus: Net change in capital and surplus	(761,672)	4,919,257	15,699,536	4,400,658	8,244,932
Surplus, end of year	$50,748,629	$51,510,301	$46,591,044	$30,891,508	$26,490,850

Managed Health Services Insurance Corporation
Statement of Cash Flow
For the Year 2017

Premiums collected net of reinsurance			$ 91,726,169
Net investment income			1,135,278
Miscellaneous income			71,195,810
Total			164,057,257
Less:			
Benefit- and loss-related payments		$136,986,984	
Commissions, expenses paid and aggregate write-ins for deductions		11,238,489	
Federal and foreign income taxes paid (recovered) $0 net tax on capital gains (losses)		5,333,489	
Total			153,558,962
Net cash from operations			10,498,295
Proceeds from investments sold, matured or repaid:			
Bonds	$15,666,929		
Other invested assets	389,404		
Net gains (losses) on cash, cash equivalents, and short- term investments	51		
Miscellaneous proceeds	99,801		
Total investment proceeds		16,156,186	
Cost of investments acquired—long-term only:			
Bonds		16,456,132	
Total investments acquired			
Net cash from investments			(299,946)
Cash provided/applied:			
Dividends to stockholders		10,000,000	
Net cash from financing and miscellaneous sources			(10,000,000)
Net change in cash, cash equivalents, and short-term investments			198,348
Cash, cash equivalents, and short-term investments:			
Beginning of year			9,531,572
End of year			$ 9,729,920

Growth of Managed Health Services Insurance Corporation

Year	Assets	Liabilities	Capital and Surplus	Revenue Earned	Medical Expenses Incurred	Net Income
2017	$69,639,214	$18,890,584	$50,748,630	$163,337,653	$135,610,137	$ 9,244,977
2016	72,288,233	20,777,936	51,510,297	183,619,380	148,869,886	9,488,622
2015	75,737,193	29,146,151	46,591,042	196,772,711	147,924,937	15,757,178
2014	69,019,916	38,128,408	30,891,508	174,619,085	141,975,985	6,717,775
2013	56,856,411	30,365,561	26,490,850	203,658,847	174,457,501	8,156,437
2012	53,129,138	34,883,216	18,245,919	201,949,751	180,491,424	7,131,280

Year	Profit Margin	Medical Expense Ratio	Administrative Expense Ratio	Change in Enrollment
2017	5.6%	83.0%	8.8%	-7.0%
2016	5.1	81.1	11.6	-3.4
2015	8.0	75.2	12.4	-9.2
2014	3.8	81.3	11.8	14.4
2013	4.0	85.7	8.5	-2.3

Enrollment and Utilization

Year	Enrollment*	Hospital Days/1,000	Average Length of Stay
2017	70,175	434.47	4.4
2016	74,331	436.17	4.4
2015	77,157	416.29	4.3
2014	78,712	469.51	4.5
2013	71,447	434.66	4.2

* Includes enrollees served under the NHP subcontract

Per Member Per Month Information

	2017	2016	Percentage Change
Premiums:			
Medicaid	$212.42	$227.46	-6.6%
Risk Revenue	171.54	173.08	-0.9
Blended	192.43	201.53	-4.5
Expenses:			
Hospital/medical benefits	122.77	126.89	-3.2
Other professional services	19.78	19.61	0.9
Emergency room and out-of-area	16.21	15.70	3.3
Prescription drugs (hospital and medical)	0.97	3.38	-71.3
Other medical and hospital	0.00	0.00	0.0
Incentive pool and withhold adjustments	0.10	(0.07)	-232.9
Subtotal (hospital and medical)	159.83	165.50	-3.4
Less: Net reinsurance recoveries	0.07	2.11	-96.8
Total medical and hospital	159.76	163.39	-2.2
Claims adjustment expenses	2.52	2.48	1.6
General administrative expenses	14.50	20.81	-30.3
Increase in reserves for accident and health contracts	0.00	(0.85)	-100.0
Total underwriting deductions	176.78	185.83	-4.9
Net underwriting gain or loss	$ 5.65	$ 15.70	-0.3

The company has been profitable for each of the past five years reporting total net income of $49.4 million. MHSIC paid $16.6 million in dividends to stockholders over the same period. In addition, the company had participated in the Federally Facilitated Health Insurance Exchange. As of January 1, 2017, the company discontinued its participation in the exchange which affected the company's revenue and enrollment.

Total revenue increased by 12.7% to $197 million at year-end 2015 due to the company's continued participation in the BadgerCare program and the growth in the childless adult (CLA) membership within the program. Medical expenses increased in 2016 compared to 2015 due primarily to higher claims expense on the Medicare product. Per member per month premium and medical expenses decreased by 4.5% and 2.2%, respectively, from 2016 to 2017. Total revenue decreased by 11% from $184 million in 2016 to $163 million in 2017. The decrease was primarily due to a decrease in the company's BadgerCare membership and the exit from the exchange noted above. Profit margin increased from 5.1% in 2016 to 5.6% in 2017. The increase is primarily due to the ACA fee moratorium in 2017, the company paid just under $2.0 million or $4.18 per member per month in 2016.

