Report of the Examination of

Quartz Health Plan 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 PLAN CORPORATION
Fitchburg, Wisconsin

and this report is respectfully submitted.

I. INTRODUCTION

The previous examination of Quartz Health Plan Corporation (QHIC 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

QHIC is described as a not-for-profit network model health maintenance organization (HMO) insurer. An HMO insurer is defined by s. 609.01 (2), Wis. Stat., as ". . . a health care plan offered by an organization established under ch. 185, 611, 613, or 614 or issued a certificate of authority under ch. 618 that makes available to its 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 two or more clinics.

The company was incorporated in Wisconsin on March 13, 1995, as a non-stock service insurance corporation under ch. 613, Wis. Stat., and commenced business on September 1, 1995. The company is exempt from federal income taxes under § 501(c)(4) of the Internal Revenue Code; however, the company is subject to Wisconsin franchise tax. The company is a part of a holding company system. Its ultimate parents are University Health Care, Inc. (UHC); Gundersen Lutheran Health System, Inc. (GHS); Iowa Health System, Inc. d/b/a Unity Point Health (UPH); and Aurora Health Care (AHC). Shown below is a summary of several corporate changes that occurred at the company.

June 10, 1996	Gundersen Clinic, Ltd., (the Clinic) and Gundersen Lutheran Medical Center, Inc. (the Hospital), both of whom were parent companies of QHPC, formed an affiliation through the creation of Gundersen Lutheran, Inc.
January 1, 2000	Gundersen Lutheran, Inc., became the new parent of QHPC, replacing the Clinic and the Hospital.
August 1, 2006	QHPC expanded its territory by obtaining a certificate of authority in the State of Iowa to transact business as an HMO in five northern counties.
March 26, 2013	Gundersen Lutheran, Inc., changed its legal name to Gundersen Lutheran Health System, Inc. (GHS), and the company's legal name was changed to Gundersen Health Plan, Inc.
May 1, 2016	GHS entered into a Members Agreement with University Health Care, Inc., (UHC) in which the two entities became members of QHPC. Through this transaction, the company became an affiliate of Unity Health Plans Insurance Corporation (Unity).
July 1, 2017	GHS entered into a Members Agreement with Iowa Health System, Inc. d/b/a Unity Point Health (UPH) and UHC in which all three entities will be members of the company. Through this affiliation, the company became part of the Quartz Group (or Quartz) operating under the same umbrella as Physician Plus Insurance Corporation (PPIC) and Unity Health Plans Insurance Corporation (Unity).
2018	In 2018, QHPC implemented a strategic plan of shifting commercial lines of business to another entity (QHBPC) within the family of Quartz Health Plans. The primary focus is servicing members under government funded contracts under Medicaid and Medicare, a small portion of focus also include point of service (POS) line of business and prepaid commercial group.
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.
October 15, 2020	Advocate Aurora Health, Inc. (AAH) and its subsidiary Aurora Health Care, Inc. (AHC) entered into an Exchange Agreement with GHS, UPH, and UHC where AHC made a contribution to QHPC in exchange for 15% of Class A Membership Rights of QHPC Each owner holds membership interest in QHPC.
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.

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QHPC 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 contracted 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, QHPC currently separates its service area into two distinct operational areas: Dane County and the Regional service area. Within Dane County, the UW Health and UnityPoint Health – Meriter delivery systems provide the majority of the services with some additional services provided by non-UW 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.

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. Members may self-refer to participating

providers in both the Regional and Dane County operational areas. For those members who select the HMO product, the company requires a member to obtain prior written authorization from the company for treatment from a non-participating provider (not under contract) with QHS.

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 groups (DRGs), discounted fee-for-service, and fee schedules.

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

Wisconsin Counties

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

Illinois Counties

Boone	Carroll	Jo Daviess	Lee	Ogle	Stephenson
Winnebago					

Iowa Counties

Allamakee	Clayton	Winneshiek	Fayette	Howard

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, the company 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.

