

Report
of the
Examination of
Compcare Health Services Insurance Corporation
Waukesha, Wisconsin
As of December 31, 2013

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State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Scott Walker, Governor
Theodore K. Nickel, Commissioner

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May 15, 2015

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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:

COMPCARE HEALTH SERVICES INSURANCE CORPORATION
Waukesha, Wisconsin

and this report is respectfully submitted.

I. INTRODUCTION

The previous examination of CompCare Health Services Insurance Corporation (CompCare or the company) was conducted in 2010 as of December 31, 2009. The current examination covered the intervening period ending December 31, 2013, and included a review of such 2014 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 of the company was conducted concurrently with the examination of WellPoint, Inc. The Indiana Department of Insurance (IDOI) acted in the capacity as the lead state for the coordinated exams. Work performed by the IDOI was reviewed and relied on where deemed appropriate. (On December 3, 2014, WellPoint, Inc., changed its name to Anthem, Inc. This report will generally use the WellPoint name in referring to this entity.)

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

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

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

The company is annually audited by an independent public accounting firm as prescribed by s. Ins 50.05, Wis. Adm. Code. An integral part of this compliance examination was the review of the independent accountant's work papers. Based on the results of the review of these work papers, alternative or additional examination steps deemed necessary for the completion of this examination were performed. The examination work papers contain documentation with respect to the alternative or additional examination steps performed during the course of the examination.

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 unpaid claims liability, unpaid claims adjustment expense and aggregate health care reserves. 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

Compcare Health Services Insurance Corporation is described as a for-profit mixed model health maintenance organization (HMO) insurer. An HMO insurer is defined by s. 609.01 (2), Wis. Stat., as ". . . a health care plan offered by an organization established under ch. 185, 611, 613, or 614 or issued a certificate of authority under ch. 618 that makes available to its enrolled participants, in consideration for predetermined fixed payments, comprehensive health care services performed by providers selected by the organization." Under the mixed model, the company provides care through contracts with two or more clinics, integrated delivery systems (hospital/physician joint ventures or PHOs), and individual physicians. HMOs compete with traditional fee-for-service health care delivery.

Compcare was initially operated as a line of business by the corporate predecessors of Blue Cross Blue Shield of Wisconsin (BCBSWI). Compcare received its certificate of authority on June 2, 1980, as a nonstock insurer under provisions of ch. 613, Wis. Stat., and the corporation was subsequently dissolved January 1, 1984. The current for-profit, stock company, Compcare Health Services Insurance Corporation, was incorporated January 1, 1984, under the provisions of ch. 611, Wis. Stat., and commenced business on the same date. Compcare was organized with 2,000,000 shares of \$1 par value common stock.

In preparation for a stock offering of United Wisconsin Services, Inc. (UWSI), an affiliate of BCBSWI, a corporate restructuring was completed in 1991. As part of this restructuring, BCBSWI contributed Compcare to UWSI. In addition, Dentacare, a dental line of business, was transferred to Compcare from BCBSWI. Effective January 1, 1998, Compcare transferred the Dentacare business to its wholly owned subsidiary, Heartland Dental Plan, Inc. (HDP).

In 1999 Compcare was licensed for its commercial lines of business with the BlueCross BlueShield Association (BCBSA). As a result, Compcare used the BCBSA licensee name of CompcareBlue. Compcare now markets its commercial products under the trade name of Anthem Blue Cross and Blue Shield.

In March 2001, HDP made a liquidating dividend of substantially all of its assets and liabilities to Compcare. Later that year all HDP existing policies were legally transferred to Compcare. In 2002 HDP was formally dissolved.

During 2000, Compcare received a capital contribution from Cobalt Corporation (Cobalt), its parent company at the time, of all the outstanding stock of United Wisconsin Insurance Company (UWIC), an underwriter of group disability, worker's compensation and other coverages; United Wisconsin Proservices (Proservices), a provider of electronic data submission and other services to health care providers; Meridian Resource Company, LLC (MRC), which provides various investigative and collection services for health care organizations; and United Heartland Life Insurance Company (UHLIC), an underwriter of group life insurance. The equity balances of these companies at the time they were contributed to Compcare totaled \$51.6 million.

CC Holdings, LLC (Holdings) was formed in June 2001 as a wholly owned subsidiary of Compcare. The operations of Holdings consisted solely of its ownership in four wholly owned non-insurance subsidiaries: MRC, Proservices, Innovative Resources Group, LLC (IRG), and Comprehensive Receivable Group (CRG). In 2002 Holdings sold its investment in IRG to an unaffiliated third party. In April 2003, Holdings sold its investment in CRG in conjunction with a stock purchase agreement with an unaffiliated third party. In March 2004, Holdings sold Proservices in conjunction with a stock purchase agreement with an unaffiliated third party. Effective October 1, 2002, the stock of UHLIC was transferred from Compcare to Cobalt. On December 31, 2005, the company sold UWIC to an unaffiliated third party. Holdings was dissolved in 2008. As a result of these transactions, MRC became a wholly owned subsidiary of Compcare. In October 2002 ownership of Compcare was transferred from Cobalt to BCBSWI.