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, 2017, as modified for examination adjustments is as follows:

Assets	$ 69,639,216	
Less: Liabilities	18,890,586	
Assets available to satisfy surplus requirements		$50,748,630
Net premium earned	$163,337,653	
Factor	3%	
Compulsory surplus		4,900,129
Compulsory surplus excess (deficit)		$45,848,501
Assets available to satisfy surplus requirements		$50,748,630
Compulsory surplus	$ 4,900,129	
Security factor	136%	
Security surplus		6,664,175
Security surplus excess (deficit)		$44,084,455

Reconciliation of Capital and Surplus per Examination

No adjustments to surplus or reclassifications were made as a result of the examination.

The amount of surplus reported by the company as of December 31, 2017, is accepted.

VII. SUMMARY OF EXAMINATION RESULTS

Compliance with Prior Examination Report Recommendations

There were no specific comments and recommendations in the previous examination report.

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 review of the company's conflict of interest statements disclosed some individuals listed on the jurat page were either not completing the conflict of interest disclosure forms during the examination period or the disclosure forms were misplaced. It is recommended that the company have its directors, officers, and key employees complete a conflict of interest questionnaire annually as required by a directive of the Office of the Commissioner of Insurance and maintain a record of the signed questionnaire.

Executive Compensation

The State of Wisconsin requires all domestic insurance companies to file a Report on Executive Compensation. According to s. 611.63 (4), Wis. Stat., the amount of all direct and indirect remuneration for services should include retirement and other deferred compensation benefits, paid or accrued each year for the benefit of each director and each officer and employee whose remuneration exceeds the specified amount. The review of the company's executive compensation revealed that the company excluded the employer's portion of the defined contribution plan. The company should include all remuneration paid or accrued under the defined contribution plan on behalf of each reportable employee in the Report on Executive Compensation. It is recommended that the company properly complete the Report of Executive Compensation as required by s. 611.63 (4), Wis. Stat.

Business Plan

Health Maintenance Organization Insurers are required to file a written report of any proposed substantial change in its business plan pursuant to s. Ins. 9.06 (1), Wis. Adm. Code. The company expanded its service area to additional counties during the examination period.

The review of the company's business plan revealed that an amendment to the business plan was not filed with the OCI for the expansion to additional counties. Section Ins 9.06 (1), Wis. Adm. Code, requires health maintenance organization insurers to file substantial changes in its business plan at least 30 days prior to the effective date of the change. The insurer may not enter into any transaction, contract, amendment to a transaction or contract, or take action or make any omission that is a substantial change in the insurer's business plan prior to the proposed effective date of the change or if the change is disapproved. Any changes in the items listed in s. Ins 9.05 (4), Wis. Adm. Code must be filed as a change in the business plan. Substantial changes per this section include but are not limited to geographical service areas and any other change that might affect the financial solvency of the plan. However, the company filed the proposed business plan change in January of 2019, but this was after the fact. It is recommended that the company comply with s. Ins.9.06 (1), Wis. Adm. Code, with respect to changes in the business plan.

VIII. CONCLUSION

Managed Health Services Insurance Corp., is a for-profit mixed-model health maintenance organization (HMO) insurer and was incorporated August 31, 1990. The HMO provides primary and specialty health services to Medicaid/BadgerCare and Medicare enrollees through contractual arrangements with physicians, independent practice associations (IPAs), group practices, physician-hospital organizations (PHOs), and clinics.

The company derives all of its revenue from the Wisconsin Title XIX Medical Assistance, BadgerCare, Medicare, and Supplemental Security Income (SSI) Programs. The HMO contracts directly with the Wisconsin Department of Health Services (DHS) and the Centers for Medicare & Medicaid Services (CMS) to provide health care benefits to eligible Medicare and Medicaid recipients.

The company has been profitable for the past five years, reporting total a net income of $49.4 million. MHSIC paid $16.6 million in dividends to stockholders over the same period. Total revenue decreased by 11% from $184 million in 2016 to $163 million in 2017. The decrease was primarily due to a decrease in the company's BadgerCare membership and the exit from the Federally Facilitated Health Insurance Exchange. The profit margin increased from 5.1% in 2016 to 5.6% in 2017. The increase is primarily due to the ACA fee moratorium in 2017; the company paid just under $2.0 million or $4.18 per member per month in 2016.

There were no adjustments made to surplus as a result of the current examination. The examination made three recommendations as listed on the following page.

IX. SUMMARY OF COMMENTS AND RECOMMENDATIONS

1. Page 29 - Corporate Governance—It is recommended that the company have its directors, officers, and key employees complete a conflict of interest questionnaire annually as required by a directive of the Office of the Commissioner of Insurance and maintain a record of the signed questionnaire.

2. Page 29 - Executive Compensation—It is recommended that the company properly complete the Report of Executive Compensation as required by s. 611.63 (4), Wis. Stat.

3. Page 30 - Business Plan—It is recommended that the company comply with s. Ins.9.06 (1), Wis. Adm. Code, with respect to changes in the business plan.

X. ACKNOWLEDGMENT

The courtesy and cooperation extended during the course of the examination by the officers and employees of the company is 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
John Ebsen	Insurance Financial Examiner
David Jensen, CFE	IT Specialist
Jerry DeArmond, CFE	Reserve Specialist

Respectfully submitted,

Vickie Ostien
Examiner-in-Charge