Report

of the

Examination of

UnitedHealthcare of Wisconsin, Inc.

Wauwatosa, Wisconsin

As of December 31, 2017

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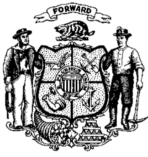

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Tony Evers, *Governor*
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April 19, 2019

Honorable Mark V. Afable
Commissioner of Insurance
State of Wisconsin
125 South Webster Street
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Commissioner:

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

UNITEDHEALTHCARE OF WISCONSIN, INC.
Wauwatosa, Wisconsin

and this report is respectfully submitted.

I. INTRODUCTION

The previous examination of UnitedHealthcare of Wisconsin, Inc., (the company, the HMO, or UHC-WI) 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 UnitedHealthcare of Wisconsin, Inc., was conducted concurrently with the examination of the following affiliated companies:

- UnitedHealthcare of Colorado, Inc.,
- UnitedHealthcare Community Plan of Georgia, Inc.,
- UnitedHealthcare of Georgia, Inc.,
- UnitedHealthcare of Kentucky, Ltd.,
- UnitedHealthcare of Ohio, Inc., and
- UnitedHealthcare of Texas, Inc.

These affiliates are domiciled in Colorado, Georgia, Kentucky, Ohio, and Texas, respectively, with Wisconsin acting as the facilitating state for the coordinated examination. Representatives of

Colorado participated in the examination and their work was reviewed and relied on as 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 insurers 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.

Independent Actuary's Review

An independent actuarial firm was engaged under a contract with the State of Pennsylvania. The actuary reviewed the adequacy of the liability for unpaid claims, risk adjustment balances, premium deficiency reserves, and other significant reserve balances for the 15 affiliated

companies. The actuary's results were reported to the examiners-in-charge. As deemed appropriate, reference is made in this report to the actuary's conclusions.

Investment Specialist's Review

An independent investment specialist was engaged under a contract with the State of Indiana. The investment specialist performed a review of the overall organizational structure of the investment management team, a review of the overall portfolio, and review of the investment process supporting the UnitedHealth Group's portfolio for 15 affiliated companies. The investment specialist's results were reported to the examiners-in-charge. As deemed appropriate, reference is made in this report to the investment specialist's conclusions.

II. HISTORY AND PLAN OF OPERATION

UnitedHealthcare of Wisconsin, Inc., is described as a for-profit network 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."

The company was incorporated on May 8, 1986, and commenced business on June 6, 1986, as the Heritage Health Plan of Wisconsin, Inc. (Heritage). At the time of formation, Heritage acquired all of the assets and assumed all of the liabilities of the PrimeCare Health Plan of Wisconsin, pursuant to an Asset Purchase Agreement dated May 8, 1986. By shareholder consent, dated May 11, 1987, the name of the HMO was changed to PrimeCare Health Plan, Inc. Several transactions took place since then as are described below.

- On March 1, 1990, UnitedHealthcare Corporation n/k/a United Health Group Inc., (UHG) then a Minnesota managed care holding company, purchased all outstanding common shares of Heritage Holding Company, Inc., which owned 100% of the HMO's outstanding common stock. Then the ownership interest in the HMO was transferred to UHC Management Company n/k/a United HealthCare Services, Inc. (UHS).
- On August 1, 1991, the HMO merged with an affiliate, Samaritan Health Plan (Samaritan) with Samaritan being the surviving corporation. The company then changed its name to PrimeCare Health Plan, Inc.
- On July 17, 1996, PrimeCare Health Plan, Inc., merged with an affiliate, MetraHealth Care Plan of Wisconsin, Inc.
- On October 9, 1999, the HMO's board amended the Articles of Incorporation to change the corporate name to the one currently used effective December 31, 1999.
- On June 30, 2000, the HMO became a wholly owned subsidiary of UnitedHealthcare, Inc., a holding company for HMOs that are part of the UnitedHealth Group.
- On March 25, 2004, UnitedHealthcare of Wisconsin, Inc., entered into an asset purchase agreement with Touchpoint Health Plan, Inc. and acquired certain intangible assets, assigned contracts, and select physical assets

UnitedHealthcare of Wisconsin, Inc. provides primary health care through physicians who either contract directly with the company, contract with an independent practice association (IPA), or are part of a clinic that has a contractual relationship with the company. The only exception to this is a lease arrangement with the physicians in the Marshfield Clinic, which is accessed through a partnership agreement with Medica Health Plans of Wisconsin. The company contracts directly with

over 36,575 physicians (primary and specialist) nationally. The following table shows the breakdown of physicians by state:

State	Physicians
Arizona	2,499
Illinois	486
Iowa	859
Kentucky	139
North Carolina	649
Ohio	696
Tennessee	361
Virginia	238
Wisconsin	30,648
Total	**36,575**

Under the Participating Physician Agreement, the physician agrees to provide health care services in accordance with the benefit plans offered by the HMO. Pursuant to the agreement, physicians agree to provide health services to all members as the patient load permits and to accept members as new patients on the same basis as other new patients in accordance with local, state, and federal laws. In addition, if the physician is a primary care physician, the physician agrees to provide advice and assistance to members in emergency situations 24 hours/day, seven days/week.

Pursuant to the Participating Physician Agreement, a physician is compensated in accordance with approved fee schedules. The agreement precludes a facility from billing members for the difference between customary charges and the amount that the physician has agreed to accept as full reimbursement under the agreement. The agreement specifically states: “Facility will not bill or collect payment from the customer, or seek to impose a lien for the difference between the amount paid under this agreement and facility’s billed charge or customary charge, or for any amounts denied or not paid under this agreement.”

