Report of the Examination of

Quartz Health Benefit Plans Corporation

Fitchburg, Wisconsin

As of December 31, 2022

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March 8, 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:

QUARTZ HEALTH BENEFIT PLANS CORPORATION
Fitchburg, Wisconsin

and this report is respectfully submitted.

I. INTRODUCTION

The previous examination of Quartz Health Benefit Plans Corporation (QHBPC or the 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 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.

Independent Actuary's Review

An independent actuarial firm was engaged under a contract with the Office of the Commissioner of Insurance. The actuary reviewed the adequacy of the aggregate accident and health reserves, unpaid claims liability, and premium deficiency reserve. The actuary’s results were reported to the examiner-in-charge. As deemed appropriate, reference is made in this report to the actuary's conclusion.

II. HISTORY AND PLAN OF OPERATION

QHBPC 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 or 193, 611, 613, or 614 or issued a certificate of authority under ch. 618 that makes available to its enrollees, in consideration for predetermined periodic fixed payments, comprehensive health care services performed by providers participating in the plan." Under the network model, the company provides care through contracts with hospitals, clinics, and otherwise independent physicians operating out of their separate offices.

The company was incorporated on October 31, 1983, as HMO of Wisconsin (HMOW), and commenced business on January 1, 1984. Its ultimate parents are University Health Care, Inc. (UHC), Gundersen Lutheran Health System, Inc. (GHS), Iowa Health System, Inc. d/b/a UnityPoint Health (UPH), and Aurora Health Care, Inc. (AHC).

Shown below is a summary of several corporate changes that occurred at the company:

November 1, 1994	United Wisconsin Services, Inc. (UWS) (a subsidiary of Blue Cross Blue Shield United of Wisconsin) acquired HMOW through a cash purchase of 100% of the stock of HMOW.
November 1, 1994	UWS acquired the insurance business of U-Care HMO, Inc., and HMOW assumed both the benefit and provider contracts of U-Care HMO, Inc.
April 1, 1995	The company changed its name to Unity Health Plans Insurance Corporation.
January 1, 2005	Unity was acquired by University Health Care, Inc. (UHC) as a wholly-owned subsidiary. UHC is a tax-exempt membership corporation composed of the University of Wisconsin Medical Foundation (UWMF), University of Wisconsin School of Medicine and Public Health, and University of Wisconsin Hospitals and Clinics Authority (UWHCA).
May 1, 2016	UHC entered into an Exchange Agreement with Gundersen Lutheran Health System, Inc. (GHS) in which common stock of Unity was transferred for membership rights of Gundersen Health Plan, Inc (GHP). Through this transaction, the company became an affiliate of GHP.

July 1, 2017	GHS, UHC, and Iowa Health System d/b/a UnityPoint Health (UPH) entered into an Exchange Agreement in which all of the common stock of Unity was transferred to Physicians Plus Insurance Corporation (PPIC) and PPIC became a wholly owned subsidiary of Quartz Holding Company (QHC). UHC, UPH, and GHS hold the capital stock of QHC. Through this transaction, the company became part of the Quartz Group (Quartz) operating under the same umbrella as PPIC and GHP.
May 20, 2019	The group officially changed the names of the three insurers to align with the Quartz name as follows: Unity Health Plans Insurance Corporation was renamed Quartz Health Benefit Plans Corporation; Gundersen Health Plan, Inc. was renamed Quartz Health Plan Corporation; and Physicians Plus Insurance Corporation was renamed Quartz Health Insurance Corporation.
February 10, 2022	Advocate Aurora Health, Inc. (AAH) and its subsidiary Aurora Health Care, Inc. (AHC) executed Phase 2 of the Exchange Agreement with GHS and UPH and whereby AHC becomes a stockholder of QHC. Each owner holds equity interest in QHC.
December 1, 2022	Bellin Health Systems (Bellin) and GHS entered into a Combination Agreement creating a new corporate entity above Bellin and GHS named Bellin Gundersen Health System, Inc. (BGHS) which has equity interest in QHC through the organizational structure. This new entity is not included in the abbreviated holding company chart shown later in this report.

QHBPC rents its provider network from Quartz Health Solutions, Inc., (QHS) which includes health care systems that offer more than 2,700 primary care physicians (PCP) and in excess of 12,600 specialty physicians in a 51-county network service area. The company also contracts with 70 hospitals to provide inpatient services. Hospitals are reimbursed on a variety of payment terms. The contracts include hold-harmless provisions for the protection of policyholders. The agreements have a one-year term, with automatic renewal, and may be terminated by either party upon 180 days' prior written notice prior to the end of a term.

For specific networks or product lines, a subset of the network is utilized. For example, for state and local government members, QHBPC currently separates its service area into two distinct operational areas: Dane County and the Regional service area. The Regional service area is made up of counties other than Dane County. Within Dane County, UW Health and UnityPoint Health – Meriter delivery systems provide the majority of the services with some additional services provided by non-UW Health entities for members selecting a PCP within Dane County. In the Regional portion of the company's service area, QHS contracts directly with hospitals, primary care, and specialty care providers and clinics as well as four ancillary health care providers. Within the Regional portion of the service area,

specifically in La Crosse County, GHS provides the majority of services. In the eastern region of the service area, Aurora provides the majority of services. For non-state and local government members, the Regional and Dane County operational areas are combined into a single provider network.