In 1999, QHPC entered into an agreement with the then federal Health Care Financing Administration to market a Medicare+Choice product. In 2005, QHPC re-contracted with the Centers for Medicare and Medicaid Services to market a Medicare Advantage Prescription Drug (MA-PD) product, Gundersen Senior Preferred (Medicare Advantage). Medicare Advantage is a comprehensive medical plan that combines coverage with those services provided by traditional Medicare with wellness, preventative care, and prescription drug benefits offered by QHPC. The MA-PD product is only offered to members that have Medicare Advantage medical coverage; it is not marketed as a stand-alone product. Medicare Advantage is currently offered in southern Wisconsin, northern Illinois, and northeast Iowa. It is available through marketing representatives who are employed directly by the plan and through outside agencies. QHPC markets comprehensive prepaid managed care products to employer groups and individuals. Product offerings include HMO, BadgerCare (Wisconsin’s State Medicaid program), Medicare Supplement benefit plans and services, and Medicare Advantage (MA). 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. Member access and benefits can vary each time they access health care services under the POS and PPO products. The Medicare Supplement benefit is provided for those members who are Medicare eligible and is a supplemental benefit for Medicare Part A and B coverage. The MA product is also offered to Medicare-eligible

individuals for Medicare Part C coverage, with Part D drug coverage available for those enrolled in Medicare Part C.

With the exception of the Medicare Advantage and BadgerCare products, QHPC markets to groups only. This marketing is done through outside agencies, as well as through QHPC's internal sales department. External broker commissions for small group policies are paid at a fixed dollar amount per contract per month, and large group policy commissions and Medicare Supplement policies pay commissions as a percentage of the premium. Medicare Advantage commissions are paid in accordance with 42 CFR § 422.2278.

The company uses an actuarially determined base as a beginning point in premium determination. This rate is adjusted to reflect the age, sex, occupation, and coverage characteristics of new groups. Experience is reviewed for renewal groups, and based on the review, a recommendation is made regarding adjusting the rate or canceling the group. The base rate is adjusted quarterly for inflation and other trending factors.

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
Randy Bruegman Madison, WI	Retired	2026
Michael Dolan, MD La Crosse, WI	Co-Chief Medical Officer – Gundersen Region Bellin and Gundersen Health System	2025
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
Alan Kaplan Waunakee, WI	Chief Executive Officer – UW Health	2026
Gerald Kember Black Earth, WI	Retired	2024
Rebekah Swain Fitchburg, WI	Group VP, Managed Health Strategy, Enterprise Advocate Health	2024
George Tervalon, III Middleton, WI	Retired	2025
Open Position (Independent)		2025

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
David Hanekom	Senior Vice President, Chief Medical Officer
Kristie Breunig	Vice President, General Counsel, and Secretary
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, effective January 1, 2022, 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 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

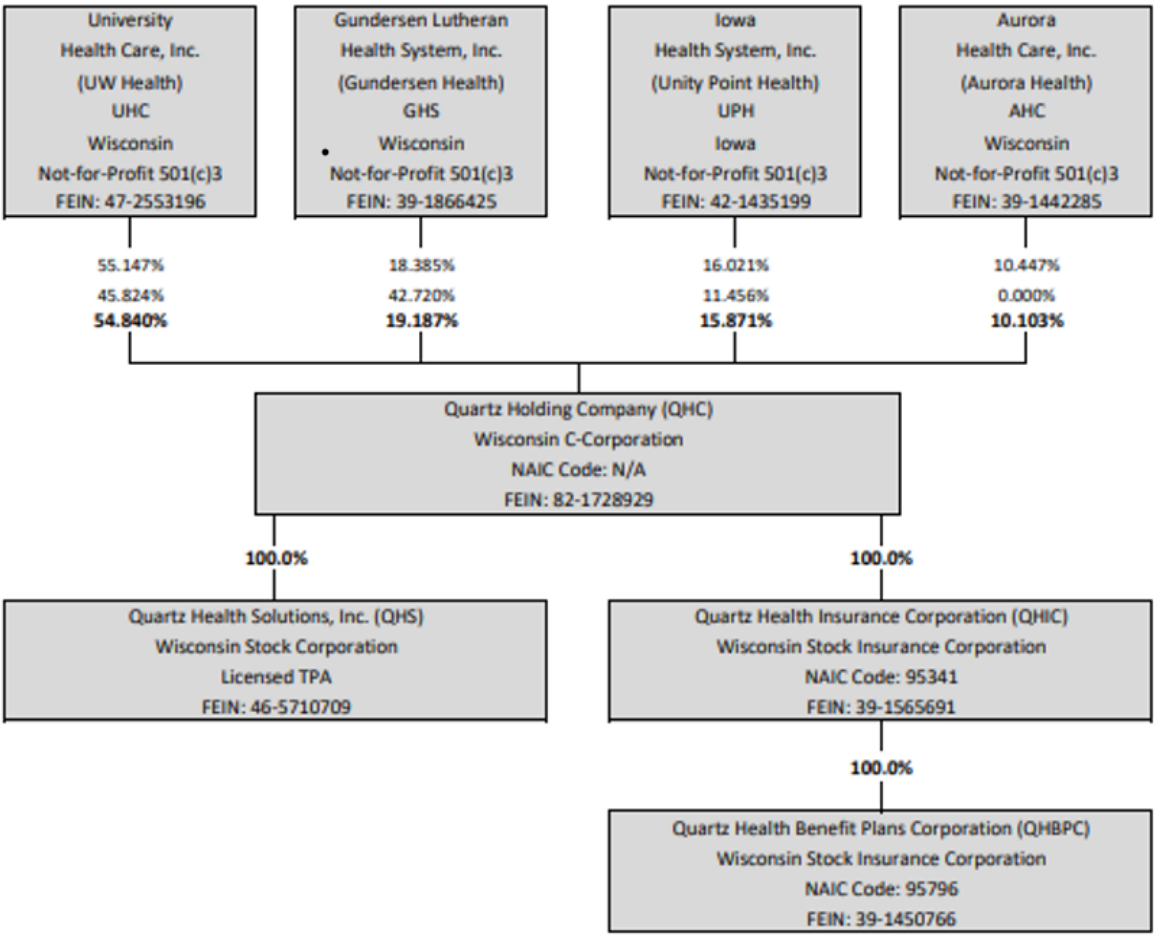
2. Enrollees will be entitled to similar, alternate coverage that does not contain any medical underwriting or preexisting limitation requirements.