Effective September 24, 2003, Cobalt was merged with and into Crossroads Acquisition Corp. (Crossroads), a wholly owned subsidiary of WellPoint Health Networks, Inc. (WHN). WHN was a publicly traded managed health care company domiciled in the state of Delaware. Blue Cross Blue Shield United of Wisconsin changed its name in November 2003 to the name that is presently used, Blue Cross Blue Shield of Wisconsin.

On November 30, 2004, WHN merged with and into Anthem Holding Corp., a directly and wholly owned subsidiary of Anthem, Inc., with Anthem Holding Corp. as the surviving entity in the merger. In connection with the merger, Anthem, Inc., changed its name to WellPoint, Inc. As previously noted, WellPoint, Inc., changed its name to Anthem, Inc., on December 3, 2014.

Compcare contracts with independent practice associations (IPAs), clinics, integrated delivery systems (hospital/physician joint ventures or PHOs), and individual physicians for the provision of enrollees' covered services. Upon enrollment the enrollee chooses a primary care physician; however, subsequent to 2005 the requirement of referrals to be preauthorized by the Primary Care Physician is no longer necessary for coverage.

The contracts include hold-harmless provisions for the protection of policyholders. Physicians are reimbursed on a capitation, discounted fee-for-service, or fee-schedule basis. In some cases, the company uses a "target" system of payment, under which a portion of the reimbursement is withheld pending an evaluation of the provider's experience for the year. Contracts with facilities typically have a three-year term and automatically renew for additional one-year terms, while contracts with providers are continuous until terminated. In general, either party may terminate contracts, without cause, with 180 days' written notice.

Compcare contracts with 132 hospitals to provide inpatient services. Hospitals are reimbursed on a negotiated diagnosis-related group rate (DRG) or per diem, or discounted from billed charges basis. The contracts include hold-harmless provisions for the protection of policyholders.

According to its business plan, Compcare's service area as of December 31, 2013, was comprised of all 72 Wisconsin counties. Compcare has an agreement with Group Health Cooperative of Eau Claire (GHC-EC) to use its provider network for Medicaid HMO business in western Wisconsin. The underwriting risk for the western Wisconsin Medicaid business is transferred 100% to GHC-EC. There was an administrative services agreement under which GHC-EC administered Compcare's Medicaid business in southeastern Wisconsin; however, the underwriting risk remains with Compcare under this agreement. The administrative services agreement was terminated and Compcare now administers the southeastern Wisconsin Medicaid

business. See the section of this report captioned “Subsequent Events” for additional details about this relationship.

The company offers comprehensive health care coverage which may be changed by riders to include deductibles and copayments. The following basic health care coverages are provided:

- Physician services
- Inpatient services
- Outpatient services
- Mental health, drug, and alcohol abuse services
- Ambulance services
- Special dental procedures (oral surgery)
- Prosthetic devices and durable medical equipment
- Newborn services
- Home health care
- Preventive health services
- Family planning
- Hearing exams and hearing aids
- Diabetes treatment
- Routine eye examinations
- Convalescent nursing home service
- Prescription drugs—copayment varies by plan
- Cardiac rehabilitation, physical, speech, and/or occupational therapy
- Physical fitness or health education (\$30.00 per year maximum)
- Kidney disease treatment
- Certain transplants
- Chiropractic services

Inpatient mental health and AODA coverage is consistent with federal mandates which became effective in 2009. Limits vary in accordance with federal law and include a minimum of 20 days inpatient, 20 visits outpatient and 15 visits for transitional care up to a maximum or unlimited coverage. Skilled nursing home care is generally limited to 30 days following a hospital stay. The company also has a number of copayment plans in which certain inpatient and physician services are subject to various levels of copayments. In southeastern Wisconsin, the company also offers a limited network of providers for employers willing to have a lesser network for a lower premium.

Certain preventive services are not covered when out-of-network providers are used. Nonemergency out-of-network inpatient and outpatient hospital services require precertification. If no precertification is done, the member could be held responsible for the charges.

In addition to its HMO products, Compcare also offers point-of-service (POS) products. The indemnity portion of Compcare's POS products is underwritten by BCBSWI (see the "Affiliated Agreements" section of this report for additional details). POS products provide comprehensive benefits similar to those listed above when participating providers are used. The enrollee may elect, at the time of service, to use providers that are not part of the company's network for higher deductibles and coinsurance levels.