QHBPC offers a variety of commercial group plans known as HMO, point of service (POS), preferred provider organization (PPO), and high deductible health plan (HDHP) that include deductible, copayment, and coinsurance products. In addition, the company offers individual HMO and Medicare Select coverages. As of December 31, 2022, 93% of the company's business was in HMO products. At enrollment, HMO members are required to select a PCP. The physical location of the PCP determines the subsequent payment arrangement. The PCP coordinates the member's medical care and is responsible for providing routine health care to that member. For state and local government members, Dane County members may self-refer to any participating provider within Dane County, while Regional members may self-refer to any participating provider within the Regional network. All other members may self-refer to participating providers in both the Regional and Dane County operational areas. For those members who select the HMO product, QHBPC requires a member to obtain prior written authorization from the company for treatment from a non-participating provider (not under contract).

Payment to providers falls under various payment arrangements depending on PCP selection, location of the member, the provider of service, and type of service. Payment arrangements include capitation, per diems, diagnosis-related group (DRGs), discounted fee-for-service, and fee schedules. Virtually all payments, however, are part of an overall capitation arrangement under which GHS, AHC, and UW Health are at risk for medical services provided.

According to its business plan, the company's service area is comprised of the following counties:

Wisconsin Counties

Adams	Dodge	Jefferson	Marinette	Pepin	Trempealeau
Brown	Eau Claire	Juneau	Marquette	Racine	Vernon
Buffalo	Fond du Lac	Kenosha	Milwaukee	Richland	Walworth
Calumet	Grant	Kewaunee	Monroe	Rock	Washington
Chippewa	Green	La Crosse	Oconto	Sauk	Waukesha
Columbia	Green Lake	Lafayette	Outagamie	Shawano	Waushara
Crawford	Iowa	Manitowoc	Ozaukee	Sheboygan	Winnebago
Dane	Jackson				

Illinois Counties

Boone	Carroll	Jo Daviess	Lee	Ogle	Stephenson
Winnebago					

The following basic health care coverages are provided by the insurance contracts:
Ambulance Services
Chiropractic Services
Diagnostic Services Diabetic Treatment and Education
Durable Medical Equipment and Medical Supplies
Emergency Room Services
Hearing Exams and hearing aids
Home Health Care Services
Hospice
Inpatient Hospital Services
Outpatient Hospital Services
Kidney Disease Treatment (including Dialysis and Transplant)
Physician Services
Skilled Nursing Care
Therapy – Physical, Speech, Occupational, Cardiac Rehab
Temporomandibular Joint Treatment (TMJ)
Transplants
Urgent Care
Vision Care
Maternity and Newborn Benefits
Mental Health Service (Psychological and Chemical Dependency - AODA)
Oral Surgery (Specific Procedures Only)
Pharmaceutical Drugs

HMO plans may include deductibles, coinsurance, and/or copayments on covered services. These out-of-pocket expense amounts vary by plan and are selected by each employer or individual policyholder. Services relating to behavioral health or alcohol and other drug abuse (AODA) coverage are covered in accordance with federal and state mental health parity laws.

In addition to HMO products, QHBPC offers a point of service (POS) plan. The POS plan covers services by participating providers as well as services by non-participating providers with two or three levels of benefits depending on the benefit plan design. Services may be subject to a copayment, deductible, or coinsurance based on the participating status of the provider.

The company offers a preferred provider organization (PPO) program. The provider network is provided on a rental basis through a rented national provider network. The PPO is generally available as an accommodation to employers with their principal location in QHBPC's service area with employees

who live outside of the service area. On a limited basis, the PPO is offered to members who reside within the QHBPC service area.

QHBPC markets comprehensive prepaid managed care products to employer groups and individuals in 45 counties covering south central and southwestern Wisconsin and seven counties in northern Illinois. The company's product offerings include health maintenance organization (HMO), point of service (POS), preferred provider organization (PPO), and Medicare Select benefit plans and services. The HMO product includes a variety of benefit coverage options with multiple co-pay and deductible options tailored to meet customer needs. Coverage primarily requires the use of providers within the contracted provider network. The POS product offers flexible options with two levels of benefit coverage available. The PPO product is provided to commercial employers located inside the 44-counties service area and for employees located outside the traditional service area through a rented national provider network. Member access and benefits can vary each time they access health care services under the POS and PPO products. The Medicare Select benefit is provided for those members who are Medicare eligible and is a supplemental benefit for Medicare A and B coverage. The company also has expanded business into the northern portion of the state of Illinois. The product offerings in this region currently include HMO products and group POS products, for which the company has an arrangement with QHIC to cede out-of-network POS group business in Illinois to QHIC.

The company currently markets to groups and individuals and uses outside agencies and an internal sales staff to procure new business. The majority of agent commissions are paid in a fixed dollar amount per contract per month. Agencies can have a mix of pay types based on the commission agreement for each of the agency's groups, including zero commissions if they are sold net of commissions. A small number of agencies are paid commissions on a percentage of premiums on new and renewal business or have a fixed annual fee.

The company uses an actuarially determined base rate as a beginning point in premium rate determination for new groups. The base rate is adjusted to reflect benefit, trend, geography, Standard Industrial Classification (SIC), administrative expense load, and demographics, including age and sex

factors. The base rate is reviewed and adjusted semiannually for inflation and utilization factors. Adjustments may also be applied for claims experience and health status during the rating process.

