

Report
of the
Examination of
Bankers Reserve Life Insurance Company of Wisconsin
St. Louis, Missouri
As of December 31, 2012

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State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Scott Walker, Governor
Theodore K. Nickel, Commissioner

Wisconsin.gov

February 7, 2014

125 South Webster Street • P.O. Box 7873
Madison, Wisconsin 53707-7873
Phone: (608) 266-3585 • Fax: (608) 266-9935
E-Mail: ociinformation@wisconsin.gov
Web Address: oci.wi.gov

Honorable Theodore K. Nickel
Commissioner of Insurance
State of Wisconsin
125 South Webster Street
Madison, Wisconsin 53703

Commissioner:

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

BANKERS RESERVE LIFE INSURANCE COMPANY OF WISCONSIN
St. Louis, Missouri

and this report is respectfully submitted.

I. INTRODUCTION

The previous examination of Bankers Reserve Life Insurance Company of Wisconsin (BRLW or the company) was conducted in 2010 as of December 31, 2009. The current examination covered the intervening period ending December 31, 2012, and included a review of such 2013 transactions as deemed necessary to complete the examination.

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

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

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

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

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

The examination of the company was conducted concurrently with the examination of Superior HealthPlan, Inc. Representatives of the Texas Department of Insurance acted in the capacity as the lead state for the coordinated exams. Work performed by the Texas Department of Insurance was reviewed and relied on where deemed appropriate. The company is annually audited by an independent public accounting firm as prescribed by s. Ins 50.05, Wis. Adm. Code. An integral part of this compliance examination was the review of the independent accountant's work papers. Based on the results of the review of these work papers, alternative or additional examination steps deemed necessary for the completion of this examination were performed. The examination work papers contain documentation with respect to the alternative or additional examination steps performed during the course of the examination.

II. HISTORY AND PLAN OF OPERATION

The company was incorporated under the laws of the state of Wisconsin on January 5, 1961, as The International Casualty Insurance Corporation. Its name was changed to International General Insurance Corporation (IGIC) in November 1961. The company's current name, Bankers Reserve Life Insurance Company of Wisconsin, was adopted on March 27, 1997.

Initially the company was licensed to write automobile and other casualty lines but delays in beginning operations resulted in withdrawal of those lines in October 1962. In May 1964, the company was licensed to write disability insurance. In July 1964, the company's license was amended to include life insurance.

On August 7, 1985, American Investors Assurance Company, a Utah-domiciled insurer, purchased 100% of the outstanding common stock of IGIC's parent company, International Inc. In 1987, Robert R. Barrow acquired control of IGIC through this purchase of all outstanding common stock of International Inc. Effective February 15, 1996, all outstanding shares of IGIC were sold to Atlantic Financial Company (AFC), a Florida corporation. Effective June 30, 1996, IGIC acquired all the outstanding shares of Bankers Reserve Life Insurance Company, a Colorado-domiciled life insurer, from its parent, AFC.

IGIC specialized in the underwriting of group credit life and group credit accident and health insurance until 1978. Tax-deferred group annuities were introduced in 1977 and sold through financial institutions until the IRS ruled that such annuities no longer had tax-deferred status. Annuities issued prior to the ruling were grandfathered and maintain tax-deferred status. These annuities are administered through the company's separate account.

IGIC began offering qualified and nonqualified individual single premium annuities in 1982. These annuities were marketed on a direct general agency basis and are administered in the company's general account. During 1982 and 1983, the company entered the ordinary life insurance market through the assumption of ordinary life insurance. These reinsurance agreements were terminated in 1984.

In 1988, IGIC began offering whole life insurance. Individual universal, term, single premium life insurance coverage, and group dental insurance were introduced in 1989. These

products were sold on a direct and general agency basis. Effective December 31, 1990, credit insurance was discontinued. During 1993, the company introduced nonparticipating whole life insurance and variations of its single premium immediate annuity to its product line. Group dental was discontinued during 1994.

Effective April 1, 1996, IGIC entered into a reinsurance contract in which 100% of its new and existing general account annuity business was ceded to Lincoln National Reinsurance Company and 60% was retro ceded back on a funds withheld basis. The withheld funds were to be invested according to IGIC's investment strategy and managed by Atlantic Portfolio & Management (APAM), an affiliate of IGIC, by now renamed BRLW. APAM attempted to increase its client's investment rate of return by utilizing a variety of financial instruments as part of its efforts to hedge and managed fluctuations in the market value of its investment portfolio attributable to changes in general interest rate levels and to manage duration and convexity mismatch of assets and liabilities. Those instruments include interest rate swap options for which the company's risk is limited to the cost of entering the contracts on the trade date. The contract or notional amounts of those instruments reflect the extent of involvement in the various types of financial instruments. The Office of the Commissioner of Insurance (OCI) approved the company's request to invest its funds directly, under the management of APAM, and Lincoln National returned the related funds withheld of BRLW on June 16, 1997.

Effective February 28, 1997, the reinsurance contract with Lincoln National was terminated for all business. BRLW sold its book of individual ordinary life insurance business to Central United Life Insurance Company through a 100% quota share coinsurance, assumption reinsurance agreement, effective April 1, 1997.

BRLW then entered into a reinsurance agreement, effective February 28, 1997, in which 100% of its Platinum annuities were ceded to AXA Re Life Insurance Company and 50% was retroceded back to BRLW. In addition, BRLW entered into a reinsurance contract with Winterthur Life Re Insurance Company to cede 75% of BRLW's Platinum XI annuities, effective July 1, 1997.

In addition, the company entered into two assumption reinsurance agreements. In its first assumption reinsurance agreement effective February 28, 1997, BRLW began to assume a 15% retrocession from AXA Re on certain deferred annuities written by Security Life Insurance Company of America. This business was formerly assumed by Bankers Reserve Life Company (BRLC) through a 25% quota share reinsurance contract. Effective November 30, 1997, OCI approved a 100% quota share coinsurance, assumption reinsurance agreement between BRLW and BRLC, whereby BRLW assumed BRLC's direct written block of annuity business.

With its second assumption reinsurance agreement effective July 1, 1999, Life and Health Insurance Company of America (LHA) acquired Bankers Reserve Life Insurance Company of Wisconsin (BRLW). In preparation for the sale of BRLW, all the general account business written in BRLW was reinsured 100% to Liberty Bankers Life Insurance Company (Liberty Bankers), a sister company of BRLW. At the same time that BRLW put the reinsurance in place in favor of Liberty Bankers, BRLW also started the process of getting the various insurance departments to approve the forms that were being written under BRLW for writing under Liberty Bankers. By the time LHA bought BRLW, this process was already well advanced so that by the end of the year 2000 all forms had been approved to be written under Liberty Bankers.

The purpose of this acquisition was for LHA to gain access to certain key states in which the company was licensed to write business. LHA did not want the current book of business that Bankers had already written. Due to the difficulty in raising capital to finance the expansion, LHA did not write any business through BRLW and the company was then sold to Centene Corporation in March 2002.