The company contracts with 176 hospitals to provide inpatient services in the State of Wisconsin. Hospitals are reimbursed on a negotiated per diem, per case, per visit and discounted fee-for-service basis. The contracts include hold-harmless provisions for the protection of policyholders.

The company’s Wisconsin service area is comprised of the following 59 counties:

Adams	Florence	Juneau	Marquette	Price	Vernon
Brown	Fond du Lac	Kenosha	Menominee	Racine	Vilas
Buffalo	Forest	Kewaunee	Milwaukee	Richland	Walworth
Calumet	Grant	La Crosse	Monroe	Rock	Washington
Columbia	Green	Lafayette	Oconto	Rusk	Waukesha
Clark	Green Lake	Langlade	Oneida	Sauk	Waupaca
Crawford	Iowa	Lincoln	Outagamie	Shawano	Waushara
Dane	Iron	Manitowoc	Ozaukee	Sheboygan	Winnebago
Dodge	Jackson	Marathon	Pepin	Taylor	Wood
Door	Jefferson	Marinette	Portage	Trempealeau	

According to its financial statement as of December 31, 2017, the company is licensed in nine states, including the State of Wisconsin. During 2017, the company produced $5,534,296,448 of health premiums written from a total enrollment of 619,612 members nationally. The state breakouts are shown in the following table:

State	2017 Health Premiums Written	2017 Enrollment
Arizona	$158,923,445	15,793
Illinois	$102,850,893	8,769
Iowa	$205,459,108	19,883
Kentucky	$34,366,742	3,106
North Carolina	$1,378,003,346	110,224
Ohio	$973,420,526	78,595
Tennessee	$433,935,578	38,727
Virginia	$272,061,681	25,702
Wisconsin	$1,975,275,129	318,813
Total	**$5,534,296,448**	**619,612**

The company offers comprehensive health care coverage through its commercial HMO product, which may be changed by riders to include deductibles and copayments. The following basic health care coverage is provided:

- Ambulance Services
- Chiropractic Treatment
- Clinical Trials
- Dental/Anesthesia Services – Hospital or Ambulatory Surgery
- Dental Services – Accident Only
- Diabetes Treatment
- Emergency Services
- Home Health Care
- Hospice
- Hospital – Inpatient Services
- Kidney Disease Treatment
- Lab, X-Ray, Diagnostic Services
- Maternity Services
- Mental Health and Substance Abuse Services – Outpatient, Inpatient and Transitional Care
- Ostomy Supplies

- Outpatient Pharmaceutical Products
- Outpatient Surgery, Diagnostic, and Therapeutic Services
- Physician's Office Services
- Preventive Care Services
- Professional Surgical and Medical Services
- Prosthetic Devices & Durable Medical Equipment
- Reconstructive Procedures
- Rehabilitation Services – Outpatient Therapy
- Skilled Nursing Facility/Inpatient Rehabilitation Facility Services
- Temporomandibular Joint Disorders
- Transplantation Services
- Urgent Care Services
- Vision Exam

UnitedHealthcare of Wisconsin, Inc., offers a variety of commercial products that are marketed to groups of various sizes. For all commercial business, the company adjusts the base rates monthly (quarterly for small group Patient Protection and Affordable Care Act [ACA] plans) to reflect medical trends. The company periodically makes updates to reflect emerging experience. Additionally, when major rating factors change, the company makes revenue neutrality adjustments to ensure that the total projected revenue for the product remains the same. Commercial plans include small group (ACA compliant, transitional relief and grandfathered) and large group plans. In addition to these commercial plans, the company offers plans which are sponsored by various agencies of the government including; Medicare Advantage, dual special needs, institutional special needs, and Medicaid plans. For 2017, the UHC-WI's membership was made up of 68% Medicare, 25% Medicaid, and 7% commercial.

Small Group Commercial - ACA

Small group ACA plans are those offered to groups with an average number of employees of one to 50 that are fully compliant with the requirements of the ACA. Any groups in the one-to-50 segment with an effective date of January 1, 2014, or later will fall into this category. The rates are calculated on a guaranteed issue, member-level basis. The rates only vary due to group differences in the following factors:

- Geographic location
- Age of enrolled employees
- Plan benefit design
- Plan an effective quarter

Nothing besides the above is taken into account when rating a group. So two groups with the same demographics, effective date, plan design, and rating region will have the exact same premium.

Small Group Commercial - Transitional Relief

Small group transitional relief plans are those offered to groups with an average number of employees of one to 50 when they were purchased that are compliant with all Centers for Medicare and Medicaid Services (CMS) and Office of the Commissioner of Insurance (OCI) regulations applicable to small group transitional relief plans. Any group in the one-to-50 segment that initially purchased their plan with an effective date after March 23, 2010, and on or before October 1, 2013, falls into this category. These were available for purchase with effective dates from April 1, 2010, through October 1, 2013, and are no longer open to new business. They are currently open to renewal groups only with the restriction that the policies must end no later than December 31, 2019, based on current policies.

The renewal premiums are calculated similarly to their ACA-compliant plans with several key differences. Rates are still based on the factors listed above with the following major differences (note that the below list is not inclusive of all differences):

- Location – Rates can be different at the ZIP-code level rather than the county/rating area level
- Age/gender – ACA business in the State of Wisconsin must use the federally prescribed age curve. In accordance with the regulations applicable to transitional business, UHC-WI uses a different age curve for these plans. Additionally, rates can vary by gender and employer industry as well.
- Plan effective date – Plan base rates change monthly instead of quarterly
- Rate Bands – Unlike for ACA-compliant plans, the rates for transitional plans can be adjusted within the applicable rating band.

Small Group Commercial - Grandfathered

Small group grandfathered plans are those offered to groups with an average number of employees of one to 50 when they were purchased that are compliant with all CMS and OCI regulations applicable to grandfathered plans. These plans are no longer available for new business. These plans are currently available for renewals indefinitely. They are rated in a similar manner to transitional relief plans.