The company uses an Adjusted Community Rating (ACR) methodology to determine group renewal rates. Depending on the size of the group, this methodology may include evaluation of a group's incurred claim experience and makes adjustments for any high-cost claims above the pooling point for current group enrollment levels and for any benefit changes made. Incurred claim experience from a prior base period is trended to the current base period time frame. The current and prior years of incurred claims experience are melded by a weighting factor determined by total group size. A completion factor is applied to the incurred claims. The incurred claims are trended to the next contract year and blended with manual claims using a credibility factor determined by the number of member months of claims experience to yield projected claims for the next contract year. An administrative expense is added onto projected claims to obtain the total premium needed for the next contract year. This methodology is reviewed and adjusted on at least an annual basis.

III. MANAGEMENT AND CONTROL

Board of Directors

The board of directors consists of 12 members. The board of directors consists of four independent directors; three GHS directors; three UHC directors; one AHC director; and one UPH director. 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 company group.

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

Name and Residence	Principal Occupation	Term Expires
Gerald Arndt Onalaska, WI	Retired - Gundersen Health System	2026
Michael Dolan, MD La Crosse, WI	Co-Chief Medical Officer – Gundersen Region Bellin and Gundersen Health System	2025
Heidi Eglash La Crosse, WI	Attorney	2026
Susan Erickson Sauk City, WI	Retired – UnityPoint Health	2026
William Farrell La Crescent, MN	Chief Business & Strategy Officer – Gundersen Health System	2024
Robert Flannery Waunakee, WI	Chief Financial Officer – UW Health	2025
Carey Gehl Middleton, WI	Vice President, Strategic Growth & Regional Relations – UW Health	2024
Kevin Hauser Richland Center, WI	Retired	2025
Alan Kaplan Waunakee, WI	Chief Executive Officer – UW Health	2026
Gerald Kember Black Earth, WI	Retired	2024
John Sickels Wausau, WI	Retired – Incredible Bank	2025
Rebekah Swain Fitchburg, WI	Group VP, Managed Health Strategy, Enterprise Advocate Health	2024

Officers of the Company

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

Name	Office
Christine Senty	President and CEO
Jeffrey Butcher	Senior Vice President, Treasurer, and CFO
Kristie Breunig	Vice President, General Counsel, and Secretary
David Hanekom	Senior Vice President, Chief Medical Officer
Jami Berger	Senior Vice President, Chief Clinical Officer
Jamie Stock-Retzloff	Assistant Secretary

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:

Audit Committee
Gerald Arndt, Chair
Susan Erickson
Robert Flannery
Kevin Hauser

Finance Committee
Robert Flannery, Chair
Rebekah Swain
Susan Erickson
Alan Kaplan, MD
George Tervalon
Heidi Eglash
Michael Dolan, MD
Jodi Vitello (Non-voting member)
Gary Hovila (Non-voting member)
Steve Little (Non-voting member)

Nominating Committee
Carey Gehl, Chair
Rebekah Swain
William Ferrell
Jerry Kember
Susan Erickson

The company has no employees. Necessary staff is provided through a management agreement with QHS. Under the agreement, QHS agrees to negotiate employer, provider, subscriber, and other contracts; advises the board; maintains the accounting and financial records; recruits marketing, utilization review, and claims processing personnel; and provides or contracts for claims processing and management information systems (MIS). In return for the services provided, the company will pay to QHS an advance payment equal to 1/12th of the annual operating budget no later than the fifth day of each month. Within 30 days following the calendar year-end, QHS shall submit to the company a statement reflecting the actual costs of services that have been provided to the company for the year.

The term of the agreement continues until the parties agree to terminate. The company may terminate the agreement upon 30 days' written notice if the default of standards of performance continues 30 days after notice of such default.

Insolvency Protection for Policyholders

Under s. Ins 9.04 (6), Wis. Adm. Code, HMOs are required to either maintain compulsory surplus at the level required by s. Ins 51.80, Wis. Adm. Code, or provide for the following in the event of the company's insolvency:

1. Enrollees hospitalized on the date of insolvency will be covered until discharged; and

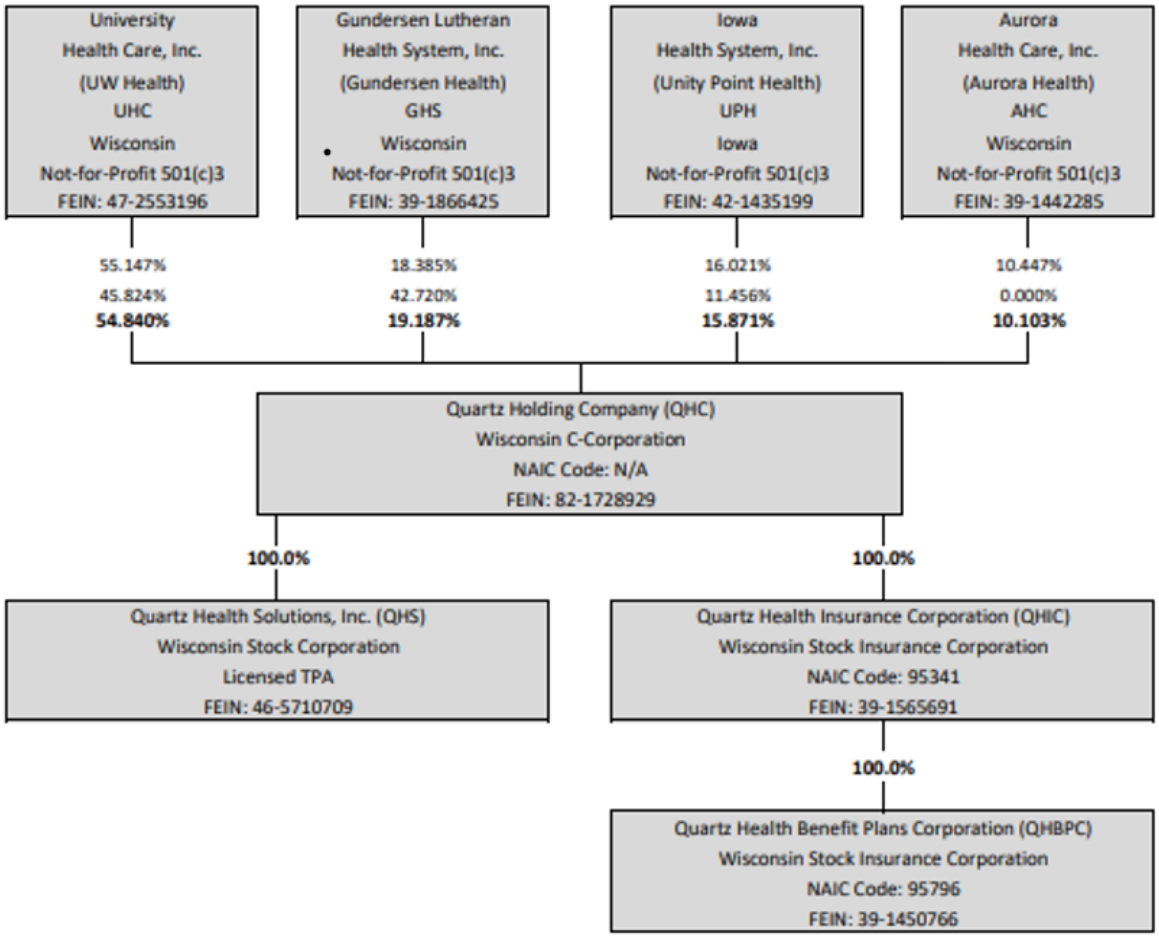
2. Enrollees will be entitled to similar, alternate coverage that does not contain any medical underwriting or preexisting limitation requirements.

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

IV. AFFILIATED COMPANIES

Quartz Health Benefit Plans Corporation is a member of a holding company system. Its ultimate parents are UHC, GHS, UPH, and AHC. The abbreviated organizational chart below depicts the relationships among the affiliates in the group. A brief description of affiliates deemed significant follows the organizational chart.

Holding Company Chart - Abbreviated
As of December 31, 2022



University Health Care, Inc.

UHC is a not-for-profit corporation organized under Ch. 181, Wis. Stat. The University of Wisconsin Hospitals and Clinics Authority (“UWHCA”) and the University of Wisconsin Medical Foundation (“UWMF”) are equal members of UHC. UHC serves as a network development vehicle by developing regional programs and clinical centers and developing business relationships with other health care providers.

UHC is no longer an audited entity; therefore, the examination reviewed the consolidated GAAP financial information of UW Hospitals and Clinics Authority d/b/a UW Health, the parent of UHC, which includes the financial information of UHC.

As of December 31, 2022, UWHCA’s audited GAAP financial statements reported assets of $109.3 million, liabilities of $20.9 thousand, and net assets of $109.3 million.

Gundersen Lutheran Health System, Inc.

Gundersen Lutheran Health System, Inc. located in La Crosse, Wisconsin, is the parent of Gundersen Lutheran Health System, an integrated health care system that provides comprehensive medical care to patients primarily in Wisconsin, as well as in Iowa and Minnesota.

As of December 31, 2022, GHS’s audited GAAP financial statements reported assets of $2.2 billion, liabilities of $0.7 billion, and net assets of $1.5 billion. Operations for the 2022 year had a net loss of $(0.1 billion) on a total revenue of $1.5 billion.

Iowa Health System, Inc.

Iowa Health System is an Iowa nonprofit corporation formed in December 1994. Iowa Health System and its subsidiaries provide inpatient and outpatient care and physician services from 20 hospital facilities and various ambulatory service and clinic locations in Iowa, Illinois, and Wisconsin. Primary, secondary, and tertiary care services are provided to residents of Iowa, Illinois, Wisconsin, and adjacent states.

As of December 31, 2022, UPH’s audited GAAP financial statements reported assets of $6.4 billion, liabilities of $2.7 billion, and net assets of $3.7 billion. Operations for the 2022 year produced excess revenue over expenses of $(0.8 billion) on a total revenue of $4.3 billion.

Aurora Health Care, Inc.

Advocate Aurora Health, Inc., a Delaware nonprofit corporation, owns and operates primarily not-for-profit healthcare facilities in Illinois and Wisconsin. Advocate Aurora Health, Inc. is the sole corporate member of Advocate Health Care Network, an Illinois not-for-profit corporation, and Aurora Health Care, Inc., a Wisconsin nonstock not-for-profit corporation.

As of December 31, 2022, AHC's audited GAAP financial statements reported assets of $21.9 billion, liabilities of $8.4 billion, and net assets of $13.3 billion. Operations for the 2022 year produced excess revenue over expenses of $(0.8 billion) on a total revenue of $14.5 billion.

Quartz Holding Company

QHC operates as a shell company that exists for the sole purpose of holding ownership in QHIC and QHS.

Quartz Health Solutions, Inc.

QHS is a service organization that performs administrative and claims processing for the holding group and employers of self-funded group health plans.

Quartz Health Plan MN Corporation

Quartz Health Plan MN Corporation is a non-profit HMO established to provide comprehensive health care insurance for Minnesota insureds. QHPMC is licensed to write business for small and large group commercial and Medicare.