Compcare has more recently entered the individual exchange under the Affordable Care Act, with Qualified Health Plans (QHPs) for enrollment dates that began on January 1, 2014. The QHPs include the Blue Priority Plans (HMO only) and three stand-alone dental plans. These plans were offered on the health care exchange for coverage beginning on January 1, 2014. Individual exchange products through Compcare were available in 31 counties in Wisconsin.

Compcare derives approximately 25% of its written premiums from Wisconsin's Medicaid/Badgercare Program. Compcare contracts directly with the Wisconsin Department of Health Services (DHS) to provide specified health care benefits to eligible Medicaid Assistance/Badgercare recipients. In exchange for these services, Compcare is paid a monthly capitation rate, which is designed to be less than the cost of providing the same services covered under the contract to a comparable Medicaid population on a fee-for-service basis. The current contract with DHS will expire on December 31, 2015.

In addition to writing Medicaid business and business on the health care exchange, the company markets to both groups and individuals. The company uses both internal sales staff and outside agencies. Agents are paid a commission on new and renewal business. Commissions are calculated based on either per contract/per month, ranging from \$3 to \$38, or a percentage of premiums, ranging from 2% to 18%.

Compcare uses an actuarially determined base as a beginning point in premium determination in its group business. An actuarial review of the rates is performed at least semiannually and rates are adjusted for inflation. Rates are adjusted to reflect the age, sex, area (county) and plan of benefits for new groups. Experience and predictive risk scores are reviewed

for renewal groups and, based on the review, a recommendation is made regarding adjusting the rate or canceling the group. Underwriters have the authority to adjust the rates after the initial rate quote. For individual business Compcare uses the community rating method as mandated by the Affordable Care Act.

III. MANAGEMENT AND CONTROL

Board of Directors

The board of directors consists of three members. Directors are elected annually to serve a one-year term. Officers are elected at the board's annual meeting. Members of the company's board of directors are also members of other boards of directors in the holding company group. All board members have executive management positions within the holding company structure and they receive no distinct and separate compensation for service as directors.

Currently the board of directors consists of the following persons:

Name and Residence	Principal Occupation	Term Expires
Wayne Scott DeVeydt Indianapolis, Indiana	Executive Vice President and Chief Financial Officer of WellPoint, Inc.	2016
Lawrence Glenn Schreiber Muskego, Wisconsin	President and CEO of BCBSWI and Compcare	2016
Catherine Irene Kelaghan Carmel, Indiana	Chief Legal Officer and Vice President and Counsel of WellPoint, Inc.	2016

Officers of the Company

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

Name	Office	2013 Compensation*
Lawrence Glenn Schreiber	President and CEO	\$ 844,792
Robert David Kretschmer	VP and Treasurer	1,855,414
Kathleen Susan Kiefer	VP and Secretary	606,933
Karen Elizabeth Geiger	Assistant Secretary	242,432
Eric (Rick) Kenneth Noble	Assistant Treasurer	223,648

* Compensation reflects the gross amount paid to the individuals in 2013 by WellPoint, Inc., and its affiliates.

Committees of the Board

The company's bylaws allow for the formation of certain committees by the board of directors. All insurance operations of the WellPoint Group are governed by WellPoint's board and board-appointed committees. The subsidiary insurance companies, which include Compcare, do not have any board-appointed committees. WellPoint's board-appointed committees include

1) Governance Committee, 2) Audit Committee, 3) Compensation Committee, and 4) Planning Committee. WellPoint's board and each of the committees meet at least quarterly throughout the year. Annually WellPoint conducts a stockholders' meeting where its directors are nominated and voted upon.

The company has no employees. Necessary staff is provided through a management agreement with WellPoint, Inc. Under the agreement, effective January 1, 2004, WellPoint agrees to negotiate employer, provider, subscriber, and other contracts; advises the board; maintains accounting and financial records; recruits marketing, utilization review, and claims processing personnel; provides or contracts for claims processing and management information systems. WellPoint receives reimbursement based on the actual cost of the services rendered. The term of the agreement is for one year with automatic renewal. The company may terminate the agreement upon 90 days' written notice.

Insolvency Protection for Policyholders

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

1. Enrollees hospitalized on the date of insolvency will be covered until discharged; and
2. Enrollees will be entitled to similar, alternate coverage which does not contain any medical underwriting or preexisting limitation requirements.