51+ Commercial Group

These are plans available to groups with an average number of employees of 51+. They are rated based on group size, group industry, age/gender, employer location, effective date, benefit design, and more. Additionally, these plans are underwritten for health status, so two groups with identical characteristics in all of the above may not have the identical premium.

Effective January 1, 2018, the company no longer offers comprehensive medical insurance to the State of Wisconsin employee plan under the HMO license.

Medicare Advantage

The company serves as a plan sponsor offering Medicare Advantage and Medicare Part D prescription drug insurance coverage under a contract with CMS. Under the Medicare program, there are seven separate elements of payment received by the company either during the year or at settlement in the subsequent year. The payment elements are CMS premium, member premium, CMS low-income subsidy, CMS catastrophic reinsurance subsidy, CMS low-income member cost-sharing subsidy, CMS risk share, and the CMS coverage gap discount program.

The company has a contract with CMS to serve as a plan sponsor offering a dual special needs plan (DSNP) product. This product is solely funded by CMS. A DSNP is a specialized type of Medicare Advantage Prescription Drug Plan (MAPD) that is limited to dual eligible members and provides additional Medicaid coordination and clinical programs.

The company serves as a plan sponsor offering Institutional special needs plans (ISNP) under a contract with CMS. An ISNP is designed to meet the needs of enrollees who reside in contracted nursing facilities by providing primary care and care management within the nursing facility, which includes Medicare-covered benefits, supplemental services, and Part D benefits.

Effective January 1, 2016, CMS contracts for Medicare Advantage and Part D business in eight states from various affiliated entities were novated to the company. The Medicare revenue associated with this novation represented 64% and 62% of the total direct written premium as of December 31, 2017, and 2016, respectively. The novation agreements resulted in full control of the contracts being transferred to the company for dates of service on or after January 1, 2016. Approval for this novation was received from OCI and CMS. There was no transfer of assets or surplus as a result of the novation.

Medicaid

The company has a contract with the Wisconsin Department of Health Services (DHS) to provide health care services to Medicaid-eligible beneficiaries in Wisconsin. The current contract is effective through December 31, 2019, and is subject to annual renewal provisions thereafter.

III. MANAGEMENT AND CONTROL

Board of Directors

The board of directors consists of six members. All directors are elected annually to serve a one-year term. Officers are elected annually by the board of directors. Directors need not be residents of the State of Wisconsin or shareholders of the corporation. The bylaws state that the board of directors may establish reasonable compensation of all directors for services to the corporation as directors, officers, or otherwise. All directors currently receive compensation.

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

Name and Residence	Principal Occupation	Term Expires
Catherine Suzanne Harvey Milwaukee, Wisconsin	Health Plan Chief Executive Officer, Central Region, Medicare and Retirement UnitedHealth Group Incorporated	2020
Dustin Larry Hinton Menomonee Falls, Wisconsin	Health Plan Chief Executive Officer, Central Region, Employee and Individual UnitedHealth Group Incorporated	2020
Dennis James Mouras Ypsilanti, Michigan	Health Plan Chief Executive Officer, Community and State UnitedHealth Group Incorporated	2020
Daniel Brian Ross, M.D. Franksville, Wisconsin	Medical Director, Community and State, Wisconsin UnitedHealth Group Incorporated	2020
Susan Draney Schick Wayne, Pennsylvania	Chief Growth Officer, Community and State UnitedHealth Group Incorporated	2020
Ellen Ray Sexton Prior Lake, Minnesota	Health Plan Chief Executive Officer, Community and State UnitedHealth Group Incorporated	2020

Officers of the Company

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

Name	Office	2017 Compensation[1]
Ellen Rae Sexton	President, Chief Executive Officer	$739,325
Brian Benjamin Perry	Chief Financial Officer	189,737
Christina Regina Palme-Krizak	Secretary	28,458
Robert Worth Oberrender	Treasurer	18,347

[1] The company chose to report the 2017 Executive Compensation on an allocated basis.

Committees of the Board

The company's bylaws allow for the formation of certain committees by the board of directors. The company had no committees at the time of this examination. The audit committee, which resides at United HealthCare Services, Inc., consists of the following persons:

Central Region Audit Committee
Salli Thompson, Chair
John Tenaglia
Elizabeth Sween

The company has no employees. All business is administered by employees of United Healthcare Services, Inc., (UHS) per the terms of the Management Services Agreement (MSA) effective March 1, 2011. Pursuant to the terms of the MSA, UHS will provide management services to the company under a fee structure, which is based on a percentage of premium charges representing UHS's expenses for services or use of assets provided to the company. In addition, UHS provides or arranges for services on behalf of the company using a passthrough of charges incurred by UHS on a per member per month basis or using another allocation methodology consistent with the MSA. These services may include but are not limited to integrated personal health management solutions, such as disease management, treatment decision support, and wellness services, including a 24-hour call-in service, access to a network of transplant providers, and discount program services. The amount and types of services provided pursuant to the pass-through provision of the MSA can change year over year. Direct expenses not covered under the MSA, such as broker commissions, exam fees, ACA assessments, and premium taxes are paid by UHS on behalf of the company. UHS is reimbursed by the company for these direct expenses. The company is a party to various purchased service agreements with various related parties, whereby these related parties provide a combination of network management and benefits administration to the company. In all instances, the fees and costs of such services are to be reasonable and consistent with those provided by a third-party provider. The MSA shall continue until it is terminated. The company may terminate the agreement upon 60-days' written notice if the default of standards of performance continues 30 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

