Report of the Examination of

Managed Health Services Insurance Corp.

West Allis, Wisconsin

As of December 31, 2022

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June 7, 2024

Honorable Nathan D. Houdek
Commissioner of Insurance
State of Wisconsin
125 South Webster Street
Madison, Wisconsin 53703

Commissioner:

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

MANAGED HEALTH SERVICES INSURANCE CORP.
West Allis, Wisconsin

and this report is respectfully submitted.

I. INTRODUCTION

The previous examination of Managed Health Services Insurance Corp. (MHSIC or the HMO or company) was conducted in 2018 as of December 31, 2017. The current examination covered the intervening period ending December 31, 2022, and included a review of such subsequent transactions as deemed necessary to complete the examination.

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

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

All accounts and activities of the company were considered in accordance with the risk-focused examination process. This may include assessing significant estimates made by management and evaluating management's compliance with statutory accounting principles, annual statement instructions, and Wisconsin laws and regulations. The examination does not attest to the fair presentation of the financial statements included herein. If during the course of the examination an adjustment is identified, the impact of such adjustment will be documented separately at the end of the "Financial Data" section in the area captioned "Reconciliation of Surplus per Examination."

Emphasis was placed on those areas of the company's operations accorded a high priority by the examiner-in-charge when planning the examination. 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 concerning the alternative or additional examination steps performed during the examination.

II. HISTORY AND PLAN OF OPERATION

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

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

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

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

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

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

	Revenue	Enrollment
Managed Health Services BC+	$120,057,392	60,920
Managed Health Services SSI	45,653,638	7,165
Medicare	64,148,030	3,472
Network Health Plan BC+	107,823,553	59,852*
Network Health Plan SSI	21,628,833	4,773*
Total	$359,311,446	136,182

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

The HMO provides primary and specialty health services to Medicaid/BadgerCare and Medicare enrollees through contractual arrangements with physicians, independent practice associations (IPAs), group practices, physician-hospital organizations (PHOs), and clinics. Physician services are reimbursed on either a capitated or fee schedule basis. 2,792 clinics serve the Medicaid/BadgerCare and Medicare enrollees.

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

Inpatient services to Medicaid enrollees are provided through contracts with 128 hospitals. The hospitals are paid on a Diagnosis Related Group (DRG) or per diem basis. The contracts include hold-harmless provisions for the protection of policyholders, automatically renew for one-year terms, and may be terminated by either party upon 180 days' written notice prior to the next termination date of the contract between the HMO and DHS or CMS.

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

The HMO's service area for the Medicare Advantage Special Needs Plan is comprised of the following 35 counties:

Adams	Fond du Lac	Manitowoc	Outagamie	Walworth
Brown	Green Lake	Marathon	Ozaukee	Washington
Calumet	Jefferson	Marinette	Portage	Waukesha
Clark	Kenosha	Marquette	Racine	Waupaca
Columbia	Kewaunee	Menominee	Shawano	Waushara
Dane	Langlade	Milwaukee	Sheboygan	Winnebago
Dodge	Lincoln	Oconto	Taylor	Wood

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

III. MANAGEMENT AND CONTROL

Board of Directors

The board of directors consists of 13 members. All directors are elected annually to serve a one-year term. The officer roles of president, secretary, and treasurer are elected by the shareholder; other officer roles are appointed by the board. Members of the company's board of directors may also be members of other boards of directors in the holding HMO group.

