Report

of the

Examination of

Partnership Health Plan, Inc.

Eau Claire, Wisconsin

As of December 31, 2010

TABLE OF CONTENTS

Page

I. INTRODUCTION 1

II. HISTORY AND PLAN OF OPERATION 3

III. MANAGEMENT AND CONTROL 7

IV. AFFILIATED COMPANIES 10

V. REINSURANCE 12

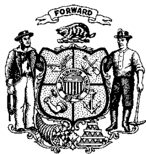
VI. FINANCIAL DATA 13

VII. SUMMARY OF EXAMINATION RESULTS 20

VIII. CONCLUSION 28

IX. SUMMARY OF COMMENTS AND RECOMMENDATIONS 29

X. ACKNOWLEDGMENT 30



State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Scott Walker, *Governor*
Theodore K. Nickel, *Commissioner*

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September 8, 2011

Honorable Theodore K. Nickel
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:

PARTNERSHIP HEALTH PLAN, INC.
Eau Claire, Wisconsin

and this report is respectfully submitted.

I. INTRODUCTION

The previous examination of Partnership Health Plan, Inc. (the company or the Plan) was conducted in 2008 as of December 31, 2007. The current examination covered the intervening period ending December 31, 2010, and included a review of such 2011 transactions as deemed necessary to complete the examination.

The examination was conducted using a risk-focused approach in accordance with the NAIC Financial Condition Examiners Handbook, which sets forth guidance for planning and performing an examination to evaluate the financial condition and identify prospective risks of an insurer. This approach includes the obtaining of information about the company including corporate governance, the identification and assessment of inherent risks within the company, and the evaluation of system controls and procedures used by the company to mitigate those risks. The examination also included an assessment of the principles used and significant estimates made by management, as well as an evaluation of the overall financial statement

presentation and management's compliance with statutory accounting principles, annual statement instructions, and Wisconsin laws and regulations.

The examination consisted of a review of all major phases of the company's operations and included the following areas:

History
Management and Control
Corporate Records
Conflict of Interest
Fidelity Bonds and Other Insurance
Provider Contracts
Territory and Plan of Operations
Affiliated Companies
Growth of the Company
Reinsurance
Financial Statements
Accounts and Records
Data Processing

Emphasis was placed on the audit of 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

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

The company was incorporated on June 27, 2005, and commenced business on January 1, 2006. The Plan was originally capitalized in December 2005 through the transfer of $4 million from its sole member, Community Health Partnership, Inc. (CHP), to meet the initial capital requirements established by the Wisconsin Office of the Commissioner of Insurance.

The company has no employees. The operations of the Plan are administered by CHP under an administrative services agreement (described in the “Affiliated Companies” section of the report). The company also contracts with a nonaffiliated third-party administrator for the provision of certain services including, but not limited to, claims administration.

Since inception, the company and CHP have worked cooperatively to offer the Family Care Partnership Program (FCPP). FCPP is an integrated Medicare/Medicaid product for dual-eligible enrollees[1] that was originally operated under demonstration authority but has since been transitioned by the Centers for Medicare and Medicaid Services (CMS) to a Medicare Advantage Special Needs Plan and by the Wisconsin Department of Health Services (DHS) to

[1] “Dual Eligibles” are defined as low-income seniors and persons with disabilities who are enrolled in Medicaid and Medicare. This population relies on Medicaid to cover Medicare premiums and cost-sharing to cover critical benefits not covered by Medicaid (such as long-term care).

the Family Care Program. The FCPP's benefits include all Wisconsin Medicaid covered benefits, all Medicare Advantage benefits, all Medicare Part D benefits, and "necessary long-term care services and support," including services to assist Plan enrollees with daily living activities.

FCPP includes a care management component, consisting of an interdisciplinary team comprised of: the enrollee, a CHP-employed Nurse Practitioner, a CHP-employed Registered Nurse, and a CHP-employed Social Services Coordinator. The teams use a Resource Allocation Decision-Making (RAD) process approved by the State of Wisconsin to pre-authorize long-term care services.

For acute and primary care, enrollees may choose any Primary Care Physician (PCP) who has agreed to work collaboratively with CHP Nurse Practitioners. Currently, there are approximately 1,159 primary care physicians that members may choose from and over 162 in-network specialists as defined by CMS. The PCP does not act as a gatekeeper and specialty care does not require prior authorization or referral.

