Report of the Examination of

MercyCare HMO, Inc.

Janesville, Wisconsin

As of December 31, 2018

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State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

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January 23, 2020

Commissioner:

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

MERCYCARE HMO, INC.
Janesville, Wisconsin

and this report is respectfully submitted.

I. INTRODUCTION

The previous examination of MercyCare HMO, Inc. (MCHMO or the company) was conducted in 2015 as of December 31, 2014. The current examination covered the intervening period ending December 31, 2018 and included a review of such 2019 transactions as deemed necessary to complete the examination.

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

All accounts and activities of the company were considered in accordance with the risk-focused examination process. This may include assessing significant estimates made by management and evaluating management's compliance with statutory accounting principles, annual statement instructions, and Wisconsin laws and regulations. The examination does not attest to the fair presentation of the financial statements included herein. If during the course of the examination an

adjustment is identified, the impact of such adjustment will be documented separately at the end of the “Financial Data” section in the area captioned "Reconciliation of Surplus per Examination."

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

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

II. HISTORY AND PLAN OF OPERATION

MercyCare HMO, Inc., is described as a for-profit 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 group model, the company contracts with a sponsoring clinic to provide primary and specialist services.

The company was incorporated on August 4, 2004 and commenced business on September 30, 2004. The company is owned by MercyCare Insurance Company (MCIC), a Wisconsin-domiciled stock insurer owned by Mercy Health System Corporation (MHS), which, in turn, is owned by Mercy Health Corporation, which owns and controls a multi-faceted health care holding company system. In 2014, MHS merged with Rockford Health System to create a five-hospital regional system that will provide services to 40 communities in northern Illinois and southern Wisconsin. On November 25, 2015, pursuant to s. 611.72, Wis. Stat., a filing was submitted to this office to restructure the two holding companies. The holding company system underwent significant restructuring from the merger of MHS and Rockford Health System. Effective January 1, 2016, the ultimate controlling person of the holding company system became Mercy Health Corporation.

Effective January 1, 2007, MCIC entered a program agreement with MCHMO for the provision of offering a combined product. Under the agreement, MCHMO and MCIC offer a Point of Service (POS) benefit in one contract under several liabilities in MCHMO's service area. MCHMO is responsible for coverage of emergency care, services, and supplies provided by or referred by MCHMO contracted providers, and all coverage under the POS contract issued by MCIC that is assumed by MCHMO under the Assumption Agreement of September 30, 2004, under which MCHMO assumed the HMO coverage portion of the POS contracts issued by MCIC. MCIC provides coverage for non-emergency services and supplies not provided by or referred by an MCHMO contracted provider. The POS contract’s premiums and costs are allocated between MCIC and MCHMO.

Members may choose a primary care physician at the time of enrollment but for most products, a selection is not required. Generally, referrals are not necessary if the member sees a specialist in MCHMO's provider network. Referrals outside the network must be preapproved by the plan. The company has approximately 167 contracted primary care physicians and 447 specialists.

MCHMO provides most of the health care services to enrollees covered by its benefit contracts through a provider agreement with Mercy Health System Corporation. MHS agrees to provide inpatient, outpatient, physician and other services customarily provided by the hospital to enrollees. The contract has hold-harmless provisions that prohibit MHS from billing enrollees for covered services and MHS is subject to the statutory hold-harmless provisions of ch. 609, Wis. Stat. Should the company become insolvent, MHS agrees to provide covered services to enrollees hospitalized on the date of insolvency until the member is discharged. The company was added to the original contract between MCIC and MHS which had an initial term ending December 31, 1994. The contract automatically renews for additional terms of one year unless one party notifies the other of its intent not to renew at least 90 days prior to the end of the term.

Hospital inpatient and hospital outpatient services are capitated with MHS. The provider contract includes a provision that the insurer will not cover certain serious adverse events such as errors made by health care providers. Additionally, the insurer will not pay for services provided by non-health plan approved providers, excluded services defined in the member's group policy, services not provided under the direction of the member's physician in accordance with policies and procedures, and services that are not emergencies or are not medically necessary in the health plan's judgment. Members are responsible for their own errors and for receipt of benefits that are not covered services. As mentioned earlier, Mercy Hospital is capitated for the services they perform. The other hospitals listed are reimbursed on a discounted fee-for-service basis. These contracts also include hold-harmless provisions for the protection of policyholders prohibiting the hospitals from billing patients for amounts due from MCHMO.

In addition to Mercy Hospital and Trauma Center of Janesville, Wisconsin (Mercy Hospital) owned and operated by MHS, MCHMO contracts with the following hospitals:

Watertown Regional Medical Center
Fort Atkinson HealthCare

Meriter Hospital—Madison (only upon referral)
Milwaukee Children's Hospital-Milwaukee (only upon referral)
University HealthCare (only upon referral)
Rosecrance Behavioral Health (only upon referral)
Rogers Memorial Hospital (behavioral health services only upon referral)

The company currently contracts with individual physicians for primary care and specialty services, as well as contracts for ancillary and mental health services. The contracts include hold-harmless provisions for the protection of policyholders prohibiting physicians from billing patients for amounts due from MCHMO. The contracts have a one-year term and may be terminated upon 60 days' prior written notice by either party. These contracts limit the providers' risk to services rendered. Physicians are paid based on Optum's publication “Relative Values for Physicians” which are based on physician survey data from Relative Value Studies, Inc.