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

Name	Principal Occupation	Term Expires
John D. Finerty, Jr., Chair Milwaukee, WI	Attorney, Michael Best & Friedrich, LLP	2024
Dennis W. Sheperd, MD Elm Grove, WI	Physician, Medical College of WI	2024
John J. Bartkowski, PhD Glendale, WI	Retired Health Administrator	2024
Michael Rohrkaste Neenah, WI	Executive Director, Fox Valley Memory Project	2024
Sheldon Wasserman, MD Glendale, WI	OB/GYN, Milwaukee	2024
Titus J. Muzi Waukesha, WI	President, Managed Health Services Insurance Corp.	2024
Gregory M. Wesley Milwaukee, WI	Executive, Medical College of Wisconsin	2024
Martha J. Smith Scottsdale, AZ	Officer and Director Centene affiliated entities	2024
Stephanie Chedid Mequon, WI	President, Chief Executive Officer Luthor Manor	2024
Willie Hines, Jr. Milwaukee, WI	Secretary, Executive Director Housing Authority of City of Milwaukee	2024
Robert Lyon, MD Matthews, NC	Retired Chief Medical Director MHS Health Wisconsin	2024
James Villla Milwaukee, WI	Chief Executive Officer, NAIOP Commercial Real Estate Development Association	2024
Joan Prince, PhD Glendale, WI	Retired Vice Chancellor, University of Wisconsin, Milwaukee	2024

Officers of the Company

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

Name	Office
Titus J. Muzi	President
Christopher A. Koster	Secretary
Andrew L. Asher	Treasurer
Tricia L. Dinkelman	Vice President of Tax
Eric Brotten	Compliance Officer

Committees of the Board

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

Strategic Planning Committee
John D. Finerty, Jr. Chair*
Sherry B. Husa*
Titus J. Muzi*
Joan Prince*
James Villa*

* Indicates committee member is on the board of directors.

The company has no employees. Necessary staff are provided through a management agreement with Centene Management Company LLC, (CMC), a wholly owned subsidiary of Centene Corporation. Under the agreement, effective January 1, 1997, CMC agrees to provide the company with administrative and financial services necessary to manage its business operations and agrees to assume responsibility for all costs associated therewith. Areas/systems for which CMC assumes responsibility, under the terms of the agreement, include the following: program planning and development, management information systems, financial systems and services, claims administration, utilization review, provider and enrollee services and records, quality assurance/quality improvement, and marketing services. The company amended and restated this agreement effective January 1, 2023. Under the terms of the Amended and Restated Agreement, CMC is compensated for its services on an actual cost basis, calculated in accordance with statutory accounting principles.

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

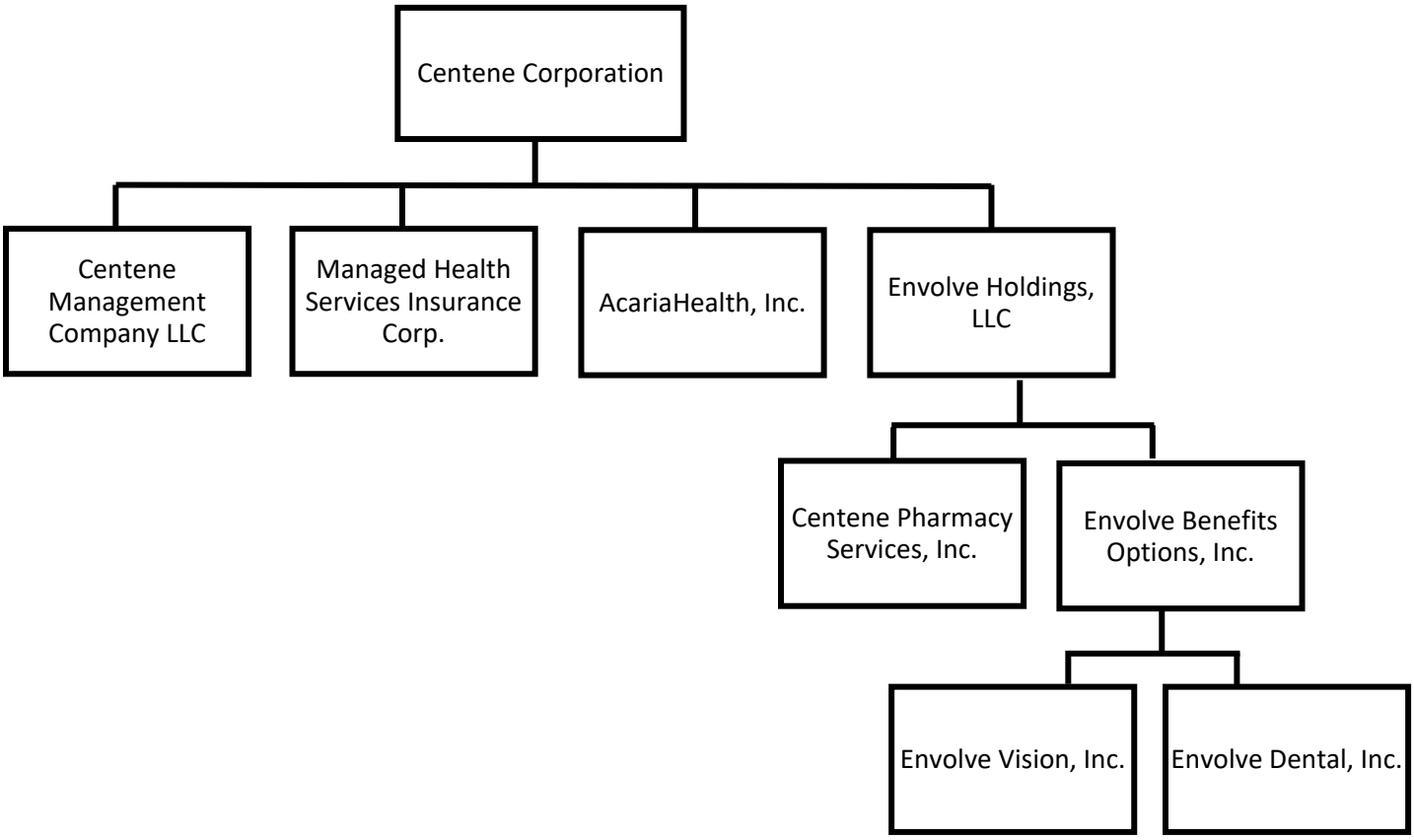
2. Enrollees will be entitled to similar, alternate coverage that does not contain any medical underwriting or preexisting limitation requirements.