The company's principal provider networks are Marshfield Clinic, Mayo Health System, OakLeaf Medical Network, and UW Family Medicine, which maintain clinics throughout the Plan's service area of Chippewa, Dunn, Eau Claire, Pierce, and St. Croix counties. Physicians are required to provide services on a 24-hour basis. The provider contracts provide for reimbursement on a fee-for-service basis and include hold-harmless provisions for the protection of enrolled members.

The Plan contracts with area hospitals to provide inpatient services to the Plan's members. Hospitals are reimbursed in accordance with Medicare/Medicaid DRGs or on a fee-for-service basis. The contracts include hold-harmless provisions for the protection of policyholders. The following is a list of hospitals serving the Plan's enrollees:

Abbott Northwestern Hospital
Buffalo Hospital
Cambridge Medical Center
Mayo Clinic Health System Chippewa Valley
Mayo Clinic Health System Eau Claire – Luther Campus
Mayo Clinic Health System Northland
Mayo Clinic Health System Oakridge
Mayo Clinic Health System Red Cedar
Mercy Hospital
OakLeaf Surgical Hospital
Our Lady of Victory Hospital
River Falls Area Hospital
Sacred Heart Hospital
St. Francis Regional Medical Center
St. Joseph's Hospital – Chippewa Falls
St. Joseph's Hospital of Marshfield
United Hospital
Unity Hospital

The company offers comprehensive health care coverage coupled with personal and long-term care services. The following basic health care coverages are provided:

Physician services
Inpatient services
Outpatient services
Mental health, drug, and alcohol abuse services
Ambulance services
Special dental procedures (oral surgery)
Prosthetic devices and durable medical equipment
Newborn services
Home health care
Preventive health services
Family planning
Hearing exams and hearing aids
Diabetes treatment
Routine eye examinations
Convalescent nursing home service
Prescription drugs – co-payments as dictated by Medicare Part D
Cardiac rehabilitation, physical, speech, and/or occupational therapy
Physical fitness or health education
Kidney disease treatment
Certain transplants
Chiropractic services

Individuals enrolled in the Partnership Program are subject to specified co-pays but do not pay premiums. Program participants are required to meet all of the Wisconsin Medicaid

financial eligibility requirements. The company is compensated through capitation payments received from the State of Wisconsin Department of Health Services (DHS) and the Centers for Medicare and Medicaid Services (CMS). The capitation rates have been actuarially determined, taking into account the health care needs of the Plan's members.

Marketing is targeted specifically to those individuals that meet the established requirements of the Medicaid (financial eligibility) and nursing home level of care (functional eligibility), as well as residency within the Plan's designated service area. Marketing materials require pre-approval from both DHS and CMS prior to use.

III. MANAGEMENT AND CONTROL

Board of Directors

The board of directors consists of ten members. Directors are elected annually to serve a three-year term. Officers are elected by the board of directors. Members of the company's board of directors may also be members of other boards of directors in the holding HMO group. The board members currently do not receive any compensation for serving on the board.

Currently the board of directors consists of the following persons:

Name and Residence	Principal Occupation	Term Expires
Ruth Adix Altoona, WI	Parent	2013
Rick Lambert Chippewa Falls, WI	Business President	2013
Peter Nied Menomonie, WI	Bank Vice President	2013
Laura Plummer Eau Claire, WI	Rehabilitation Technologist/Sensory Specialist	2014
Scott Polenz Eleva, WI	Hospital CEO	2014
Rick Schemm Eau Claire, WI	Human Resources Director	2012
Debra Svihovec, Chair Elk Mound, WI	Vice President, Senior Benefits Consultant	2013
Lynn Thompson Eau Claire, WI	Energy Co-op CEO	2011
John Wesolek Menomonie, WI	University Dean, Retired	2011
Beverly Wickstrom Eau Claire, WI	Attorney	2014

Officers of the Company

The officers elected by the board of directors and serving at the time of this examination are as follows:

Name	Office	2010 Salary
Paul Cook	President and CEO	$186,600
Deborah Svihovec	Chairperson	0
Lynn Thompson	Treasurer	0
Scott Polenz	Vice Chairperson and Secretary	0