As of December 31, 2022, QHPMC's audited statutory financial statement reported assets of $15.8 million, liabilities of $9.9 million, and capital and surplus of $5.9 million. Operations for 2022 produced a net income of $26.3 thousand on revenues of $38.8 million.

Quartz Health Plan Corporation

QHPC is a Ch. 613 not-for-profit service corporation operating under Wis. Stat. § 609.03(3), as a health maintenance organization insurer. QHPC has been a part of an insurance holding company system since its incorporation in 1995.

As of December 31, 2022, QHPC's audited statutory financial statement reported assets of $88.6 million, liabilities of $52.7 million, and capital and surplus of $35.9 million. Operations for 2022 produced a net loss of $(6.2 million) on revenues of $390.6 million.

Quartz Health Insurance Corporation

QHIC is a Ch. 611 stock insurance corporation operating as a for-profit Wisconsin-domiciled indemnity health insurance company. QHIC is a wholly owned subsidiary of Quartz Holding Company, which is owned by AHC, UHC, GHS, and UPH. Control of QHIC is maintained by AHC, UHC, GHS, and UPH through stock ownership and board of director representation.

As of December 31, 2022, QHIC's audited statutory financial statement reported assets of $143.1 million, liabilities of $0.5 million, and capital and surplus of $142.6 million. Operations for 2022 produced a net income of $0.4 million on revenues of $3.1 million.

Agreements with Affiliates:

Credentialing Agreement

QHS and QHBPC have a Credentialing Delegation Agreement, effective January 1, 2023, where QHPC delegates credentialing services to QHS. The organization has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners to provide care to members. QHS ensures that this process is being followed and reviews the providers for credentialing and recredentialing purposes.

Management Services Agreement

QHS and QHBPC have a Management Services Agreement, effective January 1, 2022, wherein QHS agrees to provide administrative and management services to QHBPC, and QHBPC agrees to be charged for those services by QHS. Under the terms of the agreement, QHS is to provide management and administrative services to the company, which includes but is not limited to, actuarial services, underwriting, human resource, legal, accounting, sales/marketing, claims management/settlement, employees, provider contracting, and network management. In return for the services provided, the company will pay to QHS an advance payment equal to 1/12th of the annual operating budget no later than the fifth day of each month. Within 30 days following the calendar year-end, QHS shall submit to the

company a statement reflecting the actual costs of services that have been provided to the company for the year. Any under or overpayment shall be settled within five business days after reconciliation has been performed based on the statement submitted by QHS.

Office Space Agreement

QHBPC and QHS have an Office Space Agreement where QHBPC owns an office in Sauk City, Wisconsin, and is leasing the office space to QHS. QHS pays an annual rent payment to the company in equal monthly installments. Other costs associated with the real property such as real estate taxes, costs of repair and maintenance, insurance, and personal property taxes are paid by QHS as additional rent to the minimum rent.

Network Access Agreement

QHS and QHPC, QHPMC, QHIC, and QHBPC have a Network Access Agreement, effective January 1, 2022, under which QHS will maintain a network of contracted Participating Providers without any assumption of underwriting risk. In exchange, the licensed entities will make health services available to participants by contracting with QHS for its network of providers.

Pharmacy Network Access Agreement

QHS and QHPC, QHPMC, QHIC, and QHBPC have a Pharmacy Network Access Agreement that establishes the rental pharmacy network structure under which QHS maintains a pharmacy network and the licensed entities contract with QHS to utilize the established network. The company agrees to pay a fee per member per month to access the pharmacy network which is referred to as the “Quartz Network”.

Tax Sharing Agreement (State)

QHC, QHBPC, QHIC, QHPC, and QHS have a Tax Sharing Agreement to fairly allocate state tax and liabilities, credits, refunds, benefits, and similar items related to the consolidated state income tax return. Under the agreement, each party participates in a state income tax return filed on a consolidated basis. The method of allocation among the companies is based upon the separate return calculation with current credit for net losses. Final settlement for any return filed will be made no later than 30 days after the return is filed or with the exception of a return with a refund, within 30 days of receipt of the refund.

Tax Sharing Agreement (Federal)

QHC, QHBPC, QHIC, QHPC, and QHS have a Tax Sharing Agreement to fairly allocate federal tax liabilities, credits, refunds, benefits, and similar items related to the consolidated federal income tax return. Under the agreement, each party participates in a federal income tax return filed on a consolidated basis. The method of allocation among the companies is based upon the separate return calculation with current credit for net losses. Final settlement for any return filed will be made no later than 30 days after the return is filed or with the exception of a return with a refund, within 30 days of receipt of the refund.

Administrative Services Agreement

QHBPC and QHIC have an Administrative Services Agreement to jointly offer a Point of Service (POS) product, where QHBPC will assume risk for the in-network portion of the POS products offered to small groups and large groups in the state of Illinois, and QHIC will assume risk for the indemnity portion, or out-of-network benefits. Under this agreement QHBPC receives 70% of the gross premium and is responsible for HMO services, and QHIC receives 30% of the gross premium and is responsible for indemnity services received. Per the agreement QHBPC administers all the benefits received under the policy. This agreement was entered into to ensure compliance with Illinois Administrative Code regarding the sale of POS products.