In addition to MHS, the company contracts with the following medical groups:

Fort Atkinson Healthcare – Physicians
Watertown Physician Practices LLC
University HealthCare Inc.
Beloit Area Community Health Center
Medical College of Wisconsin

The company's service area is comprised of Rock, Jefferson, and Walworth counties in Wisconsin and Winnebago and Boone counties in Illinois. The company offers comprehensive health care coverage which may be changed by riders to include deductibles and copayments. The following basic health care coverage is provided:

Physician services
Inpatient services
Outpatient services
Mental health, drug, and alcohol abuse services
Ambulance services
Special dental procedures (oral surgery)
Prosthetic devices and durable medical equipment
Newborn services
Home health care
Preventive health services
Family planning
Hearing exams and hearing aids
Diabetes treatment
Routine eye examinations
Convalescent nursing home service
Prescription drugs
Cardiac rehabilitation, physical, speech, and/or occupational therapy
Physical fitness or health education ($100 to $200 per year maximum dependent on plan design)
Kidney disease treatment

Certain transplants
Chiropractic services

Outpatient and inpatient behavioral health and alcohol and other drug abuse (AODA) coverage are provided in accordance with federal and state mental health parity laws. Copayments for emergency services range from $0 to $500, which may be waived upon admission into an inpatient facility. Skilled nursing care coverage ranges from 30 to an unlimited number of days per confinement, hearing aids are limited to one per ear every 36 months, infertility lifetime maximums range from $2,000 to unlimited to not covered, home health care is limited to 60 visits per year, physical therapy/occupational therapy is limited to 40 visits per contract year, and speech therapy is limited to 30 visits per contract year. Plan coverage is contingent on non-emergency services being provided by participating physicians and hospitals or on the company's preapproval of a referral from a participating physician. The company has plans in which office visits have copayments ranging from $0 to $75. Some plans also have a 0% to 30% coinsurance requirement, subject to out-of-pocket maximums ranging from $250 to $10,000/single and $500 to $24,500/family.

The company currently markets to groups, individuals (both Affordable Care Act [ACA] and non-ACA), and Medicare individuals. The company also has a Medicaid contract with the Wisconsin Department of Health Services. The company uses an internal marketing staff as well as outside agents. Most agent commissions are paid in a range from $3.50 to $34.00 per contract per month. A small number of agents are paid commissions of up to 6% of premiums on new and renewal business. There are approximately 188 independent agents and four internal sales staff writing for the company.

The company uses an actuarially determined base as a beginning point in premium determination. This rate is adjusted to reflect the coverage characteristics, age, occupation, gender, experience (if available), and individual medical history for new groups. Experience is reviewed, as well, for renewal groups. Based on the review, a recommendation is made regarding any rate adjustments. The base rate is adjusted quarterly for inflation and other trending factors.

III. MANAGEMENT AND CONTROL

The board of directors consists of nine members. Eight directors are elected annually to serve a one-year term and the president and chief executive officer of the company is an ex-officio member. Officers are appointed by the board of directors. Members of the company's board of directors may also be members of other boards of directors in the holding company group. The board members currently receive no compensation specific to their service on the company's board.

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

Name and Residence	Principal Occupation	Term Expires
Javon R. Bea Janesville, Wisconsin	President and Chief Executive Officer Mercy Health Corporation	Ex-officio
Mark L. Goelzer, M.D. Janesville, Wisconsin	Medical Consultant	2021
Mark D. Kopp Janesville, Wisconsin	Attorney Consigny Law Firm, S.C.	2018
Elizabeth A. Hansch Janesville, Wisconsin	Retired Interior Designer	2018
Rowland J. McClellan Janesville, Wisconsin	Retired Bank President	2021
Thomas R. Pool Rochester, Minnesota	Retired	2020
Larry E. Squire Janesville, Wisconsin	Regional President Johnson Bank	2018
Katherine Schack Harvard, Illinois	Retired Owner and Manager Harvard Retirement Home	2022
Dave L. Syverson Rockford, Illinois	Illinois State Senator	2022

Officers of the Company

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

Name	Office	2018 Compensation
Javon R. Bea	President and Chief Executive Officer	$ 0
E. Patrick Cranley	Vice President	$345,243
Thomas D. Budd	Secretary/Treasurer	$ 0

The officer's salaries are paid by MHS through a support service agreement with the company. The above represents the total gross compensation for the whole health system.

The company's bylaws allow for the formation of certain committees by the board of directors. MercyCare HMO, Inc., has not formed any committees; therefore, the company's entire board of directors constitutes the audit committee.

The company has no employees. Necessary staff is provided through a management agreement with MHS. Under the agreement, effective January 1, 2007, MHS agrees to provide a full range of administrative services in the following areas:

- Financial and medical management
- Provider relations
- Claims and data processing
- General administration
- Marketing and underwriting
- Regulatory relations

The monthly compensation paid to MHS for providing these services is billed at the actual cost to perform them. MHS bills MCIC and MCHMO for an estimate of such cost each month, along with any reconciliation of actual amounts due for any prior month, in advance of the month. MCIC shall pay each such bill within 10 days after receipt. MCIC and MCHMO promptly allocate such compensation between them based on their proportionate share of total premiums written by each during the month at issue. The term of the agreement is three years with automatic renewal. 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