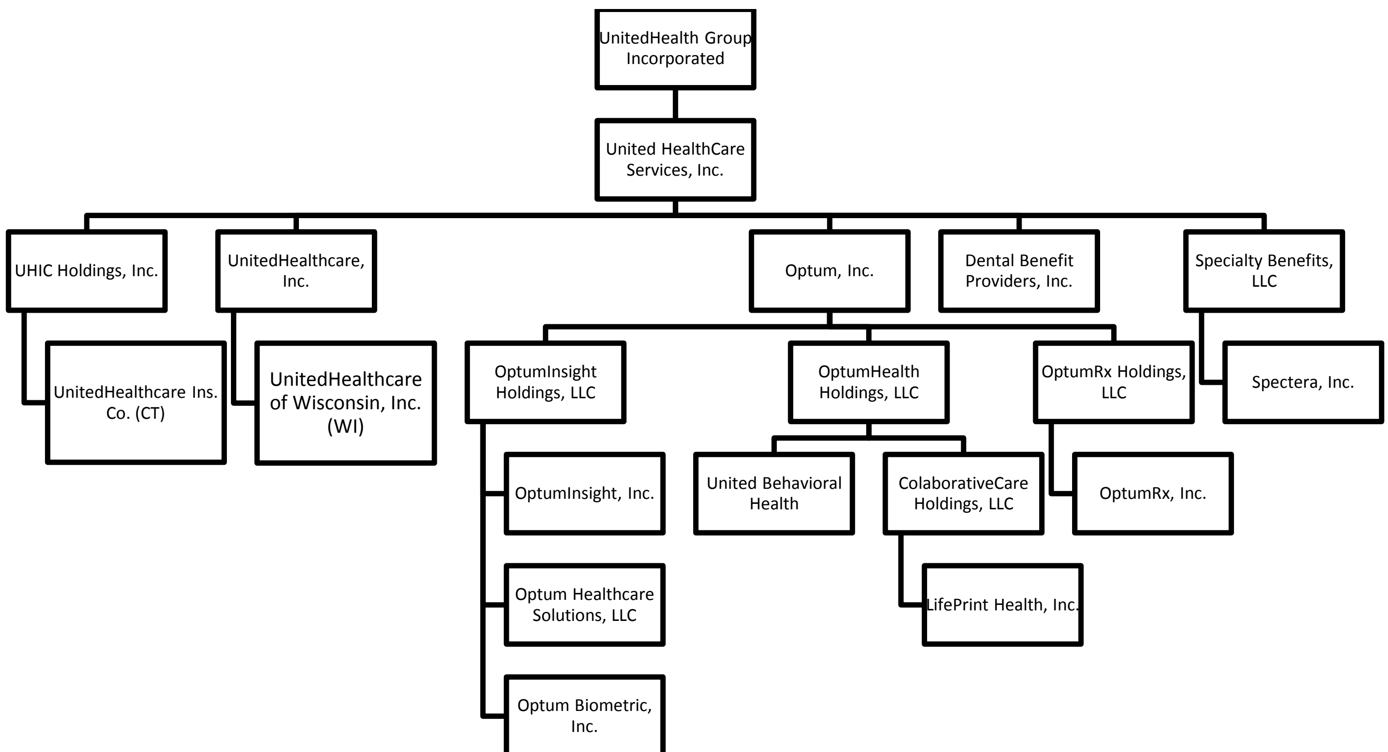
2. Enrollees will be entitled to similar, alternate coverage which does not contain any medical underwriting or preexisting limitation requirements.

The company has met this requirement through its reinsurance contract, as discussed in the section of this report captioned “Affiliated Agreements”.

IV. AFFILIATED COMPANIES

UnitedHealthcare of Wisconsin, Inc., is a member of a holding company system consisting of 864 companies. The following abbreviated organizational chart depicts the relationships among key affiliates in the group. A brief description of affiliates deemed significant follows the organizational chart.

Abbreviated Organizational Chart
As of December 31, 2017



Note: Not all subsidiaries of UHG have been included in this organizational chart. UHG had 863 subsidiaries, including the company on December 31, 2017.

UnitedHealth Group Incorporated

UnitedHealth Group Incorporated (the group, UHG) has core competencies in data and health information; advanced technology; and clinical expertise to help meet the demands of its health system. These core competencies are deployed within two distinct, but strategically aligned, business platforms: health benefits operating under UnitedHealthcare Services, Inc., and health services operating under Optum, Inc. As of December 31, 2017, the group's audited financial statement

reported total assets of $139.1 billion, liabilities of $87.0 billion, and total equity, net of redeemable noncontrolling interests, of $49.8 billion. Operations for 2017 produced net income of $10.8 billion on revenues of $201.2 billion.

UnitedHealthcare Services, Inc.

UnitedHealthcare Services, Inc., (UHS) provides health care benefits to a wide array of customers and markets. UHS markets these health care benefits to three customer groups. The Employer & Individual (E&I) lines of business serve employers ranging from sole proprietorships to large, multi-site, and national employers; public sector employers; and other individuals. The Medicare & Retirement (M&R) lines deliver health and well-being benefits for Medicare beneficiaries and retirees. The community & state (C&S) lines manage health care benefit programs on behalf of state Medicaid and community programs and their participants. As of December 31, 2017, this company's audited financial statement reported assets of $119.6 billion, liabilities of $52.9 billion, and equity of $66.7 billion. Operations resulted in net earnings of $8.9 billion on revenues of $182.0 billion

Optum, Inc.