Committees of the Board

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

Executive Committee
Laura Plummer, Chair
Deborah Svihovec
Lynn Thompson

Finance/Investment Committee
Lynn Thompson, Chair
Mark Deyo-Svendsen
Rick Lambrecht
Peter Nied
Laura Plummer

The company has no employees. Necessary staff is provided through a management agreement with Community Health Partnership, Inc. (CHP). Under the agreement, effective October 4, 2005, CHP agrees to perform all duties necessary to administer the operations of the company (including, but not limited to, negotiating and entering into contracts with health care providers for the purpose of obtaining quality assurance and fee discounts relating to the Plan's business). As compensation for these services, the company agrees to reimburse CHP for the cost of direct services, as well as the allocated portion of indirect services incurred in administering the company's operations. The agreement is in effect as of the effective date and will continue indefinitely until terminated. The agreement may be terminated upon mutual written agreement of the parties. The agreement may also be terminated for cause by either party if the other party breaches any term or condition of the agreement and such party fails to cure such breach within 30 days after receipt of written notice of such breach.

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

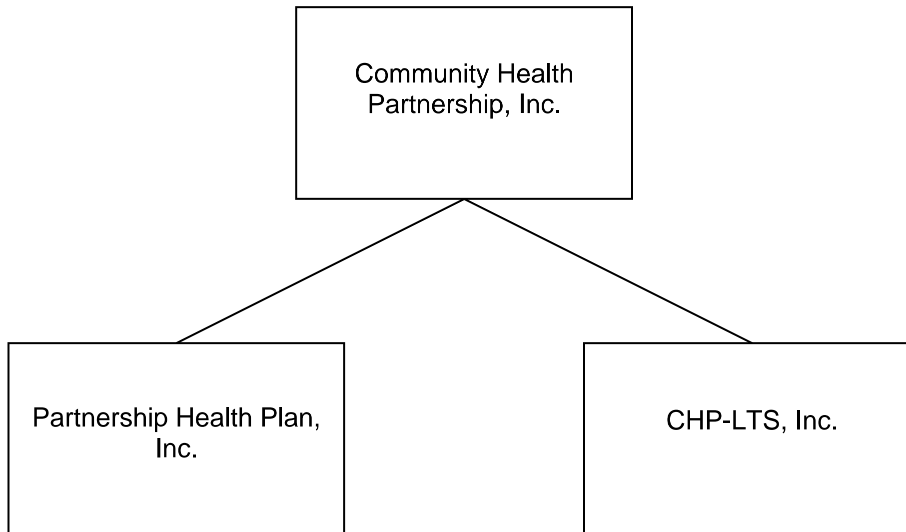
2. Enrollees will be entitled to similar, alternate coverage which does not contain any medical underwriting or preexisting limitation requirements.

The company has not met this requirement. This is discussed further in the "Reinsurance" section of this report.

IV. AFFILIATED COMPANIES

The company is a member of a holding company system. Its ultimate parent is Community Health Partnership, Inc. 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, 2010



Community Health Partnership, Inc.

Community Health Partnership, Inc. (CHP) is a not-for-profit corporation organized for the purpose of providing health and long-term care services to elderly in the Wisconsin counties of Chippewa, Dunn, Eau Claire, Pierce, and St. Croix. As of December 31, 2010, CHP's consolidated audited financial statement reported assets of $77,748,766, liabilities of $64,585,482, and net assets of $13,163,284. Operations for 2010 produced net income of $148,801 on revenues of $186,177,514.

As previously mentioned, the Plan has no employees. Necessary services are provided through the Plan's administrative services agreement with CHP. Under the agreement, effective October 4, 2005, CHP agrees to perform all duties necessary to administer the operations of the Plan (including, but not limited to, negotiating and entering into contracts with

health care providers for the purpose of obtaining quality assurance and fee discounts relating to the Plan's business). As compensation for these services, the Plan agrees to reimburse CHP for the cost of direct services, as well as the allocated portion of indirect services incurred in administering the Plan's operations. The agreement may be terminated upon mutual written agreement of the parties. The agreement may also be terminated for cause by either party if the other party breaches any term or condition of the agreement and such party fails to cure such breach within 30 days after receipt of written notice of such breach.

CHP-LTS, Inc.