Since the acquisition by Centene Corporation, BRLW has provided reinsurance to affiliated health plans providing multi-line managed care programs and related services to individuals receiving benefits under Medicaid, including Supplemental Security Income (SSI) and the Children's Health Insurance Program (CHIP). Centene's health plans operate in 18 states: California, Florida, Georgia, Illinois, Indiana, Kansas, Kentucky, Louisiana, Massachusetts,

Mississippi, Missouri, New Hampshire, New Jersey, Ohio, South Carolina, Texas, Washington, Wisconsin.

BRLW also entered into three agreements with the state of Texas Health and Human Services Commission. The first of these three agreements which began on September 1, 2004, and renewed in 2010, serves children enrolled in the Children's Health Insurance Program (CHIP). The second agreement which began on April 1, 2008, which services children enrolled in the state of Texas' Foster Care Program was renewed in 2010. A third agreement which began on March 1, 2012, and renews in 2015, serves Medicaid enrollees in the Rural Service Area and Medicaid and Aged, Blind, or Disabled (ABD) enrollees in the Hidalgo service area.

As stated previously, the company assumes business from affiliated health maintenance organization (HMO) insurers through several reinsurance agreements. In 2012, BRLW assumed reinsurance premium of \$58 million and ceded \$979 thousand for a total net premium for reinsurance business of \$57 million. Also in 2012 BRLW reported \$1.7 billion of direct premium from the company's three agreements with the state of Texas Health and Human Services Commission. The growth of the company is discussed in the "Financial Data" section of this report.

As of December 31, 2012, BRLW only wrote direct business in Texas but was licensed in the following 41 states:

Arizona	Maine	Oregon
Arkansas	Maryland	Pennsylvania
Colorado	Michigan	Rhode Island
Delaware	Mississippi	South Carolina
District of Columbia	Missouri	South Dakota
Florida	Montana	Tennessee
Georgia	Nebraska	Texas
Idaho	Nevada	Utah
Illinois	New Jersey	Virginia
Indiana	New Mexico	Washington
Iowa	North Carolina	West Virginia
Kansas	North Dakota	Wisconsin
Kentucky	Ohio	Wyoming
Louisiana	Oklahoma	

III. MANAGEMENT AND CONTROL

Board of Directors

The board of directors consists of nine members. All directors are elected annually to serve a one-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. The board members currently receive no compensation for serving on the board.

Currently the board of directors consists of the following persons:

Name and Residence	Principal Occupation	Term Expires
Michael F. Neidorff St. Louis, Missouri	Chairman and Chief Executive Officer Centene Corporation	2013
William N. Scheffel St. Louis, Missouri	Executive Vice President, Chief Financial Officer and Treasurer, Centene Corporation	2013
Keith H. Williamson St. Louis, Missouri	Senior Vice President, Corporate Secretary and General Counsel, Centene Corporation	2013
Holly Munin Austin, Texas	Chief Executive Officer (Foster Care) Centene Corporation	2013
Mark W. Eggert Austin, Texas	Executive Vice President, Health Plan Business Unit, Centene Corporation	2013
Kathy C. Bradley-Wells Washington, D.C.	Vice President, Legal Affairs Centene Corporation	2013
Jeffrey A. Schwaneke St. Louis, Missouri	Assistant Treasurer Centene Corporation	2013
Christopher D. Bowers St. Louis, Missouri	Senior Vice President, Health Plans Centene Corporation	2013
Tricia L. Dinkleman St. Louis, Missouri	Vice President, Director of Tax Centene Corporation	2013

Officers of the Company

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

Name	Office	2012 Salary*
Michael F. Neidorff	President	\$1,048,857
Keith H. Williamson	Secretary	54,253
William N. Scheffel	Treasurer	95,971
Holly Munin	Vice President	585,895
Christopher D. Bowers	Vice President	81,207
Mark W. Eggert	Vice President	81,709

* The officers' salaries are paid by Centene Management Corporation, a wholly owned subsidiary of Centene Corporation, through a management agreement with BRLW. The salaries shown above are the amounts allocated to BRLW through the management agreement.

Committees of the Board

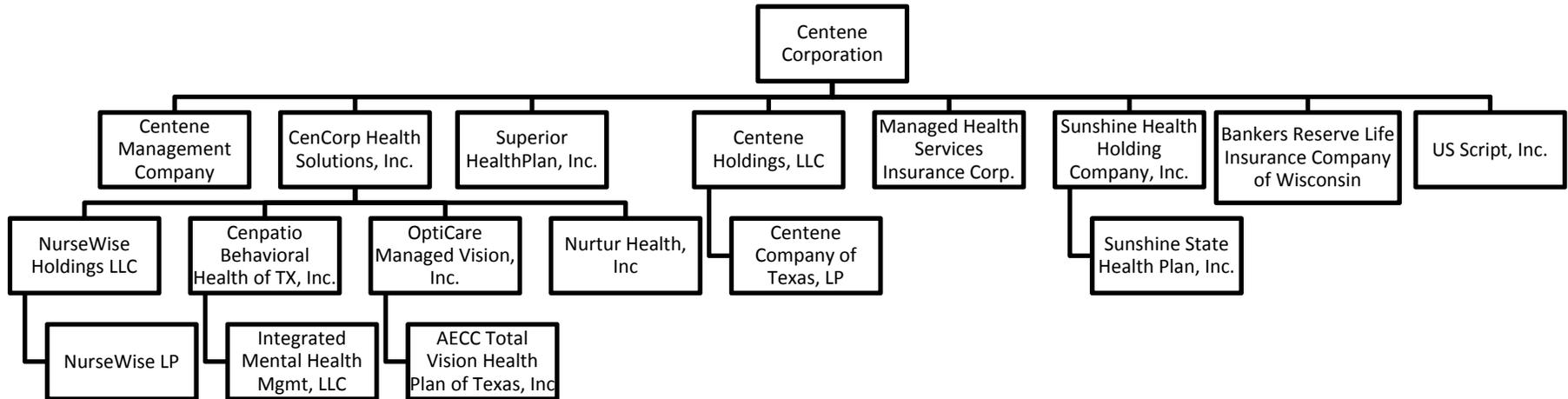
The company's bylaws allow for the formation of certain committees by the board of directors. There were no committees at the time of the examination.

The company has no employees. Necessary staff is provided through a management agreement with Centene Management Corporation (CMC), a wholly owned subsidiary of Centene Corporation. Under the agreement, effective March 1, 2002, CMC agrees to provide the company with administrative and financial services necessary to manage the business operations of the company and agrees to assume responsibility for all costs associated therewith. Areas for which CMC assumes responsibility, under the terms of the agreement, include the following: program planning and development, management information systems, financial systems and services, claims administration, provider and enrollee services and records, utilization and peer review, quality assurance/quality improvement, and marketing services. CMC receives a management fee equal to actual expenses incurred. This agreement shall renew automatically for successive one-year renewal terms unless either party gives the other at least 90 days' written notice.

IV. AFFILIATED COMPANIES

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

**Holding Company Chart
As of December 31, 2012**



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Note: Not all of the 104 subsidiaries of Centene Corporation have been included in this organizational chart.