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

IV. AFFILIATED COMPANIES

The company is a member of a holding company system. Its ultimate parent is Centene Corporation. The abbreviated organizational chart below depicts the relationships among the company and certain affiliates in the group. A brief description of the significant affiliates of the company follows the organizational chart.

Abbreviated Organizational Chart
As of December 31, 2022



Note: Not all the subsidiaries of Centene Corporation have been included in this organizational chart as there were 425 companies in the group as of December 31, 2022.

Centene Corporation

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

As of December 31, 2022, the audited financial statements of Centene Corporation reported assets of $76.9 billion, liabilities of $52.6 billion, and stockholders' equity of $24.2 billion. Operations for 2022 produced net earnings of $1.2 billion.

Centene Management Company LLC

Centene Management Company LLC (CMC), originally incorporated in 1996 as Coordinated Care Medicaid Management Corporation, was created to provide management and administrative services to Centene Corporation's HMO subsidiaries. CMC, a wholly owned subsidiary of Centene Corporation, is a for-profit corporation that holds management agreements with Centene Corporation's subsidiaries and employs all staff, both at corporate headquarters and at the health plans. Licenses and certifications as required by individual state regulations are current. Specifically, in Wisconsin, CMC holds a license as an Employee Benefit Plan Administrator. The unaudited financial results reported assets of $11.4 million, liabilities of $5.8 million, and stockholders' equity of $5.6 million. Operations for 2022 resulted in a net loss of $0.1 million on revenues of $9.1 million.

Agreements with Affiliates

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

- Effective June 14, 2018, the company entered into a tax-sharing agreement with Centene Corporation. Under this agreement, Centene Corporation will file a consolidated tax return for

member companies; member companies, in turn, agree to make quarterly payments to Centene Corporation in an amount equal to the full separate federal, state, and local income tax liability attributable to the net taxable income of each member that would have been paid if such member had filed separate federal, state, and local tax returns.