CHP-LTS is a non-stock, non-profit corporation that operates as a care management organization that provides long-term care services through a contract with the Department of Health Services (DHS) and enrolls only individuals who are eligible for Medicaid services for the purpose of participating in the Family Care Program. As of December 31, 2010, the company's audited financial statement reported assets of $19,035,615, liabilities of $25,109,174, and equity of $(6,073,559). Operations for 2010 produced a net loss of $85,638 on revenues of $58,360,993.

V. REINSURANCE

The company has reinsurance coverage under the contract outlined below:

Reinsurer:	HCC Life Insurance Company
Type:	Specific Excess of Loss Reinsurance
Term:	November 1, 2010, through October 31, 2011
Lines of business:	A. Medicare (Dual Eligible 18-64) B. Medicare (Dual Eligible 65+)
Insuring clause:	Subject to all the terms of this agreement, the Reinsurer will reimburse the Plan the Percentage Payable of Eligible Expenses that exceed the applicable Specific Retention up to any applicable maximums.
Lifetime maximum:	$2,000,000
Coverage:	Expenses for health care services and supplies provided to a member that are incurred during the contract year and are: A. Covered by the Membership Services Agreement, B. Listed on the Eligible Expense Matrix attached to the agreement, C. Performed by a Plan participating provider; or performed by a nonparticipating provider utilized (1) due to a referral by the Plan, (2) due to an emergency, and (3) due to the member being inpatient confined on the date they became a member; and D. Not excluded under this agreement
Premium:	$12.76 PMPM Medicaid and Dual Eligible (18-64) $5.21 PMPM Medicaid and Dual Eligible (65+)
Insolvency clause:	The reinsurance contract does not contain an insolvency clause.

VI. FINANCIAL DATA

The following financial statements reflect the financial condition of the company as reported in the December 31, 2010, annual statement to the Commissioner of Insurance. Also included in this section are schedules that reflect the growth of the company for the period under examination. Adjustments made as a result of the examination are noted at the end of this section in the area captioned "Reconciliation of Net Worth per Examination."

Partnership Health Plan, Inc.
Assets
As of December 31, 2010

	Assets	Nonadmitted Assets	Net Admitted Assets
Bonds	$12,306,287	$	$12,306,287
Stocks:			
Preferred stocks			
Common stocks	1,250,348		1,250,348
Cash, cash equivalents and short-term investments	29,674,252		29,674,252
Investment income due and accrued	97,416		97,416
Uncollected premiums and agents' balances in the course of collection	677,063	123,958	553,105
Accrued retrospective premiums	2,528,894		2,528,894
Amounts recoverable from reinsurers	27,615		27,615
Receivables from parent, subsidiaries and affiliates	144	144	0
Health care and other amounts receivable	2,525,603	242,345	2,283,258
Aggregate write-ins for other than invested assets	271,692	19,417	252,275
Total Assets	$49,359,314	$385,865	$48,973,449

Partnership Health Plan, Inc.
Liabilities and Net Worth
As of December 31, 2010

Claims unpaid		$10,048,191
Accrued medical incentive pool and bonus payments		
Unpaid claims adjustment expenses		283,000
Aggregate health policy reserves		1,108,387
Premiums received in advance		24,341,179
General expenses due or accrued		236,852
Remittance and items not allocated		31,064
Amounts due to parent, subsidiaries and affiliates		1,827,647
Liability for amounts held under uninsured accident and health plans		3,212,421
Aggregate write-ins for other liabilities		1,006
Total liabilities		41,089,747
Gross paid in and contributed surplus	$1,800,000	
Unassigned funds (surplus)	6,083,702	
Total capital and surplus		7,883,702
Total Liabilities, Capital and Surplus		$48,973,449

Partnership Health Plan, Inc.
Statement of Revenue and Expenses
For the Year 2010

Premium income		$114,779,012
Medical and hospital:		
Hospital/medical benefits	$ 71,413,280	
Other professional services	9,317,102	
Emergency room and out-of-area	479,365	
Prescription drugs	6,575,902	
Aggregate write-ins for other medical and hospital	14,394,275	
Subtotal	102,179,924	
Less		
Net reinsurance recoveries	27,615	
Total medical and hospital	102,152,308	
Claims adjustment expenses	6,622,966	
General administrative expenses	6,401,825	
Total underwriting deductions		115,177,099
Net underwriting gain or (loss)		(398,086)
Net investment income earned	342,629	
Net realized capital gains or (losses)	74,277	
Net investment gains or (losses)		416,906
Aggregate write-ins for other income or expenses		3,120
Net Income (Loss)		$ 21,939