Centene Corporation

Centene Corporation, originally incorporated in 1993 as Coordinated Care Corporation, is a publicly held, for-profit company, headquartered in St. Louis, Missouri. It is the ultimate controlling person in the holding company system. It is a multi-line health care enterprise operating in two segments: Medicaid Managed Care and Specialty Services. Centene's Medicaid Managed Care segment provides Medicaid and Medicaid-related health plan coverage to individuals through government subsidized programs, including Medicaid, the Children's Health Insurance Program, or CHIP, Foster Care, Medicare Special Needs Plans and the Supplemental Security Income Program, also known as the Aged, Blind or Disabled Program, or collectively ABD.

As of December 31, 2012, the audited consolidated financial statements reported assets of \$2.7 billion, liabilities of \$1.7 billion, and net worth of \$954 million. Operations for 2012 produced net loss of \$11 million on revenues of \$8.7 billion.

Centene Management Company LLC

Centene Management Company LLC (CMC), originally incorporated in 1996 as Coordinated Care Medicaid Management Corporation, was created to provide management and administrative services to Centene Corporation's HMO subsidiaries. CMC, a wholly owned subsidiary of Centene Corporation, is a for-profit corporation that holds management agreements with Centene's subsidiaries and employs all staff, both at corporate headquarters and at the health plans. Licenses and certifications as required by individual state regulations are current. Specifically, in Wisconsin, CMC holds a license as an Employee Benefit Plan Administrator. The audited financial results are included in the financial statements and position of the Centene Corporation listed above.

Managed Health Services Insurance Corporation

Managed Health Services Insurance Corporation is a wholly owned subsidiary of Centene Corporation. The company was organized under the laws of Wisconsin on August 31, 1990, as a network model health maintenance organization (HMO) and provides managed care services to individuals receiving benefits under Medicaid. The company provides these services

under a contract with the Wisconsin Department of Health Services (DHS) and a subcontract of another entity's contract with DHS. As of December 31, 2012, the company's audited financial statements reported assets of \$53 million, liabilities of \$35 million, and capital and surplus of \$18 million. Operations for 2012 produced a net income of \$7 million on revenues of \$118 million.

Sunshine State Health Plan, Inc.

Sunshine State Health Plan, Inc., is a wholly owned subsidiary of Centene Corporation. The company was incorporated under the laws of Florida on April 3, 2007, as a health maintenance organization (HMO) for the purpose of providing comprehensive managed health care services to low-income (primarily Medicaid-eligible) residents of Florida. As of December 31, 2012, the company's audited financial statements reported assets of \$87 million, liabilities of \$46 million, and capital and surplus of \$41 million. Operations for 2012 produced a net loss of \$394 thousand on revenues of \$559 million.

Superior HealthPlan, Inc.

Superior HealthPlan, Inc., is a wholly owned subsidiary of Centene Corporation. The company was incorporated under the laws of Texas on February 14, 2007, as a network model health maintenance organization (HMO). The company holds a contract with the Texas Health and Human Service Commission to provide Medicaid, Children's Health Insurance Program, and Supplemental Security Income Program managed care services. The company also holds a contract with the Centers for Medicare and Medicaid Services to participate in the Medicare Advantage Program. As of December 31, 2012, the company's audited financial statements reported assets of \$332 million, liabilities of \$169 million, and capital and surplus of \$163 million. Operations for 2012 produced net loss of \$41 million on revenues of \$1.5 billion.

Agreements with Affiliates

Bankers Reserve Life Insurance Company of Wisconsin has entered into the following affiliated agreements as described below:

- Effective December 31, 2002, the company entered into a tax-sharing agreement with Centene Corporation (Centene). Under this agreement, Centene files a consolidated tax return for member companies; member companies in turn agree to make quarterly payments

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

- Effective March 1, 2002, the company entered into an administrative service agreement with Centene Management Corporation (CMC). This agreement is discussed in the caption of the report entitled "Management and Control."
- Effective September 1, 2004 (last amended on September 1, 2012), the company entered into a delegated services agreement with Integrated Mental Health Services (IMHS). Under this Foster Care agreement, the company delegates to IMHS certain services related to behavioral health. The company agrees to reimburse IMHS on a per member per month basis.
- Effective September 1, 2004, the company entered into an Administrative Services Agreement with Superior HealthPlan, Inc. (SHP). BRLW entered into a contract with Texas Health and Human Services Commission (HHSC) to be the Exclusive Provider Organization (EPO) for the Children's Health Insurance Program (CHIP). SHP agrees to provide the company with the administrative services reasonably necessary to manage the business operations and affairs of the company and shall be responsible for all costs associated therewith. This agreement shall automatically renew for successive one-year contract unless either party gives 90 days' written notice.
- Effective September 1, 2004 (last amended April 1, 2012), the company entered into a service agreement with NurseWise LP (NurseWise). The company entered into a contract with the Texas HHSC and the EPO for CHIP. Under this agreement, NurseWise shall establish a "Care Line" for the company's members to call with health inquiries. The company agrees to reimburse NurseWise on a per member per month basis.
- Effective September 1, 2005, the company entered into a vision services agreement (EPO Vision) with AECC Total Vision Health Plan of Texas, Inc. (Vision Network). Vision Network agrees to serve as the company's vision services vendor under the company's CHIP contract with HHSC, and the company compensates Vision Network for its provision of services in

such capacity. The company and Vision Network agree to expand its scope to include covered persons enrolled in the company's STAR Health (Foster Care) Program. The company agrees to reimburse Vision Network on a per member per month basis.

- Effective April 1, 2008 (last amended March 1, 2012), the company entered into an administrative services agreement with Centene Management Company LLC (CMC) and Centene Company of Texas, LP (CTX). The company entered into a contract with the Texas HHSC to be the EPO for the Texas Foster Care managed care program (STAR Health Program). CMC contracted with the company to provide certain administrative services for the company's STAR Health enrollees. CTX contracted with the company to provide certain administrative services for the company's STAR Health enrollees. CMC and CTX hires, maintains and supervises all personnel necessary to provide the administrative services for the company's STAR Health Program. CMC and CTX provide the company with the administrative services necessary to manage certain, specified business operations and affairs for the company's STAR Health Program, including: program planning and development, management information system, financial systems and services, claims administration, provider services and records, marketing services, and human resource services. The company pays a monthly administrative fee for services of 6% of all gross revenues for the company's STAR Health Program. This agreement shall automatically renew for one-year periods, unless either party gives 90 days' written notice.
- Effective January 1, 2009 (last amended March 1, 2012), the company entered into a disease management program services agreement with Nurtur Health, Inc. (f.k.a. Air Logix). The company arranges for provision of health care services, including disease prevention services and chronic disease management services to members. Nurtur Health, Inc., entered into a disease management program services agreement with the company to provide disease management services to the company members enrolled in the CHIP EPO program. Both parties agree to expand scope to include the provision of disease management services to members enrolled in the company's STAR Health (Foster Care) program effective

April 1, 2008. This agreement shall automatically renew in one year periods, unless either party gives 90 days' written notice.