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

IV. AFFILIATED COMPANIES

Quartz Health Plan Corporation is a part 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 the significant affiliates of the company 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 in 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)

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 for 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 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 QHC. Control of QHIC is maintained by AHC, UPH, UHC, and GHS through stock ownership and through 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.

Quartz Health Benefit Plan Corporation

QHBPC is a Ch. 611 stock insurance corporation operating under Wis. Stat. § 609.03(3), as a health maintenance organization insurer. QHBPC has been a part of an insurance holding company system since its incorporation in 1983. QHBPC is a wholly owned subsidiary of Quartz Health Insurance Corporation, which is a wholly owned subsidiary of Quartz Holding Company.

As of December 31, 2022, QHBPC's audited statutory financial statement reported assets of $304.4 million, liabilities of $167.6 million, and capital and surplus of $136.8 million. Operations for 2022 produced a net loss of $(12.5 million) on revenues of $1.6 billion.

Agreements with Affiliates:

Credentialing Agreement

QHS and QHPC 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 QHPC have a Management Services Agreement, effective January 1, 2022, wherein QHS agrees to provide administrative and management services to QHPC, and QHPC 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.

Network Access Agreement

QHS, 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, 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.

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.

4. 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 Advocate Aurora Health System (AAH) Members:

Commercial Members
Medicare Advantage
Medicare Dual Eligible

Effective date: January 1, 2022

Retention:	Commercial: $1,750,000 Medicare: $550,000
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 Plan Corporation
Assets
As of December 31, 2022

	Assets	Nonadmitted Assets	Net Admitted Assets
Bonds	$ 6,544,997	$	$ 6,544,997
Stocks:			
Common stocks	5,921,791		5,921,791
Cash, cash equivalents and short-term investments	55,720,375		55,720,375
Receivable for securities	300,000		300,000
Investment income due and accrued	25,158		25,158
Uncollected premiums and agents' balances in the course of collection	2,582,760	13,071	2,569,689
Accrued retrospective premiums and contracts subject to redetermination	3,261,194		3,261,194
Amounts recoverable from reinsurers	7,065		7,065
Other amounts receivable under reinsurance contracts	29,013		29,013
Amounts receivable relating to uninsured plans	6,861,257		6,861,257
Receivables from parent, subsidiaries and affiliates	37,377	37,377	
Health care and other amounts receivable	7,563,626	214,246	7,349,380
Write-ins for other than invested assets:			
State income tax receivable	27,728		27,728
Prepaids	13,300	13,300	
Commissions	1,014		1,014
Total Assets	$88,896,655	$277,994	$88,618,661

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

Claims unpaid		$45,719,700
Accrued medical incentive pool and bonus payments		112,500
Unpaid claims adjustment expenses		1,365,400
Aggregate health policy reserves		2,934,934
Premiums received in advance		1,189,032
General expenses due or accrued		319,664
Remittance and items not allocated		63,228
Amounts due to parent, subsidiaries, and affiliates		938,921
Escheats		63,883
Total Liabilities		52,707,262
Gross paid in and contributed surplus	$32,850,999	
Unassigned funds (surplus)	3,060,400	
Total Capital and Surplus		35,911,399
Total Liabilities, Capital and Surplus		$88,618,661