Partnership Health Plan, Inc.
Capital and Surplus Account
As of December 31, 2010

Capital and surplus prior reporting year		$7,581,273
Net income or (loss)	$ 21,939	
Net unrealized capital gains and losses	16,959	
Change in nonadmitted assets	270,901	
Aggregate write-ins for gains or (losses) in surplus	(7,370)	
Net change in capital and surplus		302,429
Capital and surplus end of reporting year		$7,883,702

Partnership Health Plan, Inc.
Statement of Cash Flows
As of December 31, 2010

Premiums collected net of reinsurance			$140,449,150
Net investment income			335,029
Total			140,804,179
Less:			
Benefit- and loss-related payments		$103,326,362	
Commissions, expenses paid and aggregate write-ins for deductions		11,812,883	
Total			115,139,245
Net cash from operations			26,664,934
Proceeds from investments sold, matured or repaid:			
Bonds	$7,063,365		
Stocks	1,430,074		
Total investment proceeds		8,493,438	
Cost of investments acquired – long-term only:			
Bonds	6,790,484		
Stocks	2,364,761		
Total investments acquired		9,155,245	
Net cash from investments			(661,807)
Cash provided/applied:			
Other cash provided (applied)			(602,300)
Net change in cash, cash equivalents, and short-term investments			24,400,827
Cash, cash equivalents, and short-term investments:			
Beginning of year			5,273,425
End of Year			$ 29,674,252

Growth of Partnership Health Plan, Inc.

Year	Assets	Liabilities	Capital and Surplus	Total Revenue	Medical Expenses Incurred	Net Income
2010	$48,973,449	$41,089,747	$ 7,883,702	$114,779,012	$102,152,308	$ 21,939
2009	25,016,319	17,435,046	7,581,273	119,316,602	109,497,004	(2,994,478)
2008	26,003,748	16,413,726	9,590,022	95,223,438	80,047,842	1,786,242
2007	18,527,758	8,129,722	10,398,035	70,761,265	56,600,047	2,255,621

Year	Profit Margin	Medical Expense Ratio	Administrative Expense Ratio	Change in Enrollment
2010	0.02%	89.00%	5.58%	-11.1%
2009	-2.51	91.77	5.63	10.2
2008	1.88	84.06	9.40	28.5
2007	3.19	82.81	9.80	37.3

Enrollment and Utilization

Year	Enrollment	Hospital Days/1,000	Average Length of Stay
2010	1,779	3,159	4.8
2009	2,001	3,086	4.8
2008	1,816	3,735	5.1
2007	1,413	4,556	5.4

Per Member Per Month Information

	2010	2009	Percentage Change
Premiums:			
Medicare	$5,987	$6,018	-0.5%
Medicaid	4,776	4,810	-0.7
Expenses:			
Hospital/medical benefits	3,165	3,209	-1.4
Other professional services	413	447	-7.6
Emergency room and out-of-area	21	23	-6.8
Prescription drugs	291	391	-25.5
Other medical and hospital	638	643	-0.8
Less: Net reinsurance recoveries	1	(5)	125.3
Total medical and hospital	4,527	4,718	-4.0
Claims adjustment expenses	294	288	1.8
General administrative expenses	284	289	-2.0
Total Underwriting Deductions	$5,104	$5,295	-3.6

The company had seen rapid growth until 2010 when membership declined 11% to 1,779 members. The company's unfavorable financial results in 2009 were a result of the company's costs being significantly higher than its capitation payments. The higher costs were due to expansion into counties during 2008 that have populations with a higher proportion of high-cost developmentally disabled members.

The substantial increase in assets and liabilities during 2010 is due to the company receiving an advanced premium payment of $24.3 million dollars from the State for January through April 2011 premiums.