- Effective January 1, 1997, (last amended January 1, 2023), the company entered into an administrative service agreement with Centene Management Company LLC (CMC). This agreement is discussed in the section of the report captioned "Management and Control."
- Effective March 1, 2006, the company entered into a pharmacy benefit management agreement with US Script, Inc. which later changed its name to Envolve Pharmacy Solutions, Inc. Under the agreement, Envolve Pharmacy Solutions, Inc. provided the company's members with access to their pharmacy network. Effective January 1, 2023, the agreement with Envolve Pharmacy Solutions, Inc. was replaced with an administrative pharmacy services agreement. Envolve Pharmacy Solutions, Inc. changed its name to Centene Pharmacy Services, Inc., effective January 1, 2023.
- Effective January 1, 2021, the company entered into an agreement with Envolve PeopleCare, Inc., to provide nurse-line management, triage services, and disease management services to the company. This agreement terminated effective January 1, 2022.
- Effective July 1, 2007, (last amended January 1, 2022), Envolve Vision, Inc. agrees to provide vision benefits management services to MHSIC enrolled government program members in Wisconsin. Effective January 1, 2022, the agreement was amended such that services provided by Envolve Vision, Inc. will be provided to the company at a "no profit/no loss basis."
- Effective January 1, 2015, (last amended January 1, 2022), the company entered into a dental services agreement with Envolve Dental, Inc. Under the agreement, Envolve Dental, Inc. provides, or arranges for the provision of, covered dental care services to MHSIC enrolled government program members in Wisconsin. Effective January 1, 2022, the agreement was amended such that services provided by Envolve Dental, Inc. will be provided to the company at a "no profit/no loss basis."

- National Imaging Associates, Inc. which was an affiliate for most of 2022, provided radiology management services to MHSIC. Centene Corporation divested its controlling interest in National Imaging Associates, Inc. on January 23, 2023.
- The company entered into a provider agreement effective March 1, 2021, under which AcariaHealth, Inc., an affiliate, provides home infusion services to the company's members.

V. REINSURANCE

The company currently has reinsurance coverage under the contract outlined below:

Nonaffiliated Ceding Contract

Reinsurer:	PartnerRe America Insurance Company
Type:	HMO Specific Excess of Loss Reinsurance
Effective date:	January 1, 2022
Expiration Date:	January 1, 2023
Retention:	Specific deductible per covered person per agreement term: $5,000,000 Maximum payable per covered person: $5,000,000
Covered business:	Medicaid TANF and SSI Non-Dual covered person
Coverage:	Covered expenses in excess of $5,000,000 are subject to a reimbursement percentage of 80% if a complete claim is received by March 1, 2024 Covered expenses in excess of $5,000,000 are subject to a reimbursement percentage of 50% if a complete claim is not received by March 1, 2024 Covered expenses in excess of $5,000,000 are subject to a reimbursement percentage of 0% if a complete claim is not received by July 1, 2024
Insolvency Coverage:	The reinsurance policy has an endorsement containing the following insolvency provisions: In the event of the insolvency of the reinsured, this agreement shall be payable directly to the reinsured or to its liquidator, receiver, conservator, or statutory successor on the basis of the liability of the reinsured without diminution because of the insolvency of the reinsured.

VI. FINANCIAL DATA

The following financial statements reflect the financial condition of the company as reported to the commissioner of insurance in the December 31, 2022, 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.

Managed Health Services Insurance Corp.
Assets
As of December 31, 2022

	Assets	Nonadmitted Assets	Net Admitted Assets
Bonds	$ 75,226,393		$ 75,226,393
Stocks:			
Common stocks	1,286,642		1,286,642
Cash, cash equivalents and short-term investments	52,135,350		52,135,350
Other invested assets	454,409		454,409
Investment income due and accrued	821,142		821,142
Uncollected premiums and agents' balances in the course of collection	9,718,850		9,718,950
Accrued retrospective premiums and contracts subject to redetermination	3,022,191		3,022,191
Amounts receivable relating to uninsured plans	4,882,489		4,882,489
Net deferred tax asset	924,622		924,622
Receivables from parent, subsidiaries and affiliates	846,959	$ 846,959	
Health care and other amounts receivable	9,105,857	2,973,829	6,132,028
Write-ins for other than invested assets:			
State Income tax recivable	16,658		16,658
Prepaid	117,593	117,593	
Total Assets	$158,559,255	$3,938,381	$154,620,874