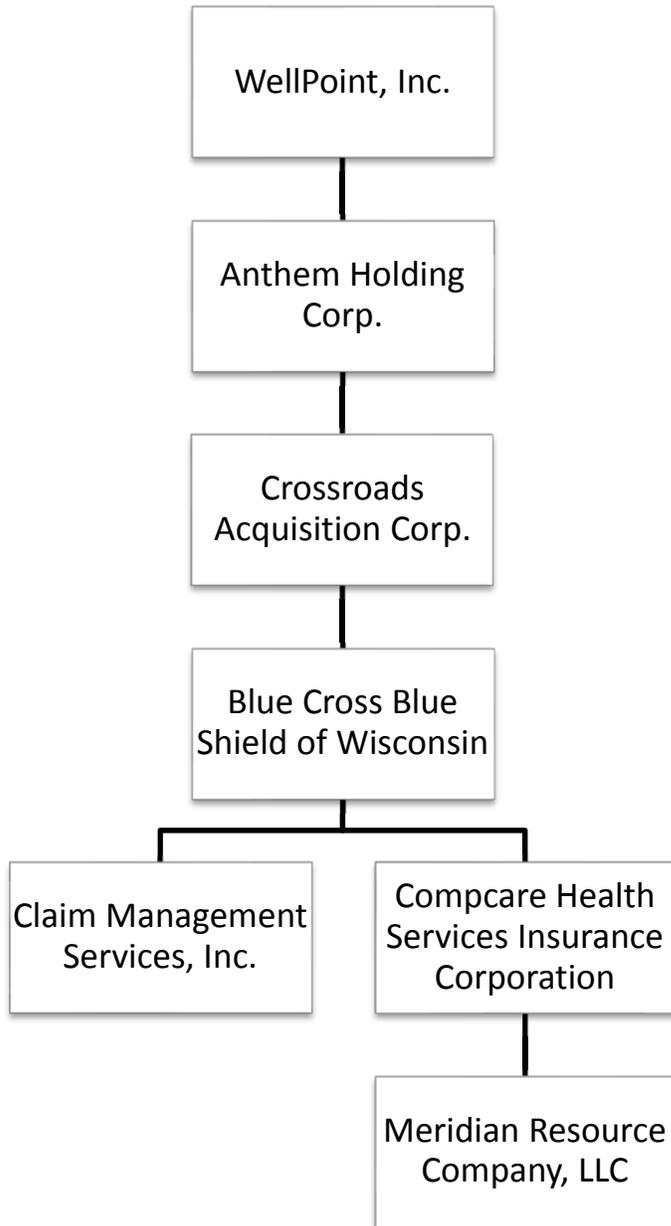
The company has met the first requirement through its Guarantee and Conversion Agreement as described in the "Agreements with Affiliates" section of this report. The second requirement is met through the requirements of the Affordable Care Act which no longer permits most medical underwriting or preexisting conditions for medical insurance.

IV. AFFILIATED COMPANIES

The company is a member of a holding company system. Its ultimate parent is WellPoint, Inc. The holding company system offers a broad spectrum of network-based managed care plans to the large and small employer, individual, Medicaid and senior markets. The managed care plans include preferred provider organizations, health maintenance organizations, point-of-service plans, traditional indemnity plans and other hybrid plans, including consumer-driven health plans, hospital-only and limited-benefit products. In addition, the holding company system provides a broad array of managed care services to self-funded customers, including claims processing, underwriting, stop-loss insurance, actuarial services, provider network access, medical cost management and other administrative services. An array of specialty and other products and services are also provided including pharmacy benefit management, group life and disability insurance, dental, vision, behavioral health benefits and long-term care insurance.

The abbreviated organizational chart below is a simplified version of the complete organizational chart due to the size and complexity of the holding company system. The chart includes affiliates that are mentioned elsewhere in the report, are party to Compcare's intermediate holding company or have agreements with the company's direct parent. A brief description of affiliates follows the organizational chart.

**Holding Company Chart
As of December 31, 2013**



WellPoint, Inc.

WellPoint, Inc., is a publicly traded company listed on the New York Stock Exchange under the ticker symbol WLP and is domiciled in the state of Indiana. WellPoint, Inc., is the largest health benefits company in terms of membership in the United States, serving approximately 35.7 million medical members as of December 31, 2013. It is also an independent licensee of the BlueCross BlueShield Association, an association of independent health benefit plans. WellPoint, Inc., and its subsidiaries offer a broad spectrum of network-based managed care plans to the large and small employer, individual, Medicaid and senior markets.

As of December 31, 2013, the consolidated GAAP audited financial statements of WellPoint, Inc., reported assets of \$59.7 billion, liabilities of \$34.8 billion, and shareholders' equity of \$24.8 billion. Operations for 2013 produced net income of \$2.5 billion. (As noted earlier in this report, on December 3, 2014, WellPoint, Inc., changed its name to Anthem, Inc.)

Anthem Holding Corp.

Anthem Holding Corp. is a holding company incorporated in the state of Indiana. Anthem Holding Corp.'s operations consist mainly of its investments in various health care entities across the United States.

As of December 31, 2013, Anthem Holding Corp.'s financial statements reported assets of \$17.9 billion, liabilities of \$1.9 billion, and equity of \$16.0 billion. Operations for 2013 produced net income of \$1.3 billion.

Crossroads Acquisition Corp.