Reconciliation of Capital and Surplus per Examination

The following schedule is a reconciliation of capital and surplus between that reported by the company and as determined by this examination:

	Increase	Decrease	
Capital and surplus December 31, 2010, per annual statement			$7,883,702
Examination adjustments:			
Wisconsin state deferred tax	$	$252,225	
Net change to capital and surplus			(252,225)
Capital and Surplus December 31, 2010, per Examination			$7,631,477

VII. SUMMARY OF EXAMINATION RESULTS

Compliance with Prior Examination Report Recommendations

There were 16 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. Management and Control – Board Approval of Investment Transactions—It is recommended that the company's board, or a committee thereof, review a summary of all investment transactions (purchases and sales) at least quarterly and reflect formal approval/disapproval of the investment transactions in the board minutes.

   Action—Compliance.

2. Management and Control – Conflict of Interest Statements—It is recommended that the company ensure that conflict of interest statements be completed every year by all officers and directors in accordance with the directive of the Commissioner of Insurance.

   Action—Compliance.

3. Investments – Investment Policy—It is recommended that the company establish a separate investment policy for Partnership Health Plan, Inc. The policy should comply with the investment guidelines set forth in ch. 620, Wis. Stat., and s. Ins 6.20, Wis. Adm. Code, and should incorporate those statutes by reference.

   Action—Compliance.

4. Investments – Investment Policy—It is further recommended that the investment policy be presented to the company's board of directors for approval, and a copy of the approved policy should be provided to the company's investment advisor to set the parameters for investment decisions made on the company's behalf.

   Action—Compliance.

5. Investments – Escheat Policy—It is recommended that the company develop a formal written escheat policy. The policy should address: (1) the company's procedures relating to stale-dated checks (sufficient to ensure compliance with the requirements of ch. 177, Wis. Stat.); and (2) the establishment and maintenance of an escheat liability account (to hold stale-dated checks outstanding for over one year).

   Action—Compliance.

6. Investments – Escheat Policy—It is further recommended that the escheat policy be presented to the company's board of directors for approval.

   Action—Compliance.

7. Investments – Authorized Check Signature Policy—It is recommended that the company formalize its authorized check signature policy in writing and present the policy to the company's board for approval. The policy should identify authorized signers for the company's checking accounts and should identify their authority limits.

   Action—Compliance.

8. Reinsurance – Reinsurance Agreement – Insolvency Clause—It is recommended that the company enter into a revised contract with its reinsurer that does not include exclusions that could arbitrarily limit the company's recovery after the point of insolvency.

   Action—Compliance.

9. Insurance Coverages – Crime Insurance—It is recommended that Partnership Health Plan, Inc., be specifically identified as a "Name Insured" to the crime insurance policy via an endorsement.

   Action—Compliance.

10. Annual Statement Reporting – HIRSP Assessment Payable—It is recommended that the company accrue an appropriate expense and liability for its HIRSP assessment payable on a monthly basis. This expense should be reported on line 25 of the Underwriting and Investment Exhibit Part 3, with a description "HIRSP Assessment Accrual" in the "Details of Write-Ins" section, in future annual statements.

    Action—Compliance.

11. Annual Statement Reporting – State Income Tax Recoverable—It is recommended that the company report state income tax recoverables as an admitted asset in future statutory financial statements, in accordance with SSAP No. 10, par. 4.

    Action—Compliance.

12. Annual Statement Reporting – Health Care Receivables – Pharmacy Rebates Receivables—It is recommended that the company adhere to the guidelines pertaining to the admissibility of pharmacy rebate receivables, as prescribed by SSAP No. 84, par. 10, in future statutory financial statements.

    Action—Compliance.

13. Annual Statement Reporting – Amounts Receivable Under Government Insured Plans—It is recommended that the company admit amounts receivable under government insured plans (i.e., receivables arising under the Plan's Medicare and Medicaid contracts), including amounts over 90 days due, in future statutory financial statements in accordance with SSAP No. 84, par. 23.

    Action—Compliance.

14. Other Annual Statement Reporting Issues – Collectibility of Receivables Under Government Insured Plans—It is recommended that the company establish a policy to evaluate the collectibility of its uncollected premium receivables. If it is determined that any portion of the receivable is uncollectible, the amount determined to be uncollectible shall be written off and charged to income in the period the determination is made in accordance with SSAP No. 84, par. 23.

    Action—Compliance.

15. Other Annual Statement Reporting Issues – Unpaid Claim Adjustment Expense Reserve—It is recommended that the company develop a methodology for reasonably estimating the true value of this liability, based on a study of past trends for this expense category.