- Effective March 1, 2012, the company entered into a pharmacy benefit management services agreement with US Script, Inc., where the following services are provided to the company: claims processing, eligibility management, benefits and utilization management, pharmacy network management, call center services for pharmacies and prescribers, and pharmacy complaints and appeals.

V. REINSURANCE

The company's reinsurance portfolio and strategy are described below. A list of the companies that have a significant amount of reinsurance in force at the time of the examination follows. The contracts contained proper insolvency provisions.

The company's major function in the Centene Corporation holding company structure is to assume business from affiliated HMOs and then cede a portion of this business to an unaffiliated reinsurer. The amount of risk retained by BRLW from these assuming contracts varies depending on HMO, type of claims, and in some cases the region in which the claim occurred for the HMO.

The strategy of having BRLW assume business from all of the affiliates and then cede to a single unaffiliated reinsurer is to minimize reinsurance costs across the holding company structure. This strategy has been profitable for BRLW over the past several years. At the time of the examination, the company has no plans to begin assuming business from unaffiliated entities.

Nonaffiliated Ceding Contracts

1. Type: Specific Excess of Loss Reinsurance
Reinsurer: Ace American Insurance Company
Covered business: Absolute Total Care, SC: Medicaid Temporary Assistance for Needy Families (TANF) and SSI Non-Dual
Buckeye Community Health Plan, OH: Medicaid TANF, ABD Adults, ABD Child and Medicaid Dual
Granite State Health Plan, NH: Medicaid TANF, SSI Dual and SSI Non-Dual
Home State Health Plan, MO: Medicaid TANF, CHIP and Foster Care
IlliniCare Health Plan, IL: Medicaid SSI Non-Dual
Kentucky Spirit Health Plan, KY: Medicaid TANF, SSI Dual, SSI Non-Dual and Foster Care
Louisiana HealthCare Connections, LA: Medicaid TANF and SSI Non-Dual
Managed Health Services Insurance Corporation, WI: Medicaid TANF, Badger Care and SSI
Peach State Health Plan, GA: Medicaid TANF and CHIP
Sunflower State Health Plan, KS: Medicaid TANF
Sunshine State Health Plan, FL: Medicaid TANF and SSI Non-Dual
Retention: Specific deductible per covered person per agreement term: \$1,250,000
Maximum payable per covered person: \$2,500,000

Coverage: 90% of covered expenses excess of specific deductible. Claims must be received by the reinsurer no later than November 1, 2014. Claims in excess of the Specific Deductible that are not referred to ClinAssist for audit will be subject to a reduced Reimbursement Percentage of 80% if received by November 1, 2014.

Limitations: Hospital inpatient services as defined by the Medicaid fee schedule where a contracted rate does not exist or an average per diem per discharge of \$10,000. Extended Care Facility/Skilled Nursing Facility/Sub-Acute Care Facility/Home Health Care Rehabilitation: the lesser of the amount paid, the contracted rate, the applicable State Medicaid fee schedule where contracted rates do not exist, or a \$1,000 per diem and further limited to 90 days in total for the combination of all categories.

Premium: \$0.04 provisional premium rate per member per month
\$0.06 maximum premium rate per member per month
Minimum premium: \$460,000

Effective date: January 1, 2013

Termination: January 1, 2014

Affiliated Assuming Contracts

1. Type: Specific Excess of Loss Reinsurance

Reinsured: Managed Health Services Insurance Corp.

Covered business: Medicaid, Badger Care, SSI, and BadgerCare Plus

Retention: Specific deductible per covered person per agreement term: \$200,000

Maximum coverage: All services: \$2,000,000 in excess of the retention

Coverage: 90% of covered expenses excess of specific deductible. Claims must be received by November 1, 2014. Organ Transplant Services: If performed at a Non-Approved Transplant Provider 50%.

Limitations: Hospital inpatient services as defined by the membership services agreement: the lesser of the amount paid, the contracted rate, the applicable Wisconsin Medicaid fee schedule where contracted rates do not exist or an average per diem per discharge of \$10,000 for allowable expenses over \$1,000,000

Premium: \$0.51 per member per month

Effective date: January 1, 2013

Termination: January 1, 2014

Insolvency coverage: BRLW agrees to provide the following coverage in the event that Managed Health Services Insurance Corp. becomes insolvent:

1. The company will continue to provide the benefits covered under the applicable membership services agreement with respect to each covered person who is confined in a hospital on the insolvency date for expenses incurred and payable by such covered person on or after such date until the earlier of:
 - a. the covered person's discharge from the hospital; or
 - b. the date the covered person becomes eligible for health insurance coverage or benefits under another group or blanket policy or plan or any federal, state or local governmental plan or program. The company shall pursue any coordination of benefits, subrogation or any other right of recovery that may be available to the company as a result of the covered persons being covered under two or more health care policies or plans.
2. The company will continue the benefits for any other covered person with respect to expenses incurred for medical services or treatment by providers received after the insolvency date until the end of the period for which applicable premium was received by the reinsured for that covered person, prior to the insolvency date, but in no event to extend beyond the end of the calendar month in which the insolvency date occurs as long as such expenses are payable for such covered person.

This insolvency coverage is subject to a \$3,000,000 maximum

2. Type: Specific Excess of Loss Reinsurance
- Reinsured: Buckeye Community Health Plan
- Covered business: Covered Families and Children (CFC) Medicaid and ABD Medicaid HMO members
- Retention: Specific deductible per covered person per agreement term: \$200,000
Maximum payable per covered person: \$2,000,000
- Coverage: 90% of covered expenses if claim is received by September 1, 2014. Claims must be received prior to September 1, 2014. Organ Transplant Services: If performed at a Non-Approved Transplant Provider 50%.
- Limitations: Hospital inpatient services as defined by the membership services agreement: the lesser of the amount paid, the contracted rate in effect at the time of admission or the applicable Ohio Medicaid fee schedule where contracted rates do not exist, Billed Charges, or an average per diem per discharge of \$10,000.
- Extended Care Facility/Skilled Nursing Facility/Sub-Acute Care Facility/Home Health Care Rehabilitation: the lesser of the amount paid, the contracted rate, the applicable Ohio Medicaid fee schedule where contracted rates do not exist, or a \$1,000 per diem.

Premium: \$2.50 per member per month CFC Medicaid
\$15.43 per member per month ABD Medicaid

Effective date: January 1, 2013

Termination: January 1, 2014

Insolvency coverage: In the event that the reinsured shall become Insolvent while the agreement is in force, the reinsured or its legal representative shall notify all applicable covered persons of this provision and the following shall apply:

1. The company will continue to provide the benefits covered under the applicable membership services agreement with respect to each covered person who is confined in a hospital on the insolvency date for expenses incurred and payable by such covered person on or after such date until the earlier of:
 - a. the covered person's discharge from the hospital; or
 - b. the date the covered person becomes eligible for health insurance coverage or benefits under another group or blanket policy or plan or any federal, state or local governmental plan or program. The company shall pursue any coordination of benefits, subrogation or any other right of recovery that may be available to the company as a result of the covered persons being covered under two or more health care policies or plans.
2. The company will continue the benefits for any other covered person with respect to expenses incurred for medical services or treatment by providers received after the insolvency date until the end of the period for which applicable premium was received by the reinsured for that covered person, prior to the insolvency date, but in no event to extend beyond the end of the calendar month in which the insolvency date occurs as long as such expenses are payable for such covered person.