Crossroads Acquisition Corp. is a holding company incorporated in the state of Delaware. Crossroads' operations consist mainly of its investment holdings in Blue Cross Blue Shield of Wisconsin and its subsidiaries.

As of December 31, 2013, the financial statements of Crossroads reported assets of \$573.7 million, liabilities of \$(31.7) million, and equity of \$605.4 million. Operations for 2013 produced net income of \$83.4 million.

Blue Cross Blue Shield of Wisconsin

Blue Cross Blue Shield of Wisconsin is a stock insurance company domiciled in the state of Wisconsin. BCBSWI was originally incorporated in 1939 as a nonstock, service insurance corporation organized pursuant to ch. 613, Wis. Stat. Effective March 23, 2001, BCBSWI converted to a stock insurance corporation organized pursuant to ch. 611, Wis. Stat. BCBSWI offers traditional indemnity and managed health care products and services to groups and individuals in Wisconsin.

As of December 31, 2013, BCBSWI's statutory-basis audited financial statements reported assets of \$474.6 million, liabilities of \$239.5 million, and capital and surplus of \$235.1 million. Operations for 2013 produced net income of \$70.0 million. (Blue Cross Blue Shield of Wisconsin was examined concurrently with Compcare, and the results of that examination are presented in a separate report.)

Claim Management Services, Inc.

Claim Management Services, Inc., is a non-insurance company incorporated in the state of Wisconsin and is a wholly owned subsidiary of BCBSWI. The company primarily acted as a third-party administrator for self-funded employee benefit plans in Wisconsin and has no current operations.

As of December 31, 2013, the financial statements of Claim Management Services, Inc., reported assets of \$525,739, liabilities of \$402,902, and equity of \$122,837. Operations for 2013 produced a net loss of \$(4,890).

Meridian Resource Company, LLC

Meridian Resources Company, LLC, is a non-insurance company organized in Wisconsin and is a wholly owned subsidiary of Compcare. Meridian Resources Company, LLC, provides various investigative and health care services for health care organizations and employer groups.

As of December 31, 2013, the financial statements of Meridian Resource Company, LLC, reported assets of \$12.7 million, liabilities of \$8.8 million, and equity of \$3.9 million. Operations for 2013 produced net income of \$2.1 million.

Agreements with Affiliates

Compcare has no employees of its own and all of its operations are conducted by employees of WellPoint, in accordance with the business practices and internal controls of that organization. In addition to ongoing common management and control by this upstream affiliate, various written agreements and undertakings affect the company's relationship to its affiliates. A brief summary of the agreements follows:

Subrogation and Worker's Compensation Claims Recovery Services Agreement

The company entered into a subrogation and worker's compensation claim recovery services agreement with Meridian Resource Company, LLC, effective March 16, 1999, where MRC is to provide various claim investigating services to Compcare. Services include, but are not limited to, investigating insurance and/or self-funded welfare benefit plan claims to identify potential subrogation, worker's compensation, and other party liability claims, as well as assisting the company in obtaining qualified counsel in situations where litigation is involved. For cases settled before litigation, MRC is to receive 25% of the total recovery as compensation for services rendered, while for litigated cases for which an outside attorney is used or a plaintiff's attorney is paid, MRC receives 15% of the total recovery. Either party may terminate this agreement at the end of any 12-month term upon 30 days' written notice.

Administrative Services Agreement

Effective August 1, 2003, BCBSWI and Compcare entered into a service agreement with respect to the Point-of-Service product (POS), where BCBSWI will underwrite the indemnity segment of the product and Compcare will underwrite the HMO segment of the product and provide administrative services for both the indemnity and HMO segments. In consideration for the services rendered by Compcare, BCBSWI is to pay the lower of 1) actual cost of the services provided or 2) 8% of the gross premium relating to POS indemnity premium. The contract specifies that 10% of the gross premium is attributable to POS indemnity premium and is remitted to the company monthly; however, the contract acknowledges that this can be adjusted throughout the policy year. This agreement may be terminated by either party upon 30 days' written notice.

Master Administrative Services Agreement

Compcare has entered into a master administrative service agreement with WellPoint and subsidiaries, effective January 1, 2004, to provide and receive certain administrative, consulting and other support services. Each service receiver will reimburse the applicable service provider for all direct and indirect costs and expenses incurred by the provider for services rendered. Costs and expenses directly traceable to an affiliate that receives services will be passed through at cost. Indirect expenses are allocated based upon the provider's internal cost accounting procedures and allocation methodologies, consistently applied. This agreement may be terminated by any party upon 90 days' written notice.

Consolidated Federal Income Tax Agreement

Effective December 31, 2005, Compcare entered into a tax allocation agreement with WellPoint and its subsidiaries. Under this agreement, WellPoint will file a consolidated tax return for member companies; member companies in turn agree to make quarterly payments to WellPoint 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. This agreement can be terminated: 1) by mutual written agreement by all parties, 2) if an affiliate is no longer a member of the WellPoint Group or 3) if the WellPoint Group fails to file a consolidated corporate income tax return for any taxable year.