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

Net premium income		$390,577,636
Medical and Hospital:		
Hospital/medical benefits	$312,356,312	
Other professional services	527,616	
Outside referrals	17,105,427	
Emergency room and out-of-area	18,042,677	
Prescription drugs	18,459,326	
Incentive pool and withhold adjustments	120,900	
Subtotal	366,612,258	
Less		
Net reinsurance recoveries	7,065	
Total medical and hospital	366,605,193	
Claims adjustment expenses	11,506,273	
General administrative expenses	19,165,791	
Total underwriting deductions		397,277,257
Net underwriting gain or (loss)		(6,699,621)
Net investment gains or (losses)		543,456
Net (loss) from agents' or premium balances charged off		(12,002)
Net Income (Loss)		$ (6,168,167)

Quartz Health Plan 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	$25,104,230	$26,131,176	$20,630,667	$16,954,638	$21,798,530
Net income (loss)	(6,168,167)	4,431,559	8,045,565	740,341	(2,055,304)
Change in net unrealized capital gains/losses	2,012,984	(3,760,860)	639,562	104,702	(225,582)
Change in nonadmitted assets	8,521,102	(8,697,642)	711,643	2,830,986	(2,563,006)
Surplus adjustments: Paid in	6,441,249	7,000,000	5,000,000		
Dividends to stockholders			(8,896,260)		
Capital and Surplus, End of Year	$35,911,398	$25,104,233	$26,131,177	$20,630,667	$16,954,638

Quartz Health Plan Corporation
Statement of Cash Flow
For the Year 2022

Premiums collected net of reinsurance			$389,727,267
Net investment income			518,507
Total			390,245,774
Less:			
Benefit- and loss-related payments		$351,640,036	
Commissions, expenses paid and aggregate write-ins for deductions		34,294,652	
Dividends paid to policyholders			
Total			385,934,688
Net cash from operations			4,311,086
Total investment proceeds		4,380,000	
Cost of Investments Acquired—Long-term Only:			
Bonds	$2,741,734		
Stocks	3,200,000		
Miscellaneous applications	300,000		
Total investments acquired		6,241,734	
Net cash from investments			(1,861,734)
Cash Provided for/Applied from Financing and Miscellaneous Sources:			
Capital and paid-in surplus, less treasury stock		13,441,249	
Other cash provided (applied)		(58,129)	
Net cash from financing and miscellaneous sources			13,383,120
Net Change in Cash, Cash Equivalents, and Short-Term Investments			15,832,472
Cash, cash equivalents, and short-term investments:			
Beginning of year			39,887,903
End of Year			$ 55,720,375

Growth of Quartz Health Plan Corporation

Year	Assets	Liabilities	Capital and Surplus	Premium Earned	Medical Expenses Incurred	Net Income
2022	$88,618,661	$52,707,262	$35,911,399	$390,577,636	$366,605,193	$(6,168,167)
2021	70,330,657	45,226,427	25,104,230	332,445,965	302,423,697	4,431,559
2020	74,707,988	48,576,812	26,131,176	280,209,411	248,855,311	8,045,565
2019	54,408,896	33,778,229	20,630,667	251,315,515	232,620,623	740,341
2018	45,411,614	28,456,976	16,954,638	215,236,693	203,223,401	(2,055,304)
2017	36,150,856	14,352,326	21,798,530	269,686,495	245,378,702	(836,174)

Year	Profit Margin	Medical Expense Ratio	Administrative Expense Ratio	Change in Enrollment
2022	-1.6%	93.9%	7.9%	8.3%
2021	1.3	91.0	7.7	15.9
2020	2.9	88.8	8.4	18.6
2019	0.3	92.6	7.5	20.0
2018	-1.0	93.2	7.9	2.3
2017	-0.3	89.6	10.8	-19.6

Enrollment and Utilization

Year	Enrollment	Hospital Days/1,000	Average Length of Stay
2022	83,902	708.0	8.0
2021	77,438	691.5	6.8
2020	66,816	713.6	6.4
2019	56,361	699.3	6.0
2018	46,952	801.3	6.1
2017	45,916	714.4	6.1

Per Member Per Month Information

	2022	2021	Percentage Change
Premiums:			
Commercial	$1,245.84	$2,431.76	-48.8%
Medicare	850.49	815.61	4.3
Medicare Supplement	248.40	227.63	9.1
Medicaid	177.48	173.34	2.4
Net Premium Income	$ 398.89	$ 375.25	6.3%
Expenses:			
Hospital/medical benefits	319.00	295.26	8.0%
Other professional services	0.54	10.24	-94.7
Outside referrals	17.47	0	100.0
Emergency room and out-of-area	18.43	17.07	8.0
Prescription Drugs	18.85	18.79	0.3