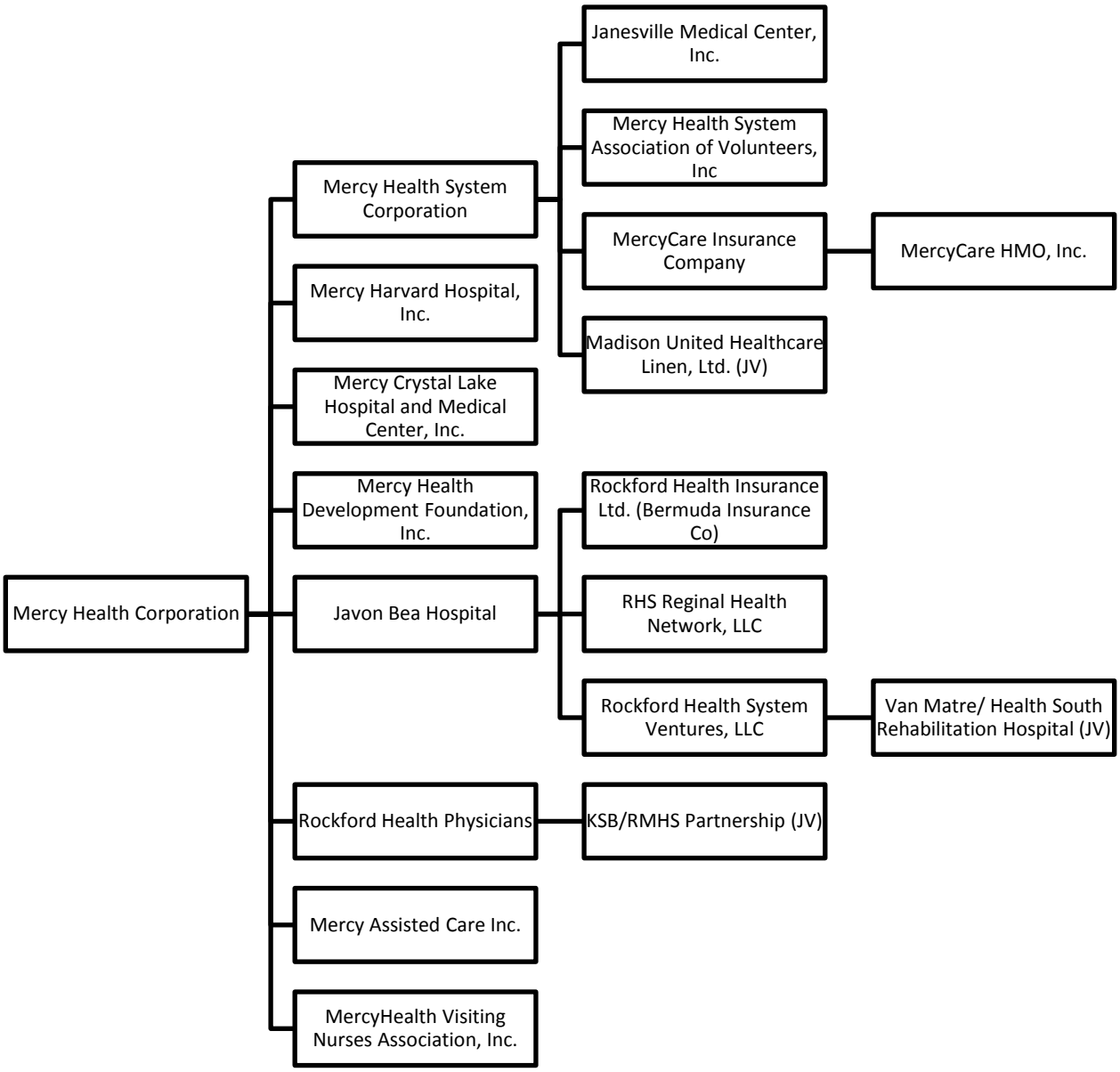
2. Enrollees will be entitled to similar, alternate coverage which does not contain any medical underwriting or preexisting limitation requirements.

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

IV. AFFILIATED COMPANIES

MercyCare HMO, Inc., is a member of a holding company system. Its ultimate parent is Mercy Health Corporation. The organizational chart below depicts the relationships among the affiliates in the group. A brief description of the significant affiliates of the company follows the organizational chart.

Holding Company Chart
As of December 31, 2018



Mercy Health Corporation (MHC)

Mercy Health Corporation is a not-for-profit corporation that serves as the ultimate parent organization for all affiliated entities. MHC provides operational support to all its affiliates. MHC underwent significant holding company restructuring since the last examination as a result of the merging of Mercy Health System and Rockford Health System. Mercy Health Corporation was formerly known as MercyRockford Health System. Part of the restructuring was to eliminate the two intermediate holding companies, Mercy Alliance, Inc., and Rockford Health System, by merging the two companies. Effective January 1, 2016, the corporation was renamed Mercy Health Corporation. As of June 30, 2019, MHC's audited consolidated financial statement reported assets of $2.04 billion, liabilities of $1.04 billion, and unrestricted net assets of $998.6 million. Operations for the fiscal year ending June 30, 2019, produced an increase in net assets of $49.4 million on total revenue of $1.12 billion.

Mercy Health System Corporation (MHSC)

Mercy Health System Corporation, headquartered in Janesville, Wisconsin, is a vertically integrated multi-specialty health care delivery system serving southern Wisconsin and northern Illinois. The system operates a 240-bed hospital with approximately 43 physician clinics in southern Wisconsin and northern Illinois. MHSC's holdings include three hospitals, two insurance companies, and a provider network of over 400 multi-specialty physicians. As of June 30, 2019, MHSC's audited financial statement reported assets of $588.5 million, liabilities of $328.1 million, and unrestricted net assets of $260.4 million. Operations for the fiscal year ending June 30, 2019, produced an increase in net assets of $23.3 million on revenues of $592.9 million.

MercyCare Insurance Company

MercyCare Insurance Company is a Wisconsin-domiciled stock insurance company. The company wholly owns MercyCare HMO, Inc. MCIC's direct parent is MHSC. As of December 31, 2018, the audited financial statements of MCIC reported assets of $12.3 million, liabilities of $2 million, and capital and surplus of $10.3 million. Operations for 2018 produced a net income of $261 thousand on revenues of $391 thousand.

Javon Bea Hospital (formerly known as Rockford Memorial Hospital)

Javon Bea Hospital operates a 94-bed hospital and another 19-bed hospital providing inpatient, outpatient, and emergency care services to residents in Rockford, Illinois. As of June 30, 2019, the audited financial statements of Javon Bea Hospital reported assets of $819.4 million, liabilities of $626.5 million, and total net assets of $192.9 million. Operations for the fiscal year ending June 30, 2019. produced a decrease in net assets without donor restrictions of $40.3 million on total revenue of $412.9 million.

Rockford Health Physicians

Rockford Health Physicians provides physician and ambulatory care services. As of June 31, 2019, the audited financial statements of Rockford Health Physicians reported assets of $130.1 million, liabilities of $47.0 million, and unrestricted net assets of $83.1 million. Operations for the fiscal year ending June 30, 2019, produced an increase in net assets of $46.7 million on total revenue of $154.9 million.