Service Agreement to Provide Hospital Bill and DRG Validation Audit Programs

The company entered into a service agreement with Meridian Resource Company, LLC, effective January 1, 2007, where MRC is to provide hospital bill audit and diagnostic-related grouping validation audit services to the company by screening all hospital claims and selecting the service that would offer the highest return. As compensation for services rendered by MRC, it is to receive 28% of net savings for hospital bill audits and 20% of net savings for DRG validation audits. Either party may terminate this agreement upon 60 days' prior written notice.

Guarantee and Conversion Agreement

Pursuant to a Guarantee and Conversion Agreement, effective November 30, 2004, by and between WellPoint, Inc., and Compcare, WellPoint has agreed to provide an acceptable financial guarantee of all of the financial obligations of Compcare to its customers. The BCBSA requires WellPoint to provide Compcare with an appropriate conversion of coverage agreement to ensure that enrollees who are hospitalized during the insolvency of an insurer remain in the hospital until discharged as required by s. Ins 9.04 (6), Wis. Adm. Code. The agreement guarantees to the full extent of WellPoint's assets, all of the contractual and financial obligations of Compcare to its customers in accordance with BCBSA guidelines.

V. FINANCIAL DATA

The following financial statements reflect the financial condition of the company as reported in the December 31, 2013, annual statement to the Commissioner of Insurance. Also included in this section are schedules that reflect the growth of the company for the period under examination. Adjustments made as a result of the examination are noted at the end of this section in the area captioned "Reconciliation of Capital and Surplus per Examination."

Compcare Health Services Insurance Corporation
Assets
As of December 31, 2013

	Assets	Nonadmitted Assets	Net Admitted Assets
Bonds	\$185,785,419	\$	\$185,785,419
Cash, cash equivalents and short-term investments	(17,328,825)		(17,328,825)
Other invested assets	3,907,501	3,907,501	
Receivables for securities	21		21
Investment income due and accrued	1,908,567		1,908,567
Uncollected premiums and agents' balances in the course of collection	9,012,540	106,187	8,906,353
Accrued retrospective premiums	12,429	0	12,429
Amounts receivable relating to uninsured plans	2,792,677	373,328	2,419,349
Net deferred tax asset	7,231,100	233,699	6,997,401
Receivables from parent, subsidiaries and affiliates	4,388,982	4,388,982	
Health care and other amounts receivable	3,229,628	1,859,744	1,369,884
Aggregate write-ins for other than invested assets	<u>948,595</u>	<u>793,149</u>	<u>155,446</u>
Total Assets	<u>\$201,888,634</u>	<u>\$11,662,590</u>	<u>\$190,226,044</u>

Compcare Health Services Insurance Corporation
Liabilities and Net Worth
As of December 31, 2013

Claims unpaid		\$ 46,186,381
Accrued medical incentive pool and bonus payments		1,449,730
Unpaid claims adjustment expenses		1,653,388
Aggregate health policy reserves		6,616,336
Aggregate health claim reserves		488,502
Premiums received in advance		6,413,650
General expenses due or accrued		5,673,669
Current federal and foreign income tax payable and interest thereon		325,023
Amounts withheld or retained for the account of others		4,386,045
Remittance and items not allocated		3,910,098
Amounts due to parent, subsidiaries and affiliates		8,077,666
Liability for amounts held under uninsured plans		364,604
Aggregate write-ins for other liabilities		<u>738,880</u>
Total liabilities		86,283,972
Common capital stock	\$ 2,000,000	
Gross paid in and contributed surplus	83,046,325	
Unassigned funds (surplus)	<u>18,895,747</u>	
Total capital and surplus		<u>103,942,072</u>
Total Liabilities, Capital and Surplus		<u>\$190,226,044</u>

Compcare Health Services Insurance Corporation
Statement of Revenue and Expenses
For the Year 2013

Net premium income		\$598,595,718
Change in unearned premium reserves and reserve for rate credits		<u>663,910</u>
Total revenues		599,259,628
Medical and hospital:		
Hospital/medical benefits	\$363,187,740	
Other professional services	29,632,693	
Emergency room and out-of-area	30,622,116	
Prescription drugs	35,971,618	
Aggregate write-ins for other medical and hospital	34,781,017	
Incentive pool and withhold adjustments	<u>1,285,324</u>	
Subtotal	495,480,508	
Claims adjustment expenses	20,257,627	
General administrative expenses	43,935,517	
Increase in reserves for life and accident and health contracts	<u>(3,957,872)</u>	
Total underwriting deductions		<u>555,715,780</u>
Net underwriting gain or (loss)		43,543,848
Net investment income earned	13,430,707	
Net realized capital gains or (losses)	<u>357,721</u>	
Net investment gains or (losses)		13,788,428
Net gain or (loss) from agents' or premium balances charged off		(1,462)
Aggregate write-ins for other income or expenses		<u>8,209</u>
Net income or (loss) before federal income taxes		57,339,023
Federal and foreign income taxes incurred		<u>16,710,487</u>
Net Income (Loss)		<u>\$ 40,628,536</u>