V. REINSURANCE

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

1. Reinsurer: Zurich American Insurance Company

   Type: Excess of Loss Reinsurance

   Scope: Membership service agreements pursuant to which the Reinsured retains financial responsibility for eligible health care services provided to the following Members:

   University of Wisconsin (UW)/Meriter Risk Pool:
   - Commercial HMO/POS/PPO
   - Medicare Advantage (not including dual eligible)
   - Rockford, Illinois Commercial and Medicare Advantage (Not Including Dual Eligible)

   Gundersen Risk Pool:
   Medicare Advantage (not including dual eligible)

   Effective date: January 1, 2022

   Retention: Gundersen Risk Pool
   Medicare: $600,000

   UW/Meriter Risk Pool
   Commercial: $2,100,000
   Medicare: $575,000

   Coverage: 90% coverage for amounts in excess of the company's retention for all covered services unless otherwise noted.

   95% coverage for amounts in excess of the company's retention for Prescription Drugs related to fully implemented Summit ReSources Recommendation

   Termination: The contract will terminate at the end of the contract period on December 31, 2022. Either party may elect to terminate the contract, in part or in whole, prior to the expiration date by providing a 30-days' notice to the other party. Any losses incurred on or after the termination date are not covered under the contract.

2. Reinsurer: Zurich American Insurance Company

   Type: Excess of Loss Reinsurance

   Scope: Membership service agreements pursuant to which the Reinsured retains financial responsibility for eligible health care services provided to the following ProHealth Members:
   Commercial; and Medicare Advantage (not including Dual Eligible)

Effective date:	January 1, 2022
Retention:	Commercial Members: $1,500,000 Medicare Advantage Members: $425,000
Coverage:	80% coverage for amounts in excess of the company's retention for all covered services unless otherwise noted. 85% coverage for amounts in excess of the company's retention for Prescription Drugs related to fully implemented Summit ReSources Recommendation
Termination:	The contract will terminate at the end of the contract period on December 31, 2022. Either party may elect to terminate the contract, in part or in whole, prior to the expiration date by providing a 30-days' notice to the other party. Any losses incurred on or after the termination date are not covered under the contract.

3. Reinsurer: Zurich American Insurance Company

Type:	Excess of Loss Reinsurance
Scope:	Membership service agreements pursuant to which the Reinsured retains financial responsibility for eligible health care services provided to the following Members: Gundersen Risk Pool: Commercial HMO/POS/PPO
Effective date:	January 1, 2022
Retention:	Covered services Matrix A - $1,000,000 Covered services Matrix B - $1,900,000
Coverage:	90% coverage for amounts in excess of the company's retention for all covered services unless otherwise noted. 95% coverage for amounts in excess of the company's retention for Prescription Drugs related to fully implemented Summit ReSources Recommendation
Termination:	The contract will terminate at the end of the contract period on December 31, 2022. Either party may elect to terminate the contract, in part or in whole, prior to the expiration date by providing a 30-days' notice to the other party. Any losses incurred on or after the termination date are not covered under the contract.

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.

Quartz Health Benefit Plans Corporation
Assets
As of December 31, 2022

	Assets	Nonadmitted Assets	Net Admitted Assets
Bonds	$ 83,780,993	$	$ 83,780,993
Stocks:			
Common stocks	19,967,538		19,967,538
Real Estate:			
Properties occupied by the company	276,210		276,210
Cash, cash equivalents and short-term investments	108,841,558		108,841,558
Title plants			
Investment income due and accrued	471,382		471,382
Uncollected premiums and agents' balances in the course of collection	6,113,164	702,114	5,411,050
Accrued retrospective premiums and contracts subject to redetermination	10,960,152		10,960,152
Amounts recoverable from reinsurers	24,717,317		24,717,317
Other amounts receivable under reinsurance contracts	658,740		658,740
Current federal and foreign income tax recoverable and interest thereon	3,973,229		3,973,229
Net deferred tax asset	4,019,098	1,405,414	2,613,684
Health care and other amounts receivable	45,743,018	3,277,034	42,465,984
Write-ins for other than invested assets:			
Prepaid expenses	23,625	23,625	
State income tax receivable	228,359		228,359
Total Assets	$309,774,383	$5,408,187	$304,366,196

Quartz Health Benefit Plans Corporation
Liabilities and Net Worth
As of December 31, 2022

Claims unpaid		$101,556,270
Accrued medical incentive pool and bonus payments		3,478,935
Unpaid claims adjustment expenses		3,117,734
Aggregate health policy reserves		19,382,965
Premiums received in advance		31,478,366
General expenses due or accrued		4,596,244
Remittance and items not allocated		56,346
Amounts due to parent, subsidiaries, and affiliates		2,086,825
Payable for securities		1,397,468
Escheat Payable		401,724
Total Liabilities		167,552,877
Common capital stock	$ 1,000	
Gross paid in and contributed surplus	90,798,916	
Unassigned funds (surplus)	46,013,403	
Total Capital and Surplus		136,813,319
Total Liabilities, Capital and Surplus		$304,366,196

Quartz Health Benefit Plans Corporation
Statement of Revenue and Expenses
For the Year 2022