Optum, Inc., (Optum) is a health services business serving the broad health care marketplace, including payers, care providers, employers, governments, life sciences companies, and consumers through its OptumHealth, OptumInsight, and OptumRx businesses. These businesses have dedicated units that help improve overall health system performance through optimizing care quality, reducing costs, and improving consumer experience and care provider performance by leveraging distinctive capabilities in data and analytics, pharmacy care services, population health, health care delivery, and health care operations. As of December 31, 2017, the group's SEC Form 10-K reported that OptumHealth, OptumInsight, and OptumRx produced earnings of $1.8 billion, $1.8 billion, and $3.1 billion, on revenues of $20.6 billion, $8.1 billion, and $63.8 billion, respectively. Total 2017 earnings for Optum were $6.7 billion, on revenues of $91.2 billion (after eliminations of $1.2 billion).

UnitedHealthcare Insurance Company

UnitedHealthcare Insurance Company (UHCIC) provides comprehensive commercial products to individuals and employer group. UHCIC participates on the ACA small group exchange

market in Maryland and the District of Columbia. Effective January 1, 2017, it exited the individual exchange market in all states. UHCIC provides services to the federal government under the Federal Employee Health Benefit Plan. UHCIC serves as a plan sponsor for Medicare Advantage and Medicare Part D drug insurance coverage, and Dual Special Needs Plan, under contracts with the CMS. UHCIC provides health insurance products and services to members of the American Association of Retired Persons. UHCIC is domiciled in Connecticut. As of December 31, 2017, the company's audited financial statement reported assets of $19.6 billion, liabilities of $13.2 billion, and capital and surplus of $6.3 billion. Operations for 2017 produced a net income of $2.6 billion on revenues of $51.3 billion.

Significant Affiliated Agreements[2]

Management Services Agreement

Effective March 1, 2011, the company entered into the Management Services Agreement with United HealthCare Services, Inc. UHS provides management and operational support to the company, including but not limited to those services described in Exhibit A of the agreement. The company will pay fees to UHS equal to UHS' expenses for services or use of assets provided solely to the company, and UHC-WI's allocated a portion of UHS' expenses where the services or use of assets are shared among the company and other health plans.

Collaborative Care Agreement(s)

Effective January 1, 2012, the company entered into a services agreement with LifePrint Health, Inc. to provide services related to performing medical management services for the company's Institutional Special Needs Plan members, including but not limited to care management services, referral services, and out-of-area services. There have been five amendments to this agreement.

Effective January 1, 2016, the company entered into a services agreement with LifePrint Health, Inc., to provide services related to performing medical management services for UHCWI's Institutional Special Needs Plan members that reside in an assisted living facility, including but not limited to care management services, referral services, and out-of-area services.

[2] These agreements had transactions totaling greater than $10.0 million in 2017.

Mental Health Agreement

Effective March 1, 2012, the company entered into the Behavioral Health Services Agreement with United Behavioral Health. Pursuant to the agreement, UBH is responsible for arranging for the provision of certain mental health and substance abuse treatment services for the company's commercial, Medicare, and Medicaid members. There have been six amendments to this agreement.

Pharmacy Administration Agreement(s)

Effective January 1, 2013, United HealthCare Services, Inc., entered into a prescription drug benefit administration agreement with OptumRx, Inc. Pursuant to the agreement, OptumRx provides core prescription drug benefit services and mail order pharmacy services. Under the core prescription drug benefit services, OptumRx established and maintains a network of pharmacies to service the benefit plans and provide claims processing services, benefits administration and support, marketing and sales support, account management services, rebate administration, clinical services, and finance and analytical support services. Under the mail order pharmacy services, OptumRx provides a mail order network prescription services.

Effective January 1, 2013, the company participated as a party to the agreement by signing a participating addendum. The company remains ultimately responsible for the pharmacy benefit administration services provided to its members. There are three amendments to this agreement, all relating to rates charged. Effective January 1, 2018, the agreement was replaced and superseded by the First Amended and Restated Medicare Prescription Drug Benefit Administration Agreement.

Effective December 1, 2015, the company entered into the Facility Participation Agreement. Pursuant to the agreement, OptumRx, Inc. is a specialty pharmacy provider. OptumRx provides the specialty pharmacy medications covered under the member's medical benefits. In addition to dispensing and delivering the specialty pharmacy medications, OptumRx provides information, including side effect management, storage of the medication, missed dose management, and disease state information to the company's members or their caregivers.

Effective January 1, 2018, OptumRx, Inc., and UnitedHealthcare Services, entered into the First Amended and Restated Medicare Prescription Drug Benefit Administration Agreement, including but not limited to the company. Under the terms of the agreement, OptumRx is the pharmacy benefit manager for the company's Individual Medicare Advantage Prescription Drug Plans (MA-PD) and Part D Prescription Drug Plans (PDP). The agreement is a full restatement of the previous agreement Medicare Prescription Drug Benefit Administration Agreement (both MA-PD Plans and PDP Plans), effective January 1, 2017, and has been updated to reflect current processes and procedures, the services being provided, the applicable regulatory requirements, and 2018 pricing. In addition, employer group plans have been removed from the agreement.

Effective January 1, 2018, OptumRx, Inc., and United HealthCare Services, Inc. entered into the Medicare Prescription Drug Benefit Administration Agreement (MA-PD Plans and PDP Plans), for group members, acting on behalf of its affiliates, including but not limited to the company.

Health Supplies Agreement(s)

Effective January 1, 2009, the Medicare Advantage Durable Medical Equipment and Supplies Mail Order Network Agreement was entered into by and between RxSolutions, Inc. (OptumRx) and United HealthCare Services, Inc. Effective February 1, 2009, the company entered into the Participating Addendum to the agreement. Pursuant to the agreement and Participating Addendum, OptumRx provides durable medical equipment and diabetic testing supplies to the company's Medicare Advantage members in connection its Medicare Advantage operations.