Compcare Health Services Insurance Corporation
Statement of Cash Flows
As of December 31, 2013

Premiums collected net of reinsurance		\$591,091,143
Net investment income		<u>14,656,232</u>
Total		<u>605,747,375</u>
Less:		
Benefit- and loss-related payments	\$481,181,333	
Commissions, expenses paid and aggregate write-ins for deductions	66,089,471	
Federal and foreign income taxes paid (recovered)		
\$190,139 net tax on capital gains (losses)	<u>16,530,911</u>	
Total		<u>563,801,715</u>
Net cash from operations		41,945,660
Proceeds from investments sold, matured or repaid:		
Bonds	\$45,303,970	
Miscellaneous proceeds	<u>11</u>	
Total investment proceeds		45,303,981
Cost of investments acquired – long-term only:		
Bonds	52,843,357	
Miscellaneous applications	<u>3,737,515</u>	
Total investments acquired		<u>56,580,872</u>
Net cash from investments		(11,276,891)
Cash provided/applied:		
Dividends to stockholders	(20,000,000)	
Other cash provided (applied)	<u>1,344,836</u>	
Net cash from financing and miscellaneous sources		<u>(18,655,164)</u>
Net change in cash, cash equivalents, and short-term investments		12,013,605
Cash, cash equivalents, and short-term investments:		
Beginning of year		<u>(29,342,432)</u>
End of Year		<u>\$ (17,328,827)</u>

Compcare Health Services Insurance Corporation
Reconciliation and Analysis of Surplus
For the Five-Year Period Ending December 31, 2013

The following schedule is a reconciliation of total capital and surplus during the period under examination as reported by the company in its filed annual statements:

(000s omitted)	2013	2012	2011	2010	2009
Capital and surplus, beginning of year	\$ 86,042	\$90,926	\$95,127	\$63,739	\$56,307
Net income	40,629	32,945	34,496	12,259	13,116
Change in net unrealized capital gains/losses	(7,282)	2,342	3,138	1,787	(4,781)
Change in net deferred income tax	1,066	(1,269)	(1,646)	(4,911)	(1,560)
Change in nonadmitted assets and related items	3,487	(765)	(188)	26,624	657
Cumulative effect of changes in accounting principles	0	1,862	0	0	0
Prior period correction of an error	0	0	0	(4,371)	0
Surplus adjustments:					
Paid in	0	(6,912)	(18,207)	0	0
Transfer from capital	0	6,912	18,207	0	0
Dividends to stockholders	<u>(20,000)</u>	<u>(40,000)</u>	<u>(40,000)</u>	<u>0</u>	<u>0</u>
Capital and Surplus, End of Year	<u>\$103,942</u>	<u>\$86,042</u>	<u>\$90,926</u>	<u>\$95,127</u>	<u>\$63,739</u>

Growth of Compcare Health Services Insurance Corporation

Year	Assets	Liabilities	Capital and Surplus	Premium Earned	Medical Expenses Incurred	Net Income
2013	\$190,226,044	\$86,283,972	\$103,942,072	\$599,259,628	\$495,480,508	\$40,628,536
2012	163,733,154	77,690,803	86,042,351	471,320,593	373,748,890	32,945,277
2011	164,440,419	73,513,983	90,926,436	465,620,342	365,415,247	34,496,085
2010	177,823,509	82,696,774	95,126,735	507,764,344	428,166,882	12,258,982
2009	128,396,867	64,657,876	63,738,991	473,071,827	408,407,387	13,116,035

Year	Profit Margin	Medical Expense Ratio*	Administrative Expense Ratio	Change in Enrollment
2013	6.8%	82.7%	10.7%	18.4%
2012	7.0	79.3	11.5	3.9
2011	7.4	78.5	12.7	(14.0)
2010	2.4	84.3	12.0	(0.8)
2009	2.8	86.3	13.3	(5.7)

Enrollment and Utilization

Year	Enrollment	Hospital Days/1,000	Average Length of Stay
2013	201,126	279.98	3.9
2012	169,900	188.03	4.0
2011	163,578	192.09	3.8
2010	190,215	212.99	3.8
2009	191,660	217.00	3.7

* Does not include the increase/decrease in the reserve for life and A&H contracts.