    Action—Compliance.

16. Information Systems – Business Continuity Plan—It is recommended that the company complete its business continuity plan for its functional units no later than December 31, 2009. The functional business continuity plans should be forwarded to this office for review once completed. The plan should include the requirement that it be reviewed, updated and tested at least annually.

    Action—Compliance.

Summary of Current Examination Results

Risk Based Capital

Risk Based Capital (RBC) is a measure of the amount of capital the company has as a basis of support for the degree of risk associated with the company's operations and investments. The NAIC has developed a standard action level of 200%. The company had a RBC ratio of 158% in 2009 and 176% in 2010. As a result, the company was required to file a corrective action plan in accordance ch. Ins 51, Wis. Adm. Code.

Business Continuity Plan

The examiners' review of the company's business continuity plan identified that the company was unable to provide documentation to support that the plan is updated and tested annually. The business continuity plan should be updated and tested annually for the company's functional units to ensure the plan is sufficient in case of a disaster scenario. It is recommended that the business continuity plan be updated and tested at least annually to ensure that it addresses the company's needs in a disaster scenario.

Insurance Coverages

The examination's review of the company's employee dishonesty/crime coverage identified that the company's current limit is $500,000. Guidance issued by the National Association of Insurance Commissioners (NAIC) indicates that the policy should have a minimum coverage limit of $900,000 based on its exposure. It is recommended the company increase its employee dishonesty/crime coverage limits to the minimum levels identified by the NAIC.

Insolvency Protections for Enrollees

Section Ins 9.04 (6), Wis. Adm. Code, requires health maintenance organization insurers to either maintain compulsory surplus as required for other insurers under s. Ins 51.80, Wis. Adm. Code, or to demonstrate that in the event of insolvency all of the following conditions are met:

1. Enrollees hospitalized to the date of insolvency will be covered until discharged.

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

During the examination, it was noted that the company currently does not have arrangements to provide these protections for enrollees in the event of insolvency as required by s. Ins 9.04 (6) (2), Wis. Adm. Code.

It is recommended that the company enter into an arrangement to provide protections to enrollees in the event of insolvency in accordance with s. Ins 9.04 (6) (2), Wis. Adm. Code.

Incurred But Not Reported

The examination review of incurred but not reported (IBNR) determined that the calculation, on a monthly and annual basis, is described in the Financial Reporting Policy and Procedure for the company. The Financial Reporting Policy and Procedure provides some "high-level" guidance to the calculation, but it does not include a full description of the various methodologies used and a description of the detailed process performed in making the IBNR estimate (i.e., source information, reports, steps within the calculation, etc.). The lack of sufficient guidance implies no one other than the Finance Administrator is able to perform the calculation, which results in a significant risk to the company in the event the Finance Administrator is unavailable to perform the estimate for a given period.

The examiners also determined that the Financial Reporting Policy and Procedure states that an analysis "will" be performed for IBNR based on service authorizations with historical payment experience as a percentage of authorizations. At the time of the examination, the company was unable to perform an analysis based on authorizations because of current system limitations. Therefore, the company should indicate in its policy and procedure that the use of authorizations as a reasonableness check is currently under development and not being performed at this time.

It is recommended that the company create an IBNR Policy and Procedure outside of the Financial Reporting Policy and Procedure that describes the various methodologies used in calculating IBNR and the process used in performing the actual calculation that is currently being used.

Taxes

The examination review of the asset write-in titled “WI State Deferred Tax” determined that this is a loss carryforward. In accordance with SSAP No. 10R, loss carryforwards on a state basis are not considered to be current state income taxes and should not be considered an admitted asset. As a result, a reclassification of the balance of $252,225 was made. It is recommended that the company nonadmit any state deferred tax assets pursuant to SSAP No. 10R.