Agreements with Affiliates

MercyCare HMO, Inc., has entered into several affiliated agreements. These agreements are described below:

- Effective September 30, 2004, the company entered into an assumption agreement with MCIC. Under this agreement, MCIC and MCHMO agree to have MCHMO assume all HMO coverage as well as other existing health maintenance organization business of MCIC.

- Effective January 1, 2007, the company entered into a support service agreement with MCIC and MHS for the provision of covered services to MCIC members.

- Effective January 1, 2007, the company entered a program agreement with MCIC for the provision of MCIC offering a combined product. Under this agreement, MCIC and the company offer a point-of-service benefit together in one contract in MCHMO's service area. Premium and expenses are allocated based on the following: MCHMO is responsible for HMO coverage and MCIC is responsible for indemnity coverage. This agreement is described in further detail in the section of this report captioned "History and Plan of Operation."

- Effective January 1, 2007, the company entered into a tax allocation agreement with MCIC. Under this agreement, MCIC and MCHMO agree to file a federal consolidated tax return. Each company agrees to contribute towards the payment of the consolidated tax liability in an amount determined on a separate return basis.

- Effective February 7, 2011, the company entered into a provider service agreement with MCIC and Mercy Assisted Care. Under this agreement, Mercy Assisted Care agrees to deliver or arrange for delivery of certain health care services or benefits to members of MCIC and MCHMO. The agreement also includes an amendment including a professional provider

agreement. Under this amendment, the parties agree to include Medicare Advantage Participants under the agreement.

- Effective February 7, 2011, the company entered into a provider service agreement with MCIC and Mercy Harvard Hospital. Under this agreement, Mercy Harvard Hospital agrees to deliver or arrange for delivery of certain health care services or benefits to members of MCIC and MCHMO. The agreement also includes an amendment including a professional provider agreement. Under this amendment, the parties agree to include Medicare Advantage Participants under the agreement.

- Effective February 7, 2011, the company entered into a provider service agreement with MCIC and Mercy Health System Corporation. Under this agreement, Mercy Health System Corporation agrees to deliver or arrange for delivery of certain health care services or benefits to members of MCIC and MCHMO.

- Effective November 20, 2015, the company entered into a provider service agreement with MCIC and Rockford Health Physicians. Under this agreement, Rockford Health Physicians agrees to deliver or arrange for delivery of certain health care services or benefits to members of MCIC and MCHMO.

- Effective November 20, 2015, the company entered into a provider service agreement with MCIC and Javon Bea Hospital (formerly known as Rockford Memorial Hospital). Under this agreement, Javon Bea Hospital agrees to deliver or arrange for delivery of certain health care services or benefits to members of MCIC and MCHMO.

- Effective November 24, 2015, the company entered into a provider service agreement with MCIC and Visiting Nurse Association of the Rockford Area. Under this agreement, the Visiting Nurse Association of the Rockford Area agrees to deliver or arrange for delivery of certain health care services or benefits to members of MCIC and MCHMO.

V. REINSURANCE

At the time of the examination, the company had one reinsurance treaty, which is described below.

Reinsurer:	The North River Insurance Company
Type:	Excess of Loss Reinsurance
Scope:	January 1, 2019
Retention:	$500,000 per member per agreement period
Coverage:	$5,000,000 per member per agreement period maximum
Termination:	The agreement terminates on the earliest of the following dates: a. Non-payment of premium will result in termination of this agreement. b. The date that a court of competent jurisdiction declares a party to be insolvent. c. The date of a material change, such as a change in the liability assumed by the company as solely determined by the company. d. The expiration date shown on the Schedule of Reinsurance is December 31, 2019.

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

- Date of reinsured insolvency shall be the later of the date MCHMO is declared Insolvent or the date of cessation of operations.
- Reinsurer will continue plan benefits covered under the applicable member services agreement(s) with respect to plan benefits incurred and payable for any covered person(s) confined in a hospital or any other eligible inpatient facility on the date of MCHMO's insolvency until the earliest of:
    - The covered person's(s') discharge from the hospital; or
    - The date covered person(s) becomes eligible for health coverage or benefits under another group or blanket policy or plan or any federal, state or local governmental plan or program; or
    - 365 days from the date of MCHMO insolvency.
    - The reinsurer will continue the plan benefits for the covered person(s) with respect to plan benefits incurred for medical services or treatment received after the date of MCHMO's insolvency (including services rendered to covered person(s) who were confined on the date of MCHMO insolvency but subsequently discharged from a hospital) until the end of the period for which premium was received by the MCHMO for the covered person(s) prior to the date of MCHMO insolvency not to extend beyond the end of the calendar month in which the date of MCHMO insolvency occurs as long as such plan benefits are payable by such covered person(s). In no event will the coverage extend beyond the end of the period of time for which premium prepayments were received.
    - In no event shall the company's liability under the endorsement be greater than that which the MCHMO would have been obligated to provide under the applicable member service agreement(s) between MCHMO and the covered persons including the obligation of participating providers.
    - The aggregate maximum liability of the reinsurer pursuant to this endorsement is limited to the $5,000,000.