This insolvency coverage is subject to a \$1,000,000 maximum

3. Type: Specific Excess of Loss Reinsurance

Reinsured: Sunshine State Health Plan, Inc.

Covered business: Medicaid covered persons

Retention: Specific deductible per covered person per agreement term: \$150,000
Maximum payable per covered person: \$2,000,000

Coverage: 90% of covered expenses excess of specific deductible. Claims must be received by the reinsurer no later than November 1, 2014. Organ Transplant Services: If performed at a Non-Approved Transplant Provider 50%.

Limitations: Hospital inpatient services as defined by the Medicaid fee schedule where a contracted rate does not exist or an average per diem per discharge of \$10,000.

Premium: \$0.92 per member per month

Effective date: January 1, 2013

Termination: January 1, 2014

Insolvency coverage: In the event that the reinsured shall become insolvent while the agreement is in force, the reinsured or its legal representative shall notify all applicable covered persons of this provision and the following shall apply:

1. The company will continue to provide the benefits covered under the applicable membership services agreement with respect to each covered person who is confined in a hospital on the insolvency date for expenses incurred and payable by such covered person on or after such date until the earlier of:
 - a. the covered person's discharge from the hospital; or
 - b. the date the covered person becomes eligible for health insurance coverage or benefits under another group or blanket policy or plan or any federal, state or local governmental plan or program. The company shall pursue any coordination of benefits, subrogation or any other right of recovery that may be available to the company as a result of the covered persons being covered under two or more health care policies or plans.
2. The company will continue the benefits for any other covered person with respect to expenses incurred for medical services or treatment by providers received after the insolvency date until the end of the period for which applicable premium was received by the reinsured for that covered person, prior to the insolvency date, but in no event to extend beyond the end of the calendar month in which the insolvency date occurs as long as such expenses are payable for such covered person.

This insolvency coverage is subject to a \$2,000,000 maximum

4. Type: Specific Excess of Loss Reinsurance

Reinsured: Magnolia Health Plan, Inc.

Covered business: As defined in the Membership Services Agreement-including Mississippi ABD Medicaid Members

Retention: Specific deductible per covered person per agreement term: \$200,000
Maximum payable per covered person: \$2,000,000

Coverage: 90% of covered expenses excess of specific deductible. Claims must be received by the reinsurer no later than November 1, 2014. Organ Transplant Services: If performed at a Non-Approved Transplant Provider 50%.

- Limitations: Behavioral Health Services is limited to coverage of psychotropic drugs. Inpatient Hospital Services are not covered; however, physicians and other ancillary services provided during a hospital stay are covered under this agreement.
- Premium: \$0.76 per member per month
- Effective date: January 1, 2013
- Termination: January 1, 2014
5. Type: Specific Excess of Loss Reinsurance
- Reinsured: Peach State Health Plan, Inc.
- Covered business: Medicaid and PeachCare for Kids recipients
- Retention: Specific deductible per covered person per agreement term: \$200,000
Maximum payable per covered person: \$2,000,000
- Coverage: 90% of covered expenses excess of specific deductible. Claims must be received by the reinsurer no later than November 1, 2014. Organ Transplant Services are reimbursed at 50% if performed at a Non-Approved Transplant Provider.
- Limitations: Hospital inpatient services as defined by the membership services agreement: the lesser of the amount paid, the contracted rate, the applicable Georgia Medicaid fee schedule where contracted rates do not exist or an average per diem per discharge of \$10,000
- Premium: \$2.32 per member per month
- Effective date: January 1, 2013
- Termination: January 1, 2014
- Insolvency coverage: In the event that the reinsured shall become insolvent while the agreement is in force, the reinsured or its legal representative shall notify all applicable covered persons of this provision and the following shall apply:
1. The company will continue to provide the benefits covered under the applicable membership services agreement with respect to each covered person who is confined in a hospital on the insolvency date for expenses incurred and payable by such covered person on or after such date until the earlier of:
 - a. the covered person's discharge from the hospital; or
 - b. the date the covered person becomes eligible for health insurance coverage or benefits under another group or blanket policy or plan or any federal, state or local governmental plan or program. The company shall pursue any coordination of benefits, subrogation or any other right of recovery that may be available to the company as a result of

the covered person being covered under two or more health care policies or plans.

2. The company will continue the benefits for any other covered person with respect to expenses incurred for medical services or treatment by providers received after the insolvency date until the end of the period for which applicable premium was received by the reinsured for that covered person, prior to the insolvency date, but in no event to extend beyond the end of the calendar month in which the insolvency date occurs as long as such expenses are payable for such covered person.

This insolvency coverage is subject to a \$2,000,000 maximum

6. Type: Specific Excess of Loss Reinsurance
 - Reinsured: Absolute Total Care, Inc.
 - Covered business: At risk members as defined in the Membership Services Agreement
 - Retention: Specific deductible per covered person per agreement term: \$200,000
Maximum payable per covered person \$2,000,000
 - Maximum coverage: Hospital inpatient services: \$10,000 maximum average per diem per discharge for allowable expenses up to \$1,000,000
 - Coverage: 90% of covered expenses excess of specific deductible. Claims must be received prior to September 30, 2010.
 - Limitations: Hospital inpatient services: the lesser of the amount paid, the contracted rate in effect at the time of admission or the applicable Medicaid Fee Schedule where contracted rates do not exist, billed charges or a \$10,000 maximum average per diem per discharge for allowable expenses up to \$1,000,000. Per Diem limit is waived for an Approved Transplant Provider Case Rate.
 - Premium: \$1.87 per member per month
 - Effective date: January 1, 2013
 - Termination: January 1, 2014
7. Type: Specific Excess of Loss Reinsurance
 - Reinsured: Louisiana Healthcare Connections, Inc.
 - Covered business: Covered Medicaid members including BCC and Foster Care members, covered SSI/ABC members
 - Retention: Specific deductible per covered person per agreement term: \$200,000
Maximum payable per covered person: \$2,000,000
 - Coverage: 90% of covered expenses excess of specific deductible. Claims must be received by the reinsurer no later than November 1, 2014.

Limitations: Hospital inpatient services, the lesser of the amount paid the contract rate. The rate defined by the Medicaid fee schedule where a contracted rate does not exist or an average per diem per discharge of \$10,000.

Premium: TANF: \$2.72 per member per month
ABD/SSI: \$5.10 per member per month

Effective date: February 1, 2013

Termination: January 1, 2014

Insolvency coverage: In the event that the reinsured shall become insolvent while the agreement is in force, the reinsured or its legal representative shall notify all applicable covered persons of this provision and the following shall apply:

1. The company will continue to provide the benefits covered under the applicable membership services agreement with respect to each covered person who is confined in a hospital on the insolvency date for expenses incurred and payable by such covered person on or after such date until the longer of the covered person's discharge from the hospital or the period of time for which premium has been received by the reinsured.
2. The company will continue the benefits for any other covered person with respect to expenses incurred for medical services or treatment by providers received after the insolvency date until the end of the period for which applicable premium was received by the reinsured for that covered person, prior to the insolvency date, but in no event to extend beyond the end of the calendar month in which the insolvency date occurs as long as such expenses are payable for such covered person.