Underwriting and Investment Exhibit Part 2B

The examination review of the Underwriting and Investment Exhibit Part 2B to the company’s paid claims data identified that the company is not completing this exhibit correctly. Columns 1 and 2, Claims Paid During the Year, of the exhibit include the net change in reserves (IBNR) and only include payments made in 2010 with dates of service in 2010. Pursuant to the NAIC Annual Statement Instructions – Health, columns 1 and 2, should include actual payments only, net of applicable Coordination of Benefits, deductibles, copayments, pharmaceutical rebates collected, risk share amounts collected, reinsurance, subrogation and provider discounts. Therefore, columns 1 and 2 should not include the net change in reserves and should include all claims paid during the year regardless of the date of service on the claim. It is recommended that the company complete the Underwriting and Investment Exhibit Part 2B in accordance with the NAIC Annual Statement Instructions – Health.

Internal Controls

The examination review of internal controls over capitation receivable found that premium is being recorded for members that are disenrolled from the program. Since it is a manual process to disenroll members, an error could be made and premium could be recorded for a member that is disenrolled. This could be prevented if the company were to run exception reports that compare capitation receivable balances to member listings. Additionally, it was noted that controls were not in place that prevented company personnel from making changes to data after the accounting period was closed.

It is recommended that the company review and enhance its internal control environment over recording of premium. In addition, the company should implement the additional controls identified to eliminate the ability to make changes to data after the period has been closed and to prevent any over/understatement in the financial statements.

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, 2010, as modified for examination adjustments is as follows:

Assets	$ 48,973,449	
Less:		
Special deposit	(365,510)	
Liabilities	(41,089,747)	
Examination adjustments	(252,225)	
Assets available to satisfy surplus requirements		$7,265,967
Net premium earned	114,779,012	
Compulsory factor	3%	
Compulsory surplus		3,443,370
Compulsory Surplus Excess/(Deficit)		$3,822,597
Assets available to satisfy surplus requirements		$7,265,967
Compulsory surplus	$ 3,443,370	
Security factor	140%	
Security surplus		4,820,718
Security Surplus Excess/(Deficit)		$2,445,249

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 2010 with a deposit of $365,510 with the State Treasurer.

VIII. CONCLUSION

Partnership Health Plan, Inc., is a nonprofit mixed model HMO that was incorporated on June 25, 2005, and commenced business on January 1, 2006. The company's operations are administered by Community Health Partnership, Inc. (CHP) under an administrative services agreement. Since inception, the company and CHP have worked together to offer the Family Care Partnership Program, an integrated Medicaid/Medicare product, to dual-eligible enrollees residing in the Plan's service area of Chippewa, Dunn, Eau Claire, Pierce, and St. Croix counties.

The company had seen rapid growth until 2010 when membership declined 11% to 1,779 members. The company's unfavorable financial results in 2009 were a result of the company's costs being significantly higher than its capitation payments. The higher costs are due in part to expansion in 2008 into counties with populations that have a higher proportion of high-cost developmentally disabled members.

The examination resulted in seven recommendations and one negative adjustment to surplus of $252,225. The adjustment is explained in the "Summary of Current Examination Results" section of this report.

IX. SUMMARY OF COMMENTS AND RECOMMENDATIONS

1. Page 23 - Business Continuity Plan—It is recommended that the business continuity plan be updated and tested at least annually to ensure that it addresses the company's needs in a disaster scenario.

2. Page 23 - Insurance Coverages—It is recommended the company increase its employee dishonesty/crime coverage limits to the minimum levels identified by the NAIC.

3. Page 24 - Insolvency Protections for Enrollees—It is recommended that the company enter into an arrangement to provide protections to enrollees in the event of insolvency in accordance with s. Ins 9.04 (6) (2), Wis. Adm. Code.

4. Page 24 - Incurred But Not Reported—It is recommended that the company create an IBNR Policy and Procedure outside of the Financial Reporting Policy and Procedure that describes the various methodologies used in calculating IBNR and the process used in performing the actual calculation that is currently being used.

5. Page 25 - Taxes—It is recommended that the company nonadmit any state deferred tax assets pursuant to SSAP No. 10R.

6. Page 25 - Underwriting and Investment Exhibit Part 2B—It is recommended that the company complete the Underwriting and Investment Exhibit Part 2B in accordance with the NAIC Annual Statement Instructions – Health.

7. Page 26 - Internal Controls—It is recommended that the company review and enhance its internal control environment over recording of premium. In addition, the company should implement the additional controls identified to eliminate the ability to make changes to data after the period has been closed and to prevent any over/understatement in the financial statements.

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
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Respectfully submitted,

Terry Lorenz
Examiner-in-Charge