Managed Health Services Insurance Corp.
Liabilities, Capital and Surplus
As of December 31, 2022

Claims unpaid		$ 41,801,442
Accrued medical incentive pool and bonus payments		1,976,874
Unpaid claims adjustment expenses		471,138
Aggregate health policy reserves		59,806,195
General expenses due or accrued		2,157,552
Current federal and foreign income tax payable and interest thereon		239,181
Amounts due to parent, subsidiaries, and affiliates		2,109,789
Liability for amounts held under uninsured accident and health plans		6,860
Aggregate write-ins for other liabilities		194,628
Total Liabilities		108,763,659
Common capital stock	$ 750,000	
Gross paid in and contributed surplus	1,250,000	
Unassigned funds (surplus)	43,857,215	
Total Capital and Surplus		45,857,215
Total Liabilities, Capital and Surplus		$154,620,874

Managed Health Services Insurance Corp.
Statement of Revenue and Expenses
For the Year 2022

Net premium income		$229,859,059
Risk revenue		129,452,386
Total revenues		359,311,445
Medical and Hospital:		
Hospital/medical benefits	$259,738,814	
Other professional services	8,520,544	
Emergency room and out-of-area	27,017,600	
Prescription drugs	4,890,536	
Incentive pool and withhold adjustments	1,846,708	
Total medical and hospital	302,014,202	
Claims adjustment expenses	3,611,080	
General administrative expenses	32,151,978	
Total underwriting deductions		337,777,260
Net underwriting gain or (loss)		21,534,185
Net investment income earned	3,114,511	
Net realized capital gains or (losses)	(26,041)	
Net investment gains or (losses)		3,088,470
Net gain or (loss) from agents' or premium balances charged off		(1,107)
Net income before federal income taxes		24,621,548
Federal and foreign income taxes incurred		5,061,354
Net Income		$ 19,560,194

Managed Health Services Insurance Corp.
Capital and Surplus Account
For the Five-Year Period Ending December 31, 2022

	2022	2021	2020	2019	2018
Capital and surplus, beginning of year	$52,068,733	$73,949,130	$56,304,129	$51,208,800	$50,748,629
Net income (loss)	19,560,194	18,969,090	24,904,705	14,911,995	12,937,134
Change in net unrealized capital gains/losses	(51,137)	59,654	275,783	77,632	280,889
Change in net deferred income tax	117,482	347,110	(24,417)	(267,397)	285,363
Change in nonadmitted assets	(838,055)	(1,256,251)	488,930	373,099	(1,043,215)
Dividends to stockholders	(25,000,000)	(40,000,000)	(8,000,000)	(10,000,000)	(12,000,000)
Net change in capital and surplus	(6,211,518)	(21,880,397)	17,645,001	5,095,329	460,171
Capital and Surplus, End of Year	$45,857,215	$52,068,733	$73,949,130	$56,304,129	$51,208,800

Managed Health Services Insurance Corp.
Statement of Cash Flow
For the Year 2022

Premiums collected net of reinsurance			$268,389,765
Net investment income			3,144,631
Miscellaneous income			129,452,386
Total			400,986,782
Less:			
Benefit- and loss-related payments		$296,943,504	
Commissions, expenses paid and aggregate write-ins for deductions		38,536,573	
Federal and foreign income taxes paid (recovered) net of tax on capital gains (losses)		4,705,397	
Total			340,185,474
Net cash from operations			60,801,308
Proceeds from Investments Sold, Matured or Repaid:			
Bonds	$7,563,290		
Other invested assets	521,202		
Net gains (losses) on cash, cash equivalents, and short-term investments	(127)		
Total investment proceeds		8,084,365	
Cost of Investments Acquired—Long-term Only:			
Bonds		17,940,620	
Net cash from investments			(9,856,255)
Cash Provided for/Applied:			
Dividends to stockholders		(25,000,000)	
Other cash provided (applied)		(942,685)	
Net cash from financing and miscellaneous sources			(25,942,685)
Net Change in Cash, Cash Equivalents, and Short-Term Investments			25,002,368
Cash, cash equivalents, and short-term investments:			
Beginning of year			27,132,982
End of Year			$ 52,135,350

Growth of Managed Health Services Insurance Corp.