VI. FINANCIAL DATA

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

MercyCare HMO, Inc.
Assets
As of December 31, 2018

	Assets	Nonadmitted Assets	Net Admitted Assets
Bonds	$ 9,244,178	$	$ 9,244,178
Common stocks	17,965,745		17,965,745
Cash, cash equivalents and short-term investments	5,665,136		5,665,136
Investment income due and accrued	91,002		91,002
Uncollected premiums and agents' balances in the course of collection	584,626		584,626
Current federal and foreign income tax recoverable and interest thereon	30,141		30,141
Net deferred tax asset	1,099,000	653,000	446,000
Receivables from parent, subsidiaries and affiliates	1,628,266	1,628,266	
Health care and other amounts receivable	2,011,551	359,469	1,652,082
Total Assets	$38,319,645	$2,640,735	$35,678,910

MercyCare HMO, Inc.
Liabilities and Net Worth
As of December 31, 2018

Claims unpaid		$12,529,879
Unpaid claims adjustment expenses		376,500
Aggregate health policy reserves		1,128,941
Premiums received in advance		1,964,980
General expenses due or accrued		274,893
Amounts due to parent, subsidiaries, and affiliates		1,924,013
Aggregate write-ins for other liabilities (including $(1) current)		6,673,293
Total Liabilities		24,872,499
Common capital stock	$ 1	
Gross paid in and contributed surplus	11,499,999	
Unassigned funds (surplus)	(693,535)	
Total Capital and Surplus		10,806,465
Total Liabilities, Capital and Surplus		$35,678,964

MercyCare HMO, Inc.
Statement of Revenue and Expenses
For the Year 2018

Net premium income		$106,795,550
Medical and Hospital:		
Hospital/medical benefits	$ 89,528,570	
Prescription drugs	11,587,746	
Subtotal	101,116,316	
Less		
Net reinsurance recoveries	421,244	
Total medical and hospital	100,695,072	
Claims adjustment expenses	2,447,709	
General administrative expenses	8,194,506	
Increase in reserves for life and accident and health contracts	(1,171,059)	
Total underwriting deductions		110,166,228
Net underwriting gain or (loss)		(3,370,678)
Net investment income earned	1,054,278	
Net realized capital gains or (losses)	(73,340)	
Net investment gains or (losses)		980,938
Net Income (Loss)		$ (2,389,740)

Capital and Surplus Account
For the Five-Year Period Ending December 31, 2018

	2018	2017	2016	2015	2014
Capital and surplus, beginning of year	$16,997,561	$15,828,077	$14,210,473	$15,079,993	$17,732,047
Net income (loss)	(2,389,740)	(1,901,043)	1,532,934	(42,598)	(1,927,040)
Change in net unrealized capital gains/losses	(2,587,180)	2,570,763	1,298,205	(1,703,124)	12,977
Change in net deferred income tax	165,000	844,000	(496,000)	62,000	210,000
Change in nonadmitted assets	(1,379,176)	(344,236)	(717,535)	814,202	(947,991)
Surplus, End of Year	$10,806,465	$16,997,561	$15,828,077	$14,210,473	$15,079,993

MercyCare HMO, Inc.
Statement of Cash Flow
For the Year 2018

Premiums collected net of reinsurance			$108,944,300
Net investment income			1,105,853
Miscellaneous income			(30,141)
Total			110,020,012
Less:			
Benefit- and loss-related payments		$107,733,589	
Commissions, expenses paid and aggregate write-ins for deductions		7,174,523	
Total			114,908,112
Net cash from operations			(4,888,100)
Proceeds from Investments Sold, Matured or Repaid:			
Bonds		5,884,981	
Cost of Investments Acquired—Long-term Only:			
Bonds	$6,152,202		
Stocks	763,821		
Total investments acquired		6,916,023	
Net cash from investments			(1,031,042)
Cash Provided/Applied:			
Other cash provided (applied)			271,084
Net Change in Cash, Cash Equivalents, and Short-Term Investments			(5,648,058)
Cash, cash equivalents, and short-term investments:			
Beginning of year			11,313,194
End of Year			$ 5,665,136

Growth of MercyCare HMO, Inc.

Year	Assets	Liabilities	Capital and Surplus	Premium Earned	Medical Expenses Incurred	Net Income
2018	$ 35,678,910	$ 24,872,499	$ 10,806,465	$ 106,795,550	$ 100,695,072	$ (2,389,740)
2017	43,947,642	26,950,080	16,997,560	92,958,755	86,370,429	(1,901,043)
2016	31,019,277	15,191,198	15,828,076	81,890,821	74,725,479	1,532,934
2015	27,271,048	13,060,576	14,210,471	79,478,955	73,422,489	(42,598)

Year	Profit Margin	Medical Expense Ratio	Administrative Expense Ratio	Change in Enrollment
2018	-2.2%	93.2%	10.0%%	-4.6%
2017	-2.0%	95.4%	7.7%	-12.3%
2016	1.9%	91.2%	8.0%	-3.6%
2015	-0.1%	92.4%	9.5%	-9.2%

Enrollment and Utilization

Year	Enrollment	Hospital Days/1,000	Average Length of Stay
2018	28,637	331.30	3.6
2017	29,969	310.50	5.6
2016	26,693	209.98	4.0
2015	27,677	187.44	3.6

Per Member Per Month Information

	2018	2017	Percentage Change
Premiums:			
Commercial	$402.99	$365.79	10.2%
Medicare Supplement	166.92	157.55	6.0%
Medicaid	163.25	152.12	7.3%
Expenses:			
Hospital/medical benefits	246.09	215.66	14.1%
Prescription Drugs	31.85	24.76	28.5%
Less: Net reinsurance recoveries	1.16	1.18	-1.7%
Total medical and hospital	279.10	241.60	15.7%
Claims adjustment expenses	6.73	5.35	25.8%
General administrative expenses	22.52	14.57	54.7%
Increase in reserves for accident and health contracts	(3.22)	6.37	-150.5%
Total underwriting deductions	$302.82	$265.56	14.0%

During 2018, the company reported a net loss primarily due to higher medical and administrative expenses. The spike in medical expenses was primarily due to the increasing membership in Commercial and ACA individual lines of business. MCHMO's membership continues to fluctuate. The decline was primarily in its Medicaid membership, offset by increased membership in the ACA Individual block of business. Revenue and medical expense changes produced a higher medical loss ratio in 2018 of 94% as compared to 2017 of 92%.

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 compulsory surplus calculation as of December 31, 2018, as modified for examination adjustments is as follows. (The adjustments are discussed in the section of this report captioned "Summary of Current Examination Results.")