Effective January 1, 2012, the company and OptumRx, Inc., entered into the Facility Participation Agreement. Under the terms of the agreement, OptumRx is a provider of durable medical equipment services and hearing aids for the company's members. The agreement is to be made available to be used by all products - commercial, Medicare, and Medicaid - that the company may offer. There have been two amendments to this agreement, both dealing with rates charged.

Medical Analytics and Recovery Agreement

Effective July 1, 2011, the company entered into the Ingenix Services Agreement with Ingenix, Inc., now called OptumInsight, Inc. Pursuant to the agreement, OptumInsight provides the company with services related to claim analytics and recovery services, retrospective fraud, waste and

abuse services, and subrogation services. There have been six amendments to this agreement, most dealing with compensation or administrative changes.

Other Affiliated Agreements

The company has various other affiliated agreements having less significant transactions during the year. They are the following:

- Point-of-Service Plus Reinsurance Agreement, effective August 1, 1990
- Tax Sharing Agreement, effective August 1, 1991
- Premium Allocation Agreement, effective January 1, 1998
- Ancillary Provider Participation Agreement, effective July 1, 2007
- Health Supplies Agreement, effective January 1, 2008
- Combined Billing and Disbursement Operations, effective April 1, 2010
- Facility Participation Agreement for Vaccinations, effective October 1, 2010
- Vision Services Agreement, effective January 1, 2012
- Dental Services Agreement, effective February 1, 2012
- Subordinated Revolving Credit Agreement, effective August 1, 2012
- Administrative Services Agreement for Specialty Services[3], effective April 1, 2013
- National Ancillary Provider Participation Agreement, effective November 1, 2017

Effective January 1, 2013, the company entered into an Insolvency Reinsurance Agreement with UnitedHealthcare Insurance Company (UHIC) for insolvency reinsurance. Effective January 1, 2016, a first amendment to the agreement was entered into. There was no substantial change to the agreement.

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

1. UHIC will continue plan benefits for members who are confined in an acute-care hospital on the date of insolvency until their discharge.

2. UHIC 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] Chiropractic and physical, occupation and speech therapy, and CAM Network Access (i.e., a network of complimentary alternative medicine providers developed by the vendor) for UHC-WI's commercial members.

V. REINSURANCE

The company has no third-party reinsurance coverage. Refer to the Section above captioned “Affiliated Agreements” for all affiliated reinsurance agreements.

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.

UnitedHealthcare of Wisconsin, Inc.
Assets
As of December 31, 2017

	Assets	Nonadmitted Assets	Net Admitted Assets
Bonds	$ 956,253,343	$	$ 956,253,343
Cash, cash equivalents and short-term investments	479,248,447		479,248,447
Receivable for securities	5,600,000		5,600,000
Investment income due and accrued	6,381,184		6,381,184
Uncollected premiums and agents' balances in the course of collection	13,564,719	2,564,375	11,000,344
Accrued retrospective premiums and contracts subject to redetermination	268,750,789		268,750,789
Amounts recoverable from reinsurers	68,633		68,633
Amounts receivable relating to uninsured plans	12,412,360	123,968	12,288,392
Net deferred tax asset	4,029,454		4,029,454
Receivables from parent, subsidiaries and affiliates	630,851	630,851	
Health care and other amounts receivable	24,531,055	8,171,963	16,359,092
Write-ins for other than invested assets:			
Deposit	10,000		10,000
Prepaid commissions	8,728	8,728	
Service fee billing	4,799	4,799	
Total assets	$1,771,494,362	$11,504,684	$1,759,989,678

UnitedHealthcare of Wisconsin, Inc.
Liabilities and Net Worth
As of December 31, 2017

Claims unpaid		$ 580,777,724
Accrued medical incentive pool and bonus payments		114,605,962
Unpaid claims adjustment expenses		5,994,553
Aggregate health policy reserves		109,060,524
Aggregate health claim reserves		1,413,808
Premiums received in advance		7,965,861
General expenses due or accrued		28,626,891
Current federal and foreign income tax payable and interest thereon		24,161,711
Ceded reinsurance premiums payable		959,634
Amounts withheld or retained for the account of others		5,936
Remittance and items not allocated		661,787
Amounts due to parent, subsidiaries and affiliates		107,609,661
Payable for securities		847,005
Liability for amounts held under uninsured accident and health plans		111,408,950
Aggregate write-ins for other liabilities (including $[1] current)		10,453
Total liabilities		1,094,110,460
Common capital stock	$ 1,000,000	
Gross paid in and contributed surplus	100,289,807	
Aggregate write-ins for special surplus funds	117,800,148	
Unassigned funds (surplus)	446,789,263	
Total capital and surplus		665,879,218
Total liabilities, capital and surplus		$1,759,989,678

UnitedHealthcare of Wisconsin, Inc.
Statement of Revenue and Expenses
For the Year 2017

Net premium income		$5,522,954,643
Change in unearned premium reserves and reserve for rate credits		(31,648,291)
Total revenues		5,491,306,353
Medical and hospital:		
Hospital/medical benefits	$3,929,640,546	
Other professional services	22,426,370	
Prescription drugs	250,609,502	
Incentive pool and withhold adjustments	120,983,334	
Subtotal	4,323,659,752	
Less		
Net reinsurance recoveries	3,776,002	
Total medical and hospital	4,319,883,750	
Non-health claims		
Claims adjustment expenses	225,380,988	
General administrative expenses	410,879,824	
Increase in reserves for life and accident and health contracts	1,516,000	
Total underwriting deductions		4,957,660,562
Net underwriting gain or (loss)		533,645,791
Net investment income earned	21,138,662	
Net realized capital gains or (losses)	(53,181)	
Net investment gains or (losses)	21,085,481	
Net gain or (loss) from agents' or premium balances charged off	(4,429,329)	
Aggregate write-ins for other income or expenses	(104,640)	16,551,512
Net income or (loss) before federal income taxes		550,197,303
Federal and foreign income taxes incurred		191,812,834
Net income (loss)		$ 358,384,469