	2022	2021	Percentage Change
Incentive pool and withhold adjustments	0.12	0	100.0
Less: Net reinsurance recoveries	0.01	0	0.0
Total medical and hospital	374.40	341.36	9.7
Claims adjustment expenses	11.75	9.08	29.5
General administrative expenses	19.57	19.99	-2.1
Total underwriting deductions	$ 405.72	$ 370.43	9.5%

Membership increased each of the last five years, with enrollment increasing from 46,952 members at the end of 2018 to 83,902 members at the end of 2022. The company saw mixed financial results during the five-year period with a net loss in two of the last five years. Premiums earned increased from $215.2 million at the end of 2018 to $390.6 million at the end of 2022 with medical expenses also increasing from $203.2 million at the end of 2018 to $366.6 million at the end of 2022. The company saw increased premiums and medical costs as they grew the business during the examination period. The company has recently seen medical expenses and utilization increase after the end of the pandemic. The company also notes that Medicare Part D was not fully capitated causing higher drug costs for the portion of business. During the same time period the company saw capital and surplus increase from $21.8 million to $35.9 million. The company saw capital and surplus increase in 2022 was primarily due to a capital contribution of $6.4 million from the parents and a $8.5 million favorable change in nonadmitted assets.

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, 2022, as modified for examination adjustments is as follows:

Assets			$88,618,660
Less:			
Special deposit			150,000
Liabilities			52,707,263
Net amount available to satisfy surplus requirements			34,131,038
Net premium earned			
HMO business	$386,505,039		
Factor	3%		
Total		$11,595,151	
Incidental Indemnity	4,072,597		
Factor	10%		
Total		407,260	
Compulsory surplus		12,002,411	
Compulsory Surplus Excess (Deficit)			$22,128,627
Net amount available to satisfy surplus requirements			$34,131,038
Compulsory surplus		12,002,411	
Security factor		140%	
Security surplus			15,483,110
Security Surplus Excess (Deficit)			$18,647,928

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 $150,000 with the State Treasurer.

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. Changes shown on this page are discussed in the "Summary of Examination Results" section of this report.

	Increase	Decrease	
Capital and surplus December 31, 2022, per annual statement			$35,911,399
Aggregate Health Policy Reserves		$6,900,000	
Net increase or (decrease)			($6,900,000)
Capital and surplus December 31, 2022, per Examination			$29,011,399

VII. SUMMARY OF EXAMINATION RESULTS

Compliance with Prior Examination Report Recommendations

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

1. Affiliated Transaction Disclosures—It is recommended that the company properly disclose its material affiliated transactions in accordance with the NAIC Health Blank Instructions 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 work papers.

Premium Deficiency Reserve Deficiency **$6,900,000**

The above balance reflects an increase of $6,900,000 to the amount reported in the company's annual statement for Aggregate Health Policy Reserves. OCI's consulting actuary compared the company's 2023 financial data to the 2022 premium deficiency reserve (PDR) projection and reported results. The company did not provide adequate documentation to show that they were following SSAP No. 54 which states that "For purposes of determining if a premium deficiency exists, contracts shall be grouped in a manner consistent with how policies are marketed, serviced and measured." The consulting actuary determined that a $6.9 million deficiency existed in the Medicare line. Despite the apparent deficiency, the consulting actuary found the explanation provided by the company to be reasonable. Adverse experiences occurred in 2022, and the company appears to be taking appropriate steps to mitigate this going forward. Nevertheless, the premium deficiency reserve held at year-end 2022 was deficient by $6.9 million, and this deficiency was material.

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 calculation disclosed 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

QHPC is a not-for-profit network model health maintenance organization (HMO) insurer operating in the states of Wisconsin, Iowa, and Illinois. The company is licensed to write business for small and large group commercial, Medicare, Medicaid, and individual. The company has risk-sharing agreements with the providers through QHS, which transfers a substantial portion of the risk to the providers with the company retaining little to no risks in its product offerings.

At the end of 2022, the company reported total net assets of $88.6 million, total liabilities of $52.7 million, and total capital and surplus of $35.9 million. Adjusted compulsory capital and surplus of $22.1 million satisfied the compulsory and security surplus requirement at year-end 2022 after a surplus adjustment of $6.9 million. The company also satisfied the special deposit requirement with the State of Wisconsin with a $150,000 deposit with the State Treasurer.

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 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.

3. Page 32 - 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