Year	Assets	Liabilities	Capital and Surplus	Premium Earned	Medical Expenses Incurred	Net Income
2022	$154,620,874	$108,763,659	$45,857,215	$359,311,445	$302,014,202	$19,560,194
2021	112,522,492	60,453,759	52,068,733	319,997,749	266,210,972	18,969,090
2020	111,366,608	37,417,479	73,949,129	273,165,886	214,254,335	24,904,705
2019	83,430,387	27,126,258	56,304,129	228,937,202	193,564,101	14,911,995
2018	86,156,944	34,948,140	51,208,802	210,301,920	176,450,514	12,937,134
2017	69,639,214	18,890,584	50,748,630	163,337,653	135,610,137	9,244,977

Year	Profit Margin	Medical Loss Ratio	Administrative Expense Ratio	Change in Enrollment
2022	5.4%	84.1%	10.0%	11.9%
2021	5.9	83.2	9.9	13.8
2020	9.1	78.4	10.4	33.2
2019	6.5	84.5	8.3	5.4
2018	6.1	83.9	8.9	0.1

Enrollment and Utilization

Year	Enrollment	Hospital Days/1,000	Average Length of Stay
2022	71,557	843.50	4.7
2021	63,970	944.90	4.7
2020	56,234	959.89	4.5
2019	42,227	1,042.57	4.4
2018	40,063	776.21	4.2

*Includes enrollees served under the NHP subcontract

Per Member Per Month Information

	2022	2021	Percentage Change
Premiums:			
Medicare	$1,598.5	$1,444.7	10.7%
Medicaid	212.3	214.9	-1.2
Risk Revenue	172.3	188.2	-8.4
Blended	228.6	224.2	1.9
Expenses:			
Hospital/medical benefits	165.2	162.9	1.4
Other professional services	5.4	4.3	25.9
Emergency room and out-of-area	17.1	17.2	-0.1
Prescription Drugs (hospital and medical)	3.1	1.4	124.3
Incentive pool and withhold adjustments	1.2	0.6	90.4
Total medical and hospital	192.1	186.5	3.0
Claims adjustment expenses	2.3	2.3	0.2
General administrative expenses	20.5	19.9	2.6
Total underwriting deductions	214.9	208.7	2.9
Net underwriting gain or loss	$ 13.7	$ 15.5	-11.6

The company has been profitable for each of the past five years during the period under examination, reporting total net income during the period of $91.3 million. Net income was $19.6 million for the year ended December 31, 2022, compared to net income of $19.0 million in 2021. The decrease was driven primarily by the increase in the utilization of benefits outpacing the increase in premium income.

Total assets increased to $154.6 million for the year ended December 31, 2022, from $112.5 million in 2021 due to increase in cash flow from operations and invested assets.

Total liabilities on December 31, 2022, increased to $108.8 million from $60.5 million at December 2021 primarily due to a $6.1 million increase in unpaid claims and an increase of $59.8 million in aggregate health reserves.

Capital and surplus were $45.9 million and $52.1 million as of December 31, 2022 and 2021, respectively. Capital and surplus decreased in 2022, due to payment of a $25 million dividend, partially offset by the net income of $19.6 million in 2022. However, through of December 31, 2020, capital and surplus increased primarily due to net income of $24.9 million exceeding dividends.

Premium earned increased from $320.0 million in 2021 to $359.3 million in 2022 due to higher membership. And hospital and medical benefit expenses increased from $266.2 million in 2021, to $302.0 million in 2022, due primarily to an increase in membership.

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 that are subject to statutory hold-harmless provisions.