UnitedHealthcare of Wisconsin, Inc.
Capital and Surplus Account
For the Five-Year Period Ending December 31, 2017

	2017	2016	2015	2014	2013
Capital and surplus, beginning of year	$452,568,675	$270,251,954	$171,105,569	$156,983,838	$139,710,343
Net income (loss)	358,384,469	199,865,316	53,561,191	31,035,039	20,449,200
Change in net unrealized capital gains/losses	(9,392)				
Change in net deferred income tax	(3,294,314)	(3,565,058)	1,694,339	1,427,824	1,029,876
Change in nonadmitted assets	3,229,780	13,016,463	(6,109,148)	(2,841,132)	(5,768,764)
Capital changes:					
Transferred from surplus			999,000		
Surplus adjustments:					
Paid in			50,000,000		
Transferred to capital					
Transferred from capital			(999,000)		
Dividends to stockholders	(145,000,000)	(27,000,000)		(15,500,000)	
Write-ins for surplus					
Rounding			3		
Change in equity for prior year adjustment					1,563,183
Surplus, end of year	$665,879,218	$452,568,675	$270,251,954	$171,105,569	$156,983,838

UnitedHealthcare of Wisconsin, Inc.
Statement of Cash Flow
For the Year 2017

Premiums collected net of reinsurance			$5,472,360,849
Net investment income			24,352,348
Total			5,496,713,197
Less:			
Benefit- and loss-related payments		$4,224,258,099	
Commissions, expenses paid and aggregate write-ins for deductions		527,576,024	
Federal and foreign income taxes paid (recovered) $0 net tax on capital gains (losses)		154,090,234	
Total			4,905,924,357
Net cash from operations			590,788,840
Proceeds from investments sold, matured or repaid:			
Bonds	$ 83,165,386		
Net gains (losses) on cash, cash equivalents, and short- term investments	(10,032)		
Total investment proceeds		83,155,354	
Cost of investments acquired—long-term only:			
Bonds	335,518,814		
Miscellaneous applications	9,910,244		
Total investments acquired		345,429,058	
Net cash from investments			(262,273,704)
Cash Provided/Applied:			
Dividends to stockholders		145,000,000	
Other cash provided (applied)		54,546,872	
Net cash from financing and miscellaneous sources			(90,453,128)
Net change in cash, cash equivalents, and short-term investments			238,062,008
Cash, cash equivalents, and short-term investments:			
Beginning of year			241,186,439
End of year			$ 479,248,447

Growth of UnitedHealthcare of Wisconsin, Inc.

Year	Assets	Liabilities	Capital and Surplus	Premium Earned	Medical Expenses Incurred	Net Income
2017	$1,759,989,678	$1,094,110,460	$665,879,218	$5,522,954,643	$4,319,883,750	$358,384,469
2016	1,223,842,722	771,274,047	452,568,675	4,547,034,828	3,516,589,546	199,865,316
2015	489,425,695	219,173,741	270,251,954	1,505,918,244	1,174,926,993	53,561,191
2014	373,186,565	202,080,996	171,105,569	1,350,412,760	1,102,300,091	31,035,039
2013	346,260,262	189,276,424	156,983,838	1,334,248,882	1,145,253,096	20,449,200

Year	Profit Margin	Medical Expense Ratio	Administrative Expense Ratio	Change in Enrollment
2017	9.7%	78.7%	11.6%	15.5%
2016	7.5	78.4	14.1	94.3
2015	5.9	78.2	15.9	2.3
2014	9.0	76.9	14.1	6.0
2013	1.6	86.2	12.2	15.5

Enrollment and Utilization

Year	Enrollment	Hospital Days/1,000	Average Length of Stay
2017	619,612	849.48	4.9
2016	536,432	818.06	4.8
2015	276,114	560.58	4.1
2014	269,947	599.54	4.3
2013	254,779	1,171.44	6.9

Per Member Per Month Information

	2017	2016	Percentage Change
Premiums:			
Commercial	$463.60	$448.71	3.3%
Medicare	989.97	971.32	1.9
Medicaid	200.64	202.20	-0.8
Blended	751.32	710.90	5.7
Expenses:			
Hospital/medical benefits	537.66	506.54	6.1
Other professional services	3.07	2.45	25.3
Prescription drugs	34.29	27.91	22.9
Incentive pool and withhold adjustments	16.55	20.74	-20.2
Less: net reinsurance recoveries	0.52	0.15	238.2
Total medical and hospital	591.05	557.49	6.0
Claims adjustment expenses	30.84	31.37	-1.7
General administrative expenses	56.22	68.95	-18.5
Increase in reserves for accident and health contracts	0.21	0.00	
Total underwriting deductions	$678.31	$657.81	3.1%

As previously noted, the Medicare Advantage business from eight states was novated to UnitedHealthcare of Wisconsin, Inc., effective January 1, 2016, as part of a strategic change in the company's business plan. This significantly affected the enrollment figures and account balances beginning in the calendar year 2016. Enrollment increased by 94.3% (2016) and 15.5% (2017). The company received a $50 million capital contribution to support the increase in premium and enrollment. Significant changes are seen in marked increases to the total assets and total liabilities account balances in 2016. These changes are attributable to this significant change in the business plan.

From a profitability standpoint, the company had an average profit margin of 6.7% over the examination period. The low of 1.6% occurred in 2013 and was due to an unusually high medical expense ratio of 86.2% in that year. The high of 9.7% occurred in 2017. This high in profitability was a function of a lowered medical expense ratio of 78.7% and a lowered administrative expense ratio of 11.7% compared to previous years under examination. The company made dividend payments of $145.0 million (2017), $27.0 million (2016), and $15.5 million (2015) to the parent company. As noted above the parent made a sizable capital contribution to the company of $50.0 million in 2015.