Net premium income		$1,562,749,933
Aggregate write-ins for other health care related revenues		10,788
Aggregate write-ins for other non-health revenues		(1,614)
Total revenues		1,562,759,107
Medical and Hospital:		
Hospital/medical benefits	$1,110,632,311	
Other professional services	6,346,470	
Outside referrals	44,425,293	
Emergency room and out-of-area	107,889,994	
Prescription drugs	204,195,031	
Incentive pool and withhold adjustments	3,022,673	
Subtotal	1,476,511,772	
Less		
Net reinsurance recoveries	27,829,178	
Total medical and hospital	1,448,682,594	
Claims adjustment expenses	36,268,787	
General administrative expenses	96,383,511	
Total underwriting deductions		1,581,334,892
Net underwriting gain or (loss)		(18,575,785)
Net investment income earned	3,222,316	
Net realized capital gains or (losses)	(1,144,814)	
Net investment gains or (losses)		2,077,502
Net gain or (loss) from agents' or premium balances charged off		(347,561)
Net income or (loss) before federal income taxes		(16,845,844)
Federal and foreign income taxes incurred		(4,366,949)
Net Income (Loss)		$ (12,478,895)

Quartz Health Benefit Plans Corporation
Capital and Surplus Account
For the Five-Year Period Ending December 31, 2022

	2022	2021	2020	2019	2018
Capital and surplus, beginning of year	$106,686,740	$118,240,427	$105,576,153	$82,603,075	$59,654,801
Net income (loss)	(12,478,895)	8,834,948	19,913,718	7,115,144	5,815,676
Change in net unrealized capital gains/losses	(99,661)	(25,006)	26,177	92,699	(56,657)
Change in net deferred income tax	(3,278,677)	5,310,478	110,355	(922,383)	1,611,206
Change in nonadmitted assets	21,180,479	(25,674,107)	133,024	4,687,619	(4,708,214)
Surplus adjustments: Paid in	24,803,334			12,000,000	19,315,000
Dividends to stockholders			(7,519,000)		
Capital and Surplus, End of Year	$136,813,320	$106,686,740	$118,240,427	$105,576,153	$82,603,075

Quartz Health Benefit Plans Corporation
Statement of Cash Flow
For the Year 2022

Premiums collected net of reinsurance			$1,583,653,820
Net investment income			3,420,239
Miscellaneous income			9,174
Total			1,587,083,233
Less:			
Benefit- and loss-related payments		$1,428,139,865	
Commissions, expenses paid and aggregate write-ins for deductions		133,794,379	
Federal and foreign income taxes paid (recovered) net of tax on capital gains (losses)		709,122	
Total			1,562,643,366
Net cash from operations			24,439,867
Proceeds from Investments Sold, Matured or Repaid:			
Bonds	$63,379,997		
Net gains (losses) on cash, cash equivalents, and short-term investments	60,928		
Miscellaneous proceeds	366,765		
Total investment proceeds		63,807,690	
Cost of Investments Acquired—Long-term Only:			
Bonds	49,196,205		
Stocks	20,053,931		
Miscellaneous applications	43,563		
Total investments acquired		69,293,699	
Net cash from investments			(5,486,009)
Cash Provided for/Applied from Financing and Miscellaneous Sources:			
Capital and paid-in surplus, less treasury stock		24,803,334	
Other cash provided (applied)		(253,645)	
Net cash from financing and miscellaneous sources			24,549,689
Net Change in Cash, Cash Equivalents, and Short-Term Investments			43,503,547
Cash, cash equivalents, and short-term investments:			
Beginning of year			65,338,012
End of Year			$ 108,841,559

Growth of Quartz Health Benefit Plans Corporation

Year	Assets	Liabilities	Capital and Surplus	Premium Earned	Medical Expenses Incurred	Net Income
2022	$304,366,196	$167,552,877	$136,813,319	$1,562,749,933	$1,476,511,772	$(12,478,895)
2021	294,507,265	187,820,525	106,686,319	1,571,117,720	1,452,554,213	8,834,948
2020	271,074,657	152,834,230	118,240,427	1,506,688,421	1,342,375,600	19,913,718
2019	292,002,512	186,426,359	105,576,153	1,421,043,643	1,307,653,644	7,115,144
2018	240,963,261	158,360,185	82,603,076	1,276,798,483	1,140,874,660	5,815,676
2017	170,152,323	110,497,522	59,654,801	960,716,464	889,252,608	684,068

Year	Profit Margin	Medical Expense Ratio	Administrative Expense Ratio	Change in Enrollment
2022	-0.8%	92.7%	8.5%	-5.8%
2021	0.6	90.9	8.5	2.6
2020	1.3	87.5	10.5	1.8
2019	0.5	90.6	8.9	8.6
2018	0.5	89.4	9.7	16.2
2017	0.1	91.6	8.3	9.4

Enrollment and Utilization

Year	Enrollment	Hospital Days/1,000	Average Length of Stay
2022	253,327	227.1	20.8
2021	268,835	309.7	4.7
2020	261,998	331.3	4.8
2019	257,264	373.2	4.4
2018	236,956	225.1	4.3
2017	204,017	208.7	4.0

Per Member Per Month Information

	2022	2021	Percentage Change
Premiums:			
Commercial	$508.66	$490.21	3.8%
Medicare Supplement	213.49	207.60	2.8
Net Premium Income	506.44	488.01	3.8
Expenses:			
Hospital/medical benefits	$359.92	$353.17	1.9%
Other professional services	2.06	12.53	-83.6
Outside referrals	14.40	0.00	
Emergency room and out-of-area	34.96	22.00	58.9
Prescription Drugs	66.17	62.55	5.8
Other medical and hospital	0.00	0.00	0.0

	2022	2021	Percentage Change
Incentive pool and withhold adjustments	0.98	0.93	5.7
Less: Net reinsurance recoveries	9.02	7.39	22.1
Total medical and hospital	469.47	443.79	5.8
Claims adjustment expenses	10.5	10.95	-4.5
General administrative expenses	31.2	30.46	2.6
Total underwriting deductions	$511.16	$485.19	5.4%