This insolvency coverage is subject to a \$2,000,000 maximum

8. Type: Specific Excess of Loss Reinsurance

Reinsured: Home State Health Plan

Retention: Specific deductible per covered person per agreement term:
VLBW cases: \$200,000
All cases other than VLBW: \$500,000
Maximum payable per covered person: \$2,000,000

Covered business: Medicaid covered persons

Coverage: 90% of covered expenses excess of specific deductible. Claims must be received by the reinsurer no later than September 1, 2014.

Limitations: Hospital inpatient services: the lesser of the amount paid, the contracted rate, the applicable Medicaid fee schedule where a contracted rate does not exist or an average per diem per discharge of \$10,000

Premium: \$4.69 per member per month

Effective date: January 1, 2013

Termination: January 1, 2014

Insolvency coverage: In the event that the reinsured shall become insolvent while the agreement is in force, the reinsured or its legal representative shall notify all applicable covered persons of this provision and the following shall apply:

1. The company will continue to provide the benefits covered under the applicable membership services agreement with respect to each covered person who is confined in a hospital on the insolvency date for expenses incurred and payable by such covered person on or after such date until the earlier of:
 - a. the covered person's discharge from the hospital; or
 - b. the date the covered person becomes eligible for health insurance coverage or benefits under another group or blanket policy or plan or any federal, state or local governmental plan or program. The company shall pursue any coordination of benefits, subrogation or any other right of recovery that may be available to the company as a result of the covered person being covered under two or more health care policies or plans.
2. The company will continue the benefits for any other covered person with respect to expenses incurred for medical services or treatment by providers received after the insolvency date until the end of the period for which applicable premium was received by the reinsured for that covered person, prior to the insolvency date, but in no event to extend beyond the end of the calendar month in which the insolvency date occurs as long as such expenses are payable for such covered person.

This insolvency coverage is subject to a \$2,000,000 maximum

9. Type: Specific Excess of Loss Reinsurance
- Reinsured: Illinicare Health Plan, Inc.
- Retention: Specific deductible per covered person per agreement term: \$200,000
Maximum payable per covered person: \$2,000,000
- Covered business: ABD Medicaid HMO members
- Coverage: 90% of covered expenses excess of specific deductible. Claims must be received by the reinsurer no later than September 1, 2014. Organ Transplant Services are reimbursed at 50% if performed at a Non-Approved Transplant Provider.
- Limitations: Hospital inpatient services: the lesser of the amount paid, the contracted rate, the applicable Medicaid fee schedule where a contracted rate does not exist or an average per diem per discharge of \$10,000

Premium: \$9.85 per member per month
Effective date: January 1, 2013
Termination: January 1, 2014
Insolvency coverage: In the event that the reinsured shall become insolvent while the agreement is in force, the reinsured or its legal representative shall notify all applicable covered persons of this provision and the following shall apply:

1. The company will continue to provide the benefits covered under the applicable membership services agreement with respect to each covered person who is confined in a hospital on the insolvency date for expenses incurred and payable by such covered person on or after such date until the earlier of:
 - a. the covered person's discharge from the hospital; or
 - b. the date the covered person becomes eligible for health insurance coverage or benefits under another group or blanket policy or plan or any federal, state or local governmental plan or program. The company shall pursue any coordination of benefits, subrogation or any other right of recovery that may be available to the company as a result of the covered person being covered under two or more health care policies or plans.
2. The company will continue the benefits for any other covered person with respect to expenses incurred for medical services or treatment by providers received after the insolvency date until the end of the period for which applicable premium was received by the reinsured for that covered person, prior to the insolvency date, but in no event to extend beyond the end of the calendar month in which the insolvency date occurs as long as such expenses are payable for such covered person.

This insolvency coverage is subject to a \$1,000,000 maximum

10. Type: Specific Excess of Loss Reinsurance
Reinsured: Kentucky Spirit Health Plan, Inc.
Retention: Specific deductible per covered person per agreement term: \$300,000
Maximum payable per covered person: \$2,000,000
Covered business: Medicaid, Foster Care, SSI Dual and SSI Non Dual members
Coverage: 90% of covered expenses excess of specific deductible. Claims must be received by the reinsurer no later than November 1, 2014. Organ Transplant Services are reimbursed at 50% if performed at a Non-Approved Transplant Provider.
Limitations: Hospital inpatient services: the lesser of the amount paid, the contracted rate, the applicable Medicaid fee schedule where a contracted rate does not exist or an average per diem per discharge of \$10,000

Premium: \$0.99 Medicaid and Foster care per member per month
 \$1.12 SSI Dual/Non Dual per member per month

Effective date: January 1, 2013

Termination: January 1, 2014

Insolvency coverage: In the event that the reinsured shall become insolvent while the agreement is in force, the reinsured or its legal representative shall notify all applicable covered persons of this provision and the following shall apply:

1. The company will continue to provide the benefits covered under the applicable membership services agreement with respect to each covered person who is confined in a hospital on the insolvency date for expenses incurred and payable by such covered person on or after such date until the earlier of:
 - a. the covered person's discharge from the hospital; or
 - b. the date the covered person becomes eligible for health insurance coverage or benefits under another group or blanket policy or plan or any federal, state or local governmental plan or program. The company shall pursue any coordination of benefits, subrogation or any other right of recovery that may be available to the company as a result of the covered person being covered under two or more health care policies or plans.
2. The company will continue the benefits for any other covered person with respect to expenses incurred for medical services or treatment by providers received after the insolvency date until the end of the period for which applicable premium was received by the reinsured for that covered person, prior to the insolvency date, but in no event to extend beyond the end of the calendar month in which the insolvency date occurs as long as such expenses are payable for such covered person.

This insolvency coverage is subject to a \$2,000,000 maximum

11. Type: Specific Excess of Loss Reinsurance

Reinsured: Sunflower State Health Plan, Inc

Retention: Specific deductible per covered person per agreement term: \$200,000
 Maximum payable per covered person: \$2,000,000

Covered business: Medicaid covered persons

Coverage: 90% of covered expenses excess of specific deductible. Claims must be received by the reinsurer no later than November 1, 2014. Organ Transplant Services are reimbursed at 50% if performed at a Non-Approved Transplant Provider.