Assets	$ 35,678,910	
Less:		
Special deposit	1,200,000	
Liabilities	24,872,499	
Investments in excess of maximum allowable by Ch. 620, Wis. Stat.	7,438,138	
Examination adjustments	894,302	
Assets available to satisfy surplus requirements		$ 1,273,971
Net premium earned	106,795,550	
Compulsory surplus	3%	3,203,867
Compulsory Surplus Excess (Deficit)		$(1,929,896)
Assets available to satisfy surplus requirements		$ 1,273,971
Compulsory surplus	$3,203,867	
Security factor	138%	
Security surplus		4,421,336
Security Surplus Excess (Deficit)		$(3,147,365)

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 2018 with a deposit of $1,200,000 with the state treasurer.

Reconciliation of Capital and Surplus per Examination

No adjustments were made to capital and surplus as a result of the examination. The amount of surplus reported by the company as of December 31, 2018, is accepted. However, as described in the section of this report captioned, “Investments,” certain investments in excess of statutory limitations caused the company to fail its compulsory surplus requirement and security surplus standard pursuant to ss. 623.11 and 623.12, Wis. Stat., and s. Ins 51.80, Wis. Adm. Code, as of December 31, 2018. Failure to comply with the compulsory surplus requirement is grounds for liquidation under s. 645.41, Wis. Stat.

VII. SUMMARY OF EXAMINATION RESULTS

Compliance with Prior Examination Report Recommendations

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

1. Investments—It is again recommended that the company deduct investments in excess of ch. 620, Wis. Stat., limitations in future compulsory and security surplus calculations.

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

2. Reinsurance—It is recommended the company report transitional reinsurance assessments and administrative expenses attributable to individual plans as ceded reinsurance premiums on line 11 of the Liabilities, Capital, and Surplus page in accordance with Statement of Statutory Accounting Principles (SSAP) No. 107, paragraphs 25-31.

   Action—Compliance.

3. Reinsurance—It is recommended the company report ceded premium attributable to individual plans on Schedule S, Part 3, Section 2, with HHS listed as the authorized reinsurer in accordance with SSAP No. 107, paragraphs 25-31 and 36.

   Action—Compliance.

4. Reinsurance—It is recommended that the company report recoveries attributable to individual insurance plans on Schedule S, Part 2, with HHS listed as the authorized reinsurer in accordance with SSAP 107, paragraphs 34-36.

   Action—Compliance.

5. Annual Statement Reporting—It is recommended that the company nonadmit pharmacy rebate receivable accruals over 90 days in compliance with SSAP No. 84, paragraph 10.

   Action—Noncompliance. Further comment is contained in the section of this report captioned, "Annual Statement Reporting."

6. Supplemental Health Care Exhibit – Expense Allocation Report—It is recommended that the company report allocations of quality improvement expenses to the medical expense category on the Supplemental Health Care Exhibit - Expense Allocation Report.

   Action—Compliance.

7. Custodial or Safekeeping Agreements—It is recommended that the company update the custodial agreement with Johnson Bank to include the proper language indemnifying MercyCare HMO, Inc., against loss due to negligence or dishonesty of the custodian's officers or employees, or burglary, robbery, holdup, theft, or mysterious disappearance, including loss by damage or destruction, and the custodial agreements must include language indicating that the loss of these indemnified securities will be properly replaced or the value of the securities or any loss of rights or privileges will be promptly replaced.

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

8. Custodial or Safekeeping Agreements—It is recommended that, if a sub-custodian is used, the custodian's indemnification for negligence or dishonesty under the custodial agreement must be extended to apply to any sub-custodian.

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

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.

Custodial or Safekeeping Agreements

The examination found that the custodial agreement has not changed since 2007, despite recommendations contained in the prior examination report indicating the necessity for certain changes. The custodial agreement with Johnson Bank includes indemnification language that does not clearly indemnify the company against loss. The agreement states:

> "Custodian shall not be liable for any loss or depreciation resulting from any action or inaction of Custodian taken in good faith pursuant to the terms of this Agreement or as a result of following a direction or instruction from Client or Investment Advisor. Custodian is specifically indemnified by Client against loss, damage and expense in carrying out Custodian's duties hereunder, provided such loss or expense is not due to its willful misconduct."

The NAIC *Financial Condition Examiners Handbook* sets forth satisfactory safeguards and controls that should be included in custodial or safekeeping agreements. These safeguards and controls include, but are not limited to:

- The custodian is obligated to indemnify the insurance company for any loss of securities in the custodian's custody occasioned by the negligence or dishonesty of the custodian's officers or employees, or burglary, robbery, holdup, theft, or mysterious disappearance, including loss by damage or destruction
- In the event of a loss of the securities for which the custodian is obligated to indemnify the insurance company, the securities shall be promptly replaced or the value of the securities and the value of any loss of rights or privileges resulting from said loss of securities shall be promptly replaced

It is again recommended that the company obtain a custodial agreement with its investment custodian that includes proper language indemnifying MercyCare HMO, Inc., against loss as noted above and the custodial agreements must include language indicating that the loss of these indemnified securities will be properly replaced or the value of the securities or any loss of rights or privileges will be promptly replaced.

Furthermore, it was noted that although the company has a custodial agreement with Johnson Bank (the bank), the assets are held by a sub-custodian, SEI Investments. According to the guidelines for custodial agreements contained in the NAIC *Financial Condition Examiners Handbook*, the terms of

the custodial agreement must define, among other things, the custodian's responsibilities for the securities that were lost due to the custodian's negligence or dishonesty. The custodial agreement between the company and the bank does not contain provisions for a sub-custodian. It is unclear what responsibility the bank has with respect to the sub-custodian and vice versa. It is again recommended that if a sub-custodian is used, the custodian's indemnification for negligence or dishonesty under the custodial agreement must be extended to apply to any sub-custodian.