On the utilization side, one can see in the financial information that the mix of Medicare patients, vis-à-vis younger populations, increased the number of hospital days per 1,000 from less than 600 (2014 and 2015) to more than 800 (2016 and 2017). Additionally, the large influx of seniors increased the average length of stay to nearly five days in 2016 and 2017. The company is compensated for the higher cost of Medicare members by CMS, with Medicare per member per month (PMPM) premiums at $989.97 (2017), compared with commercial PMPM premiums at $463.60, and Medicaid PMPM premiums at $200.64. The changes in patient mix and utilization are attributable to the change in the business plan.

The company has grown significantly over the examination period primarily as a result of the influx of Medicare Advantage business obtained from eight states that resulted from a major change in the business plan, effective on January 1, 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		$1,759,989,679
Less:		
Special deposit		11,036,661
Liabilities		1,094,110,460
Assets available to satisfy surplus requirements		654,842,558
Net premium earned	$5,491,306,352	
Factor	3%	
Compulsory surplus		164,739,190
Compulsory surplus excess (deficit)		$ 490,103,368
Assets available to satisfy surplus requirements		$654,842,558
Compulsory surplus	$164,734,190	
Security factor	110%	
Security surplus		181,213,109
Security surplus excess (deficit)		$ 473,629,449

In addition, there is a special deposit requirement equal to the lesser of the following:

1. An amount necessary to maintain a deposit equaling 1% of premium written in this state in the preceding calendar year;

2. One-third of 1% of premium written in this state in the preceding calendar year.

The company has satisfied this requirement for 2017 with a deposit of $2,448,699 with the State Controller's Office.

Reconciliation of Capital and Surplus per Examination

There were no examination adjustments or reclassifications as a result of this examination.

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.

Report on Executive Compensation

Insurers are required to file an annual report on executive compensation pursuant to s. 611.63 (4), Wis. Stat. Companies are instructed to include any and all gross direct and indirect remuneration paid and accrued during the reporting year for the benefit of an individual director, officer, or manager, and shall include wages, stock grants, gains from the exercise of stock options, and all other forms of personal compensation (including employer-paid health, life, and any other premiums). The company failed to report its executives' health insurance premiums as a component of "Other Compensation" as required by the instructions. It is recommended that the company properly fill out and submit the Report on Executive Compensation in accordance with ss. 601.42 and 611.63 (4), Wis. Stat.

Delegation of Authority Policy

The company was unable to demonstrate that there was a documented delegation of authority (DOA) process that was implemented and adhered to for the pricing decisions across Medicare Advantage and Part D, Medicaid, E&I Individual, E&I Small Group, and E&I Large Group. Examiners obtained a copy of the formal Delegation of Authority Policy. Additionally, the examiners obtained populations representing Medicare Advantage and Part D, Medicaid, E&I Individual, E&I Small Group, and E&I Large Group representing all entities under the 2017 examination. From these populations, the examiners made the following number of selections and noted the associated number of exceptions:

- E&I Individual: 1 selection; 1 exception
- E&I Small Group: 2 selections; 1 exception
- E&I Large Group: 4 selections; 1 exception
- Medicaid: 4 selections; 3 exceptions
- Medicare Advantage/Part D: 6 selections; 6 exceptions

It is recommended that the company formally document and deploy its Delegation of Authority Policy across all segments and lines of business. Evidence of adherence to this policy should be maintained.

VIII. CONCLUSION

A major change to the business plan occurred during the examination period. The Medicare Advantage business from eight states was novated to the company, effective January 1, 2016. This significantly affected the enrollment and the surplus beginning in 2016. The changes to enrollment and surplus are attributable to this significant change in the business plan.

From a profitability standpoint, the company had an average profit margin of 6.7% over the examination period. The low of 1.6% occurred in 2013 and was due to an unusually high medical expense ratio of 86.2% in that year. The high of 9.7% occurred in 2017. This high in profitability was a function of a lowered medical expense ratio of 78.7% and a lowered administrative expense ratio of 11.7% compared to previous years under examination. The company-paid dividend payments of $145.0 million (2017), $27.0 million (2016), and $15.5 million (2015) to the parent company. The parent made a sizable capital contribution to the company of $50.0 million in 2015.

On the utilization side, one can see in the financial information that the mix of Medicare patients, vis-à-vis the younger populations, increased the number of hospital days per 1,000 to more than 800 in recent years. Additionally, the large influx of seniors increased the average length of a hospital stay to nearly five days. The changes in patient mix and utilization are attributable to the significant change in the business plan.

This examination resulted in no examination adjustments or reclassifications. There were two examination recommendations noted by this examination. The prior examination resulted in no examination recommendations.

IX. SUMMARY OF COMMENTS AND RECOMMENDATIONS

1. Page 32 - Report on Executive Compensation—It is recommended that the company properly fill out and submit the Report on Executive Compensation in accordance with ss. 601.42 and 611.63 (4), Wis. Stat.

2. Page 32 - Delegation of Authority Policy—It is recommended that the company formally document and deploy its Delegation of Authority Policy across all segments and lines of business.

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
Jerry DeArmond, CFE	Reserve Specialist
David Jensen, CFE	IT Specialist
Terry Lorenz	Workpaper Quality Specialist
John Coyle	Insurance Financial Examiner
Shelly Bueno	Insurance Financial Examiner
Nicholas Hartwig	Insurance Financial Examiner

Respectfully submitted,

Gene M. Renard, CFE
Examiner-in-Charge