Limitations: Hospital inpatient services: the lesser of the amount paid, the contracted rate, the applicable Medicaid fee schedule where a

contracted rate does not exist or an average per diem per discharge of \$10,000

Premium: \$3.45 per member per month

Effective date: January 1, 2013

Termination: January 1, 2014

Insolvency coverage: In the event that the reinsured shall become insolvent while the agreement is in force, the reinsured or its legal representative shall notify all applicable covered persons of this provision and the following shall apply:

1. The company will continue to provide the benefits covered under the applicable membership services agreement with respect to each covered person who is confined in a hospital on the insolvency date for expenses incurred and payable by such covered person on or after such date until the earlier of:
 - a. the covered person's discharge from the hospital; or
 - b. the date the covered person becomes eligible for health insurance coverage or benefits under another group or blanket policy or plan or any federal, state or local governmental plan or program. The company shall pursue any coordination of benefits, subrogation or any other right of recovery that may be available to the company as a result of the covered person being covered under two or more health care policies or plans.
2. The company will continue the benefits for any other covered person with respect to expenses incurred for medical services or treatment by providers received after the insolvency date until the end of the period for which applicable premium was received by the reinsured for that covered person, prior to the insolvency date, but in no event to extend beyond the end of the calendar month in which the insolvency date occurs as long as such expenses are payable for such covered person.

This insolvency coverage is subject to a \$2,000,000 maximum

VI. FINANCIAL DATA

The following financial statements reflect the financial condition of the company as reported in the December 31, 2012, annual statement to the Commissioner of Insurance. Also included in this section are schedules that reflect the growth of the company for the period under examination.

Bankers Reserve Life Insurance Company of Wisconsin
Assets
As of December 31, 2012

	Assets	Nonadmitted Assets	Net Admitted Assets
Bonds	\$127,838,431	\$	\$127,838,431
Cash, cash equivalents and short-term investments	154,733,137		154,733,137
Other invested assets	1,932,893		1,932,893
Receivable for securities	75,000		75,000
Investment income due and accrued	1,063,250		1,063,250
Uncollected premiums and agents' balances in the course of collection	17,774,346		17,774,346
Amounts recoverable from reinsurers	3,864,330		3,864,330
Current federal and foreign income tax recoverable and interest thereon	48,745,752		48,745,752
Net deferred tax asset	7,483,163		7,483,163
Receivables from parent, subsidiaries and affiliates	43,747,895		43,747,895
Health care and other amounts receivable	2,227,641	2,227,641	
Aggregate write-ins for other than invested assets	1,318,035	151,377	1,166,658
Total assets excluding separate accounts, segregated accounts and protected cell accounts	410,803,873	2,379,018	408,424,855
From separate accounts, segregated accounts and protected cell accounts	<u>1,018,839</u>	<u> </u>	<u>1,018,839</u>
Total Assets	<u>\$411,822,712</u>	<u>\$2,379,018</u>	<u>\$409,443,694</u>

Bankers Reserve Life Insurance Company of Wisconsin
Liabilities and Net Worth
As of December 31, 2012

Claims unpaid		\$146,918,384
Accrued medical incentive pool and bonus payments		
Unpaid claims adjustment expenses		3,172,000
Aggregate health policy reserves		35,957,691
General expenses due or accrued		23,952,697
Aggregate write-ins for other liabilities [including \$(0) current]		<u>818,838</u>
Total liabilities		210,819,610
Common capital stock	\$ 2,400,000	
Gross paid in and contributed surplus	257,997,809	
Unassigned funds (surplus)	<u>(61,773,725)</u>	
Total capital and surplus		<u>198,624,084</u>
Total Liabilities, Capital and Surplus		<u>\$409,443,694</u>

**Bankers Reserve Life Insurance Company of Wisconsin
Statement of Revenue and Expenses
For the Year 2012**

Net premium income		\$1,719,296,625
Change in unearned premium reserves and reserve for rate credits		<u>(166)</u>
Total revenues		1,719,296,459
Medical and hospital:		
Hospital/medical benefits	\$1,072,492,995	
Other professional services	163,679,381	
Emergency room and out-of-area	59,990,567	
Prescription drugs	<u>331,458,029</u>	
Subtotal	1,627,620,972	
Less		
Net reinsurance recoveries	<u>(19,774,084)</u>	
Total medical and hospital	1,647,395,056	
Non-health claims		
Claims adjustment expenses	45,825,514	
General administrative expenses	166,183,365	
Increase in reserves for life and accident and health contracts	<u>35,957,691</u>	
Total underwriting deductions		<u>1,895,360,626</u>
Net underwriting gain or (loss)		(176,064,167)
Net investment income earned	1,684,521	
Net realized capital gains or (losses)	<u>5,041</u>	
Net investment gains or (losses)		1,689,562
Aggregate write-ins for other income or expenses		<u>152,711</u>
Net income or (loss) before federal income taxes		(174,221,894)
Federal and foreign income taxes incurred		<u>(47,781,256)</u>
Net Income (Loss)		<u>\$ (126,440,638)</u>

**Bankers Reserve Life Insurance Company of Wisconsin
Analysis of Surplus
For the Three-Year Period Ending December 31, 2012**

The following schedule details items affecting the company's total capital and surplus during the period under examination as reported by the company in its filed annual statements:

	2012	2011	2010
Capital and surplus, beginning of year	\$ 61,571,528	\$ 70,613,868	\$56,439,217
Net income or (loss)	(126,440,638)	14,965,051	13,531,190
Change in net unrealized capital gains and losses	(142,684)	58,380	(18,949)
Change in net deferred income tax	6,365,911	(569,170)	972,498
Change in nonadmitted assets	169,967	1,503,399	(310,088)
Capital changes:			
Paid in		1,200,000	
Surplus adjustments:			
Paid in	257,100,000	(1,200,000)	
Dividends to stockholders		(25,000,000)	
Net change in capital and surplus	<u>137,052,556</u>	<u>(9,042,340)</u>	<u>14,174,651</u>
Capital and Surplus, End of Year	<u>\$ 198,624,084</u>	<u>\$ 61,571,528</u>	<u>\$70,613,868</u>

Bankers Reserve Life Insurance Company of Wisconsin
Statement of Cash Flows
As of December 31, 2012

Premiums collected net of reinsurance		\$1,701,806,375
Net investment income		<u>2,736,995</u>
Total		1,704,543,370
Less:		
Benefit- and loss-related payments	\$1,547,608,099	
Commissions, expenses paid and aggregate write-ins for deductions	172,684,789	
Federal and foreign income taxes paid (recovered) \$0 net tax on capital gains (losses)	<u>2,834,755</u>	
Total		<u>1,723,127,643</u>
Net cash from operations		(18,584,273)
Proceeds from investments sold, matured or repaid:		
Bonds	\$ 55,857,359	
Other invested assets	785,038	
Miscellaneous proceeds	<u>517</u>	
Total investment proceeds		56,642,914
Cost of Investments Acquired - Long-Term Only:		
Bonds	113,172,444	
Other invested assets	150,000	
Miscellaneous applications	<u>55,000</u>	
Total investments acquired		<u>113,377,444</u>
Net cash from investments		(56,734,530)
Cash Provided/Applied:		
Capital and paid in surplus, less treasury stock	<u>199,100,000</u>	
Net cash from financing and miscellaneous sources		<u>199,100,000</u>
Net change in cash, cash equivalents, and short-term investments		123,781,197
Cash, cash equivalents, and short-term investments:		
Beginning of year		<u>30,951,940</u>
End of Year		<u>\$ 154,733,137</u>

**Bankers Reserve Life Insurance Company of Wisconsin
Compulsory and Security Surplus Calculation
As of December 31, 2012**