The company's calculation as of December 31, 2022, as modified for examination adjustments is as follows:

Assets	$154,620,874	
Less: Liabilities	108,763,659	
Assets available to satisfy surplus requirements		$45,857,215
Net premium earned	229,859,059	
Factor	3%	
Compulsory surplus		6,895,772
Compulsory Surplus Excess (Deficit)		$38,961,443
Net amount available to satisfy surplus requirements		$45,857,215
Compulsory surplus	$6,895,772	
Security factor	134%	
Security surplus		9,240,334
Security Surplus Excess (Deficit)		$36,616,881

Reconciliation of Capital and Surplus per Examination

No adjustments to surplus or reclassifications were made as a result of the examination. The amount of surplus reported by the company as of December 31, 2022, is accepted.

VII. SUMMARY OF EXAMINATION RESULTS

Compliance with Prior Examination Report Recommendations

There were three specific recommendations in the previous examination report. The actions taken by the company as a result of the recommendations were as follows:

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

   Action—Non-Compliance. See the Summary of Current Examination Results for more information.

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

   Action—Compliance.

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

   Action—Compliance.

Summary of Current Examination Results

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

Corporate Governance

A directive of the Office of the Commissioner of Insurance requires that companies complete and maintain a record of the conflict-of-interest statement every year. During the current examination, a review was made of the companies' conflict of interest disclosure forms and the review disclosed that some individuals listed on the jurat page were either not completing the conflict-of-interest disclosure forms during the examination period or the disclosure forms were misplaced. This was an issue that was also present during the last examination period. It is again recommended that the company have their directors, officers, and key employees complete conflict-of-interest disclosure forms annually as required by a directive of the Office of the Commissioner of Insurance and maintain a record of the signed disclosures.

Custodial or Safekeeping Agreement

The investments of the company are held under the safekeeping of The Northern Trust Company. MHSIC has a master custody agreement with The Northern Trust Company. To be in compliance, the custodial agreement must contain the following language as required by the NAIC *Financial Condition Examiners Handbook*:

- If the custodial agreement has been terminated or if 100% of the account assets in any one custody account have been withdrawn, the custodian shall provide written notification, within three business days of termination or withdrawal, to the insurer's domiciliary commissioner.

The examination review of the custodial agreement found there is no provision in the agreement stating the clause above. It is recommended that the custodial agreement be amended to include a provision that notifies the domiciliary commissioner within three business days of termination or withdrawal of account assets as recommended by the NAIC *Financial Condition Examiners Handbook*.

VIII. CONCLUSION

Managed Health Services Insurance Corp. is a for-profit insurer that derives nearly all of its revenue from the Wisconsin title XIX Medical Assistance Medicaid, BadgerCare, Supplemental Security Income, SSI programs, and from Medicare as a Medicare Advantage Special Needs Plan. The company was incorporated August 31, 1990, as a wholly owned stock insurer subsidiary of Managed Health Services, Inc., a Wisconsin non-stock, not-for-profit corporation. The HMO commenced business on December 17, 1990.

The company's assets increased 79.5% over the five-year period under examination to $154.6 million while liabilities increased by 211.2% to $108.8 million. Surplus decreased 10.5% over the five-year examination period to $45.9 million. Premium earned increased 70.9% to $359.3 million and medical expenses incurred increased 71.2% to $302.0 million over the five-year period under examination. These increases are primarily due to an increase in membership.

The current examination resulted in two recommendations and no adjustments to the surplus. The recommendations were related to corporate governance and custodial or safekeeping agreements. The recommendation regarding corporate governance was repeated from the previous examination.

IX. SUMMARY OF COMMENTS AND RECOMMENDATIONS

1. Page 27 - Corporate Governance—It is again recommended that the company have their directors, officers, and key employees complete conflict-of-interest disclosure forms annually as required by a directive of the Office of the Commissioner of Insurance and maintain a record of the signed disclosures.

2. Page 27 - Custodial or Safekeeping Agreement—It is recommended that the custodial agreement be amended to include a provision that notifies the domiciliary commissioner within three business days of termination or withdrawal of account assets as recommended by the NAIC *Financial Condition Examiners Handbook*.

X. ACKNOWLEDGMENT

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

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

Name	Title
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Jerry DeArmond, CFE	Reserve Specialist

Respectfully submitted,

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Examiner-in-Charge