Investments

Pursuant to s. 620.23, Wis. Stat., investments by Wisconsin domiciled insurers in securities of a single issuer are limited to 10% of admitted assets. Investments in loans, securities, or investments in countries other than the United States or Canada are limited to 2% of admitted assets pursuant to s. Ins 6.20 (8) (k), Wis. Adm. Code. A further additional "basket" allocation of 5% of admitted assets for any excess investment is permitted by s. 620.22 (9), Wis. Stat. Under s. 620.21 (1), Wis. Stat., assets may be counted toward satisfaction of the compulsory surplus requirement or the security surplus standard only insofar as they are invested in compliance with ch. 620, Wis. Stat.

In the reports of examination of MCHMO as of December 31, 2011, and as of December 31, 2014, it was noted that the company was not in compliance with the investment limitations of s. 620.23 (2) (b),Wis. Stat., which limits all securities of a single issuer to 10% of admitted assets. In addition, in both prior reports of examination, it was noted that the company failed to properly adjust the calculation of its compulsory surplus requirement and the security surplus standard for the amount of its investments in excess of statutory requirements.

As of December 31, 2018, MCHMO owned shares in three mutual funds. Two of those mutual funds, Vanguard 500 Index Fund Admiral Shares and Lord Abbett Value Opportunities Fund, which invest in U.S. equities, had statutory values greater than 10% of admitted assets, while the third mutual fund, Dodge & Cox International Stock Fund, which invests in foreign non-U.S. equities, had a statutory value in excess of 2% of admitted assets.

The company's adjustment to assets in the company's compulsory and security surplus calculation as of December 31, 2018, which is required to avoid overstatement of the company's position with respect to the compulsory surplus requirement and security surplus standard, was again

not properly calculated. The company correctly deducted $7,438,138 from assets for two of the three mutual funds but failed to make any deduction for its excess investment in the Dodge & Cox International Stock Fund. The table below depicts the appropriate calculation.

	Book Value	10% of Assets	Investment Above the 10% Limit
Vanguard 500 Index Fund	$9,824,617	$3,567,891	$ 6,256,726
Lord Abbett Value Opportunity Fund	4,749,303	3,567,891	$ 1,181,412
Subtotal			$ 7,438,138

	Book Value	2% of Assets	Investment Above the 2% Limit
Dodge & Cox International Stock Fund	$3,391,826	$713,578	$ 2,678,248
Subtotal of three mutual funds			$ 10,116,386
5% Basket Clause			$ 1,783,946
			$ 8,332,440

The difference between the amount the company reported and the calculation above is $894,302. The adjustments for the excess investment in securities of a single issuer, in the amount of investments in countries other than the United States or Canada, and the foregoing error are reflected in the examination's Compulsory and Security Surplus Calculation included in the "Financial Data" section of this report.

As of December 31, 2018, the examination's calculation of the company's compulsory surplus requirement was a deficit of $(1,929,896), while the examination's calculation of the company's security surplus standard was a deficit of $(3,147,365). As reflected on page 21 of this report, the company does not meet the compulsory surplus requirement and the security surplus standard either before or after adjusting for this error. Failure to comply with the compulsory surplus requirement is grounds for liquidation under s. 645.41, Wis. Stat. It is again recommended that the company deduct investments in excess of the limitations of ch. 620, Wis. Stat., in future calculations of the compulsory surplus requirement and security surplus standard.

Annual Statement Reporting

The examination disclosed that the company was not properly nonadmitting pharmacy rebate receivable accruals over 90 days past due in Exhibit 3 of its 2018 annual statement. Per

Statement of Statutory Accounting Principles (SSAP) 84, “Health Care Receivables and Receivables Under Government Insured Plans”, pharmacy rebate receivables are admitted only when:

1. Confirmation (or letter notifying estimated rebate amount) is received within 90 days prior to year-end.
2. QR rebate receivable, confirmation must be received within two months of the reporting date (12/31/2018)

This is a repeated examination recommendation. It is again recommended that the company nonadmit pharmacy rebate receivable accruals over 90 days old in compliance with SSAP No. 84, paragraph 10.

Annual Statement Reporting

The examination disclosed that the company was not reporting the accrued number of hospital patient days experienced by the total membership and hospital days incurred for 2017 were not disclosed. It is highly unlikely that the company had no member encounter hospital patient days or inpatient admissions. An *admission* is hospital inpatient care for any medical condition. *Hospital day* is a day for which contractual coverage is provided to a member while receiving inpatient care. It is recommended that the company report total hospital patient days incurred and the number of inpatient admissions in the annual statement Exhibit of Premiums, Enrollment, and Utilization, in accordance with NAIC Annual Statement Instructions – Health.

Executive Compensation

The State of Wisconsin requires that each Wisconsin-domiciled insurer file a supplement to the annual statement titled “Report on Executive Compensation” pursuant to ss. 601.42 and 611.63 (4), Wis. Stat. Compensation reported should include all gross, direct, and indirect remuneration paid and accrued during the reporting year for the benefit of the individual, including wages, salaries, bonuses, retirement benefits, deferred compensation, commissions, fees, and other forms of personal compensation. The review and reconciliation of the Report of Executive Compensation form disclosed that the company was not properly recording total compensation. As noted on the form, at the bottom of “Part 1 Officer and Executive Management Compensation,” the company marked “Yes” indicating the reporting insurer is a member of a group of insurers or holding company system, and “Yes”

indicating total gross compensation disclosed as paid to each individual is by or on behalf of all companies that are part of the group. The examination noted that the Report on Executive Compensation filed by the company for all years during the examination period did not include total gross compensation paid by the company. It is recommended that the company properly complete the Report on Executive Compensation as required by s. 611.63 (4), Wis. Stat.