Assets	\$ 409,443,694	
Less:		
Liabilities	<u>210,819,610</u>	
Assets available to satisfy surplus requirements		\$198,624,084
Net premium earned	1,719,296,625	
Compulsory factor	<u>10%</u>	
Compulsory surplus		<u>171,929,662</u>
Compulsory Surplus Excess/(Deficit)		<u>\$ 26,64,422</u>
Assets available to satisfy surplus requirements		\$198,624,084
Compulsory surplus	\$ 171,929,662	
Security factor	<u>110%</u>	
Security surplus		<u>189,122,628</u>
Security Surplus Excess/(Deficit)		<u>\$ 9,501,456</u>

Growth of Bankers Reserve Life Insurance Company of Wisconsin

Year	Assets	Liabilities	Capital and Surplus	Premium Earned	Medical Expenses Incurred	Net Income
2012	\$409,443,694	\$210,819,610	\$198,624,084	\$1,719,296,459	\$1,647,395,056	\$(126,440,638)
2011	110,071,447	48,499,920	61,571,528	437,488,030	365,905,527	14,965,051
2010	116,946,026	46,332,157	70,613,868	476,373,748	397,369,785	13,531,190
2009	114,793,146	58,353,929	56,439,217	459,358,190	400,565,116	6,588,330

Year	Profit Margin	Medical Expense Ratio	Administrative Expense Ratio	Change in Enrollment
2012	(10.2)%	95.8%	14.4%	405.84%
2011	4.7	83.4	11.9	0.35
2010	4.1	83.4	12.4	(30.52)
2009	(0.5)	87.2	13.3	4.11

Enrollment and Utilization

Year	Enrollment	Hospital Days/1,000	Average Length of Stay
2012	526,894	357.0	3.9
2011	104,163	1474.1	4.6
2010	103,797	151.5	4.5
2009	149,399	167.3	4.5

Per Member Per Month Information

	2012	2011	Percentage Net Change
Premiums:			
Commercial	\$4,086	\$4,200	(2.7)%
Medicaid	<u>3,054</u>	<u>0</u>	
Total	3,263	4,200	(22.3)
Expenses:			
Hospital/medical benefits	2,036	1,847	10.2
Other professional services	311	1,213	(74.4)
Emergency room and out-of-area	114	125	(9.3)
Prescription drugs	629	0	
Less: Net reinsurance recoveries	<u>(38)</u>	<u>(318)</u>	88.2
Total medical and hospital	3,127	3,503	(10.8)
Claims adjustment expenses	87	85	2.8
General administrative expenses	315	415	(24.0)
Increase in reserves for accident and health contracts	<u>68</u>	<u>0</u>	
Total Underwriting Deductions	<u>\$3,597</u>	<u>\$4,003</u>	(10.1)

The company's enrollment increased 406% to 526,894 members in 2012 from 104,163 in 2011. This increase was primarily due to the addition of the STAR and STAR+PLUS membership. The increase in enrollment caused total assets to increase to \$409 million at year-end 2012 from \$110 million at year-end 2011. Capital and surplus increased to \$199 million at year-end 2012 from \$62 million at year-end 2011.

The company has posted positive financial results in three of the four years under examination. The company's per member per month premium decreased 22.3% from the prior year while their total underwriting deductions decreased 10.1% from the prior year. The changes were due to the increased STAR and STAR+PLUS membership. In March 2012, the company commenced operations under a new Medicaid contract in the state of Texas. The contract added 420,000 members to the STAR and STAR+PLUS programs. Under the new contract, the company was responsible for the provision of health care of a Medicaid population previously not enrolled in managed care. The transition and introduction of such a large population into managed care produced large losses in 2012. As a result of the large losses, a capital contribution of \$257.1 million was made by Centene Corporation.

During this transition, the company introduced several market-tested means to reduce costs including, but not limited to: the identification and eradication of fraud, waste and abuse; the implementation of case management; and provider and member education. In addition, the company worked with the Texas Department of State Health Services and its actuaries to adjust premium rates to appropriate levels for the new program. As a result of these efforts, the company's financial results substantially improved during 2013.

Reconciliation of Capital and Surplus per Examination

No adjustments to surplus or reclassifications were made as a result of the examination. The amount of surplus reported by the company as of December 31, 2012, is accepted.

VII. SUMMARY OF EXAMINATION RESULTS

Compliance with Prior Examination Report Recommendations

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

1. Management and Control—It is again recommended the company comply with its bylaws.

Action—Compliance.

2. Management and Control—It is again recommended that the company implement procedures to have the BRLW board of directors monitor its financial results and formally approve its investment transactions at least quarterly and maintain minutes to document the board's active governance in accordance with s. 611.51 (6), Wis. Stat.

Action—Compliance.

3. Holding Company— It is recommended that the company accurately disclose the legal name for all agreements and transactions in force pursuant to s. Ins 40.03 (3) (c) 5., Wis. Adm. Code.

Action—Compliance.

4. Other Invested Assets—It is recommended that the company properly completes Schedule BA – Part 1 in accordance with the NAIC Annual Statement Instructions-Health.

Action—Compliance.

5. Information Technology—It is recommended that the company enhance its controls over application change management and properly define its roles and responsibilities of application change management controls to ensure the quality and integrity of information managed by IT systems.

Action—Compliance.

Summary of Current Examination Results

There were no adverse findings as a result of the examination.

VIII. CONCLUSION

Bankers Reserve Life Insurance Company of Wisconsin is licensed in 40 states and only actively writes business in the state of Texas. The company was incorporated under the laws of Wisconsin on January 5, 1961, and commenced business on July 29, 1964. The company became a member of a holding group on March 1, 2002, when it was purchased by Centene Corporation. The company primarily provides managed care services to individuals receiving benefits under the Children's Health Insurance Program (CHIP) and Foster Care Program. The company provides these services under separate contracts with the Texas Health and Human Services Commission.

In March 2012, the company commenced operations under a new Medicaid contract in the state of Texas. The contract added 420,000 members to the STAR and STAR+PLUS programs. Under the new contract, the company was responsible for the provision of health care of a Medicaid population previously not enrolled in managed care. The transition and introduction of such a large population into managed care produced large losses in 2012. As a result of the losses, a capital contribution of \$257.1 million was made by Centene Corporation. This increased capital and surplus to \$199 million at year-end 2012 from \$62 million at year-end 2011.

The company has posted positive financial results in three of the four years under examination. The company's per member per month premium decreased 22.3% from the prior year while their total underwriting deductions decreased 10.1% from the prior year. The changes were due to the increased STAR and STAR+PLUS membership.

The company complied with all five of the prior examination recommendations. No adjustments to surplus or reclassifications were made as a result of the examination. The amount of surplus reported by the company as of December 31, 2012, is accepted.

IX. SUMMARY OF COMMENTS AND RECOMMENDATIONS

There were no adverse findings as a result of the examination.

X. ACKNOWLEDGMENT

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

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

Name	Title
Holly Poore	Insurance Financial Examiner
Rich Janosik	Insurance Financial Examiner
Thomas Houston	IT Specialist

Respectfully submitted,

Terry J. Lorenz
Examiner-in-Charge