Membership increased over the examination period with enrollment increasing from 236,956 members at the end of 2018 to 253,327 members at the end of 2022. The company saw a significant increase in premiums and membership when it assumed the business from QHIC at the end of 2018. The company saw positive financial results with a positive net income in 2018 through 2021 with a net loss in 2022 of $12.5 million. The net loss in 2022 was due to an increase in claims and utilization which continued to trend toward pre-pandemic levels. Premiums earned increased from $1.3 billion at the end of 2018 to $1.6 billion at the end of 2022 with medical expenses also increasing from $1.1 billion at the end of 2018 to $1.5 billion at the end of 2022. During the same time period the company saw capital and surplus increase from $82.6 million to $136.8 million. The increases in capital and surplus were primarily driven by the positive net income during the examination period.

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			$304,366,197
Less:			
Special deposit			15,957,017
Liabilities			167,552,878
Net amount available to satisfy surplus requirements			120,856,302
Net premium earned			
HMO business	$1,535,744,323		
Factor	3%		
Total		$46,072,330	
Incidental Indemnity	27,005,611		
Factor	10%		
Total		2,700,561	
Compulsory surplus		48,772,891	
Compulsory Surplus Excess (Deficit)			$ 72,083,411
Net amount available to satisfy surplus requirements			$120,856,302
Compulsory surplus		48,772,891	
Security factor		110%	
Security surplus			53,650,180
Security Surplus Excess (Deficit)			$ 67,206,122

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 2022 with a deposit of $15,750,000 with the state treasurer.

Reconciliation of Capital and Surplus per Examination

No adjustments were made to surplus 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. Affiliated Transaction Disclosures—It is recommended that the company properly disclose its material affiliated transactions in accordance with the NAIC Annual Statement Instructions - Health and s. Ins 40.03 (3) (c) 3, Wis. Adm.

   Action—Compliance.

2. Business Continuity Plan—It is recommended that the company include critical third-party operations in its business impact analysis and risk assessment for its business continuity plan.

   Action—Compliance.

3. Other Recommendations—It is recommended that the company strengthen its IT control environment as specifically described in the management letter dated March 1, 2019.

   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 workpapers.

Premium Deficiency Reserve

A review of the company's premium deficiency reserve (PDR) calculation determined that the company is not calculating its PDR in accordance with Statement of Statutory Accounting Principle (SSAP) No. 54-*Individual and Group Accident and Health Contracts*. The review determined that the company is not separating blocks of business in the PDR analysis when they are credible. In addition, the company also must ensure that it is not offsetting losses in segments of business with gains in other segments unless it is confirmed that the profitable business can absorb the indirect expenses of the unprofitable business. It is recommended that blocks of business should be segmented when credible in calculating the premium deficiency reserve in accordance with *SSAP No. 54—Individual and Group Accident and Health Contracts*.

Actuarial Memorandum Premium Deficiency Reserve

A review of the company's Actuarial Memorandum disclosed that the company is not providing sufficient documentation regarding the premium deficiency reserve calculation. The company should provide adequate documentation so that a reviewing actuary practicing in the same field could evaluate the work performed. The documentation should show the analysis from the basic data to the conclusions and include adequate information to support the calculation. It is recommended that explanations in the actuarial memorandum include sufficient documentation to show analysis from the basic data to the conclusion so an actuary in the same field can evaluate the work performed.

Information Technology

During the course of the examination, a review was made of the company's general controls over its information systems. The review resulted in certain findings, which were presented in a management comment letter. It is recommended that the company comply with the recommendations made in the management comment letter.

VIII. CONCLUSION

QHBPC is a for-profit model health maintenance organization (HMO) insurer. Under the network model, the company provides care through contracts with hospitals, clinics, and otherwise independent physicians operating out of their separate offices. QHBPC offers a variety of commercial group plans known as HMO, point of service (POS), preferred provider organization (PPO), or high deductible health plan (HDHP) that include deductible, copayment, and coinsurance products. In addition, the company offers individual HMO and Medicare Select coverages.

At the end of 2022, the company reported total net assets of $304.4 million, total liabilities of $167.6 million, and total capital and surplus of $136.8 million. Compulsory capital and surplus of $72.1 million satisfied the compulsory and security surplus requirement at year-end 2022.

The prior examination resulted in three recommendations, all of which have been complied with. The current examination resulted in three recommendations, which are outlined in Section IX below.

IX. SUMMARY OF COMMENTS AND RECOMMENDATIONS

1. Page 31 - Premium Deficiency Reserve—It is recommended that the company comply with *SSAP No. 54—Individual and Group Accident and Health Contracts* when determining if a premium deficiency reserve is necessary for each line of business written.

2. Page 31 - Actuarial Memorandum Premium Deficiency Reserve—It is recommended that an explanation in the actuarial memorandum include sufficient documentation to show analysis from the basic data to the conclusion so an actuary in the same field can evaluate the work performed.

3. Page 31 - Information Technology—It is recommended that the company comply with the recommendations in the management comment letter.

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
Yi Xu	Insurance Financial Examiner
Benjamin Marquardt	Insurance Financial Examiner
Jacob Luebke	Insurance Financial Examiner
Eleanor Lu, CISA	IT Specialist
Nicholas Hartwig, AFE	Quality Control Specialist
Jerry DeArmond, CFE	Reserve Specialist and ACL Specialist

Respectfully submitted,

Gabriel Gorske, CFE
Examiner-in-Charge