Corporate Governance

In accordance with a directive of the Commissioner of Insurance dated March 9, 1989, each company is required to establish a procedure for the disclosure to its board of directors of any material interest or affiliation on the part of its officers, directors, or key employees which conflicts or is likely to conflict with the official duties of such person. In addition, according to the company's Conflict of Interest Policy, "Annually, members of the Board of Directors and Leadership are required to sign a declaration disclosing any relationship that may be construed as a conflict of interest." The examination disclosed the company could not produce signed forms for several individuals. It is recommended that the company's directors, officers, and management employees properly complete and disclose potential conflicts of interest on an annual basis in accordance with the company's Conflict of Interest Policy and the directive of the Wisconsin Office of the Commissioner of Insurance regarding disclosure of conflicts of interest.

Biographical Information

Pursuant to s. Ins 6.52 (5), Wis. Adm. Code, "A report shall be provided by each domestic insurer to which this rule applies with respect to the appointment or election of any new director, trustee or officer elected or appointed within 15 days after such appointment or election…" The examination revealed that the required biographical reports had not been filed on behalf of several individuals. It is recommended that the company timely file biographical information for newly elected or appointed officers and directors in accordance with s. Ins 6.52 (5), Wis. Adm. Code.

Information Systems

The company was unable to, after several requests, supply premium data information for the examination period. The company could not populate or export premium data information from Tapestry for this financial examination, there was limited information to allow verification or

confirmation of premium totals with the 2018 annual statement. It is recommended that the company develop or make appropriate modifications to the current information system to capture premium data information.

Other Information System Recommendations

It is recommended that the company strengthen its information system controls in accordance with the recommendations made in the letter to management provided in conjunction with this report.

VIII. CONCLUSION

MercyCare HMO, Inc., can be described as a for-profit group model health maintenance organization insurer organized under ch. 611, Wis. Stat. The company commenced business on September 20, 2004, when it assumed all HMO business from its parent, MercyCare Insurance Company. In 2011, company management decided to start offering Medicare Advantage products in January 2012. Due to the merger of Mercy Health System Corporation and Rockford Health System in January 2015, Rockford Health System facilities and providers were incorporated into its provider network. MCHMO was granted an Illinois Certificate of Authority in 2016 to offer HMO group plans and began expansion in the Rockford, Illinois insurance marketplace effective January 1, 2017. As of December 2018, MCHMO had 1,059 enrolled Illinois members.

In 2018, the company reported assets of $35,678,910, liabilities of $24,872,499 and surplus of $10,806,465. Operations for 2018 produced a net loss of $2,389,740. Net losses were primarily attributable to higher than anticipated medical costs in the commercial and ACA individual product lines of business. MCHMO's membership continues to decrease in the Medicare lines and is expected to decline further in 2019 but this decline is expected to be offset by an increase in the ACA individual lines. Surplus decreased 36% in 2018 primarily due to the net loss and the increase in nonadmitted assets, the latter of which is primarily attributable to receivables from MCIC and net deferred tax assets.

The examination review of invested assets found that the company exceeded the investment limitations of ch. 620, Wis. Stat. As a result, the 2018 year-end compulsory and security surplus calculations were modified by the examination. The company's compulsory surplus calculation was adjusted and modified for the examination in which indicated a compulsory deficit in the amount of $(1,929,896) and a security deficit of $(3,147,365) for 2018 year. Failure to maintain compulsory surplus is grounds for liquidation under s. 645.41, Wis. Stat.

The current examination resulted in a total of 10 recommendations, including four repeated recommendations. Recommendations repeated from the prior examination related to investments, custodial agreements, and pharmacy rebate accruals. Additional areas of improvement recommended by this examination included, but were not limited to, annual statement reporting,

reporting of executive compensation, disclosure of conflicts of interest, reporting of biographical information, and information systems output and controls.

IX. SUMMARY OF COMMENTS AND RECOMMENDATIONS

1. Page 25 Custodial or Safekeeping Agreements—It is again recommended that the company obtain a custodial agreement with its investment custodian that includes proper language indemnifying MercyCare HMO, Inc., against loss as noted above and the custodial agreements must include language indicating that the loss of these indemnified securities will be properly replaced or the value of the securities or any loss of rights or privileges will be promptly

2. Page 26 Custodial or Safekeeping Agreements—It is again recommended that if a sub-custodian is used, the custodian's indemnification for negligence or dishonesty under the custodial agreement must be extended to apply to any sub-custodian.

3. Page 27 Investments—It is again recommended that the company deduct investments in excess of the limitations of ch. 620, Wis. Stat., in future calculations of the compulsory surplus requirement and security surplus standard.

4. Page 28 Annual Statement Reporting—It is again recommended that the company nonadmit pharmacy rebate receivable accruals over 90 days old in compliance with SSAP No. 84, paragraph 10.

5. Page 28 Annual Statement Reporting—It is recommended that the company report total hospital patient days incurred and the number of inpatient admissions in the annual statement Exhibit of Premiums, Enrollment, and Utilization, in accordance with NAIC *Annual Statement Instructions – Health*.

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

7. Page 29 Corporate Governance—It is recommended that the company's directors, officers, and management employees properly complete and disclose potential conflicts of interest on an annual basis in accordance with the company's Conflict of Interest Policy and the directive of the Wisconsin Office of the Commissioner of Insurance regarding disclosure of conflicts of interest.

8. Page 29 Biographical—It is recommended that the company timely file biographical information for newly elected or appointed officers and directors in accordance with s. Ins 6.52 (5), Wis. Adm. Code.

9. Page 30 Information Systems—It is recommended that the company develop or make appropriate modifications to the current information system to capture premium data information.

10. Page 30 Other Information System Recommendations—It is recommended that the company strengthen its information system controls in accordance with the recommendations made in the letter to management provided in conjunction with this report.

X. ACKNOWLEDGMENT

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
Martha Goettelman	Insurance Financial Examiner
Mark Prodoehl	Insurance Financial Examiner
Jim Krueger	ACL Specialist
Terry Lorenz, CFE	Workpaper Specialist
Dave Jensen, CFE	IT Specialist
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Respectfully submitted,

Sheng Vang
Examiner-in-Charge