Per Member Per Month Information

	2013	2012	Percentage Change
Premiums:			
Commercial	\$355.38	\$347.56	2.2%
Medicare	831.95		
Medicaid	180.83	146.41	23.5
Other health	20.82	35.06	(40.6)
Expenses:			
Hospital/medical benefits	176.41	181.96	(3.0)
Other professional services	9.86	7.66	28.8
Emergency room and out-of-area	14.87	16.97	(12.3)
Prescription drugs	17.47	19.46	(10.2)
Other medical and hospital	16.89	2.13	692.1
Incentive pool and withhold adjustments	0.62	0.29	115.5
Total medical and hospital	236.14	228.47	3.4
Claims adjustment expenses	9.70	8.70	11.5
General administrative expenses	21.03	25.83	(18.6)
Increase in reserves for accident and health contracts	<u>(1.93)</u>	<u>1.23</u>	(257.2)
Total Underwriting Deductions	<u>\$264.95</u>	<u>\$264.23</u>	0.3

Compcare's total adjusted capital at December 31, 2013, and December 31, 2012, was \$103.9 million and \$86.0 million, respectively. Authorized control level risk-based capital (RBC) at December 31, 2013, and December 31, 2012, was \$19.9 million and \$15.9 million, respectively. This resulted in RBC ratios of 522% and 541% for 2013 and 2012, respectively. These RBC levels are comparable to the earlier two years of the examination period; 588% (2011) and 513% (2010). The RBC ratios exceed RBC action levels and are indicative of the company's sound financial position.

The company routinely pays dividends to BCBSWI, its parent company, subject to s. 617.225, Wis. Stat., and s. Ins 40.18, Wis. Adm. Code. The company paid dividends of \$100.0 million over the examination period.

The company's total admitted assets increased \$26.5 million, or 16%, from the prior year, driven primarily by an increase in cash and invested assets of \$18.8 million, mainly due to investing cash from operations. Total admitted assets of \$190.2 million (2013) increased over the examination period from a high point of \$177.8 million (2010).

Total liabilities increased \$8.6 million, or 11%, mainly due to increases in unpaid claims. Unpaid claims increased \$9.3 million due to the increase in membership. Various other

liability accounts changed to a lesser degree and were generally offsetting. Total liabilities of \$86.3 million (2013) increased over the examination period from a high point of \$82.7 million (2010).

Net income averaged \$30.1 million per year over the examination period. Net income increased \$7.7 million, or 23%, compared to 2012 primarily due to an increase in investment gains primarily due to a \$7.0 million dividend received from MRC. Total revenues climbed from \$471.3 million in 2012 to \$599.3 million in 2013. Total revenues in 2013 were well above the average revenues of \$511.0 million per year over the examination period.

Membership increased 18% from December 31, 2012, to December 31, 2013. This increase was primarily due to a competitor's exit of Medicaid business in southeast Wisconsin effective in 2013. Compcare's net Medicaid premium income increased 132.1% to \$148.8 million in 2013 from \$64.1 million in 2012. The overall impact appears favorable as underwriting losses from Medicaid declined 84% to \$0.6 million in 2013 from \$3.5 million in 2012.

While membership increased substantially in 2013, utilization appeared stable with an average length of hospitalization around 3.9 days. Per member per month (PMPM) premiums were stable on the commercial side, where a 2% increase in per member premiums was reported by the company. Medicaid has shown a PMPM premium increase of 24% in 2013. Per member total underwriting deductions increased only slightly over the previous year.

The main driver of underwriting gains for the company continues to be strong results in the Comprehensive Hospital and Medical business, where the company reported a \$40.5 million total underwriting gain for 2013. Both the Medicare and Medicaid lines generated underwriting losses for the year of \$43,162 and \$559,035, respectively.

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, 2013, as modified for examination

adjustments is as follows:

Assets	\$176,545,281	
Less:		
Special deposit	4,665,682	
Liabilities	86,283,972	
Examination adjustments		
Assets available to satisfy surplus requirements		\$85,595,627
Net premium earned	564,478,611	
Compulsory factor		3%
Compulsory surplus		<u>16,934,358</u>
Compulsory Surplus Excess/(Deficit)		<u>\$68,661,269</u>
Assets available to satisfy surplus requirements		\$85,595,627
Compulsory surplus	\$ 16,934,358	
Security factor		<u>124%</u>
Security surplus		<u>20,998,603</u>
Security Surplus Excess/(Deficit)		<u>\$64,597,024</u>

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 (excluding Medicare Advantage and Medicaid 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 2013 with a deposit of \$4,751,921 with the State Treasurer.

Reconciliation of Capital and Surplus per Examination

No adjustments were made to surplus as a result of the examination. The amount of surplus of \$103,942,072 reported by the company as of December 31, 2013, is accepted.

Examination Reclassifications

No reclassifications were made to the account balances as a result of the examination.

VI. SUMMARY OF EXAMINATION RESULTS

Compliance with Prior Examination Report Recommendations

There were seven 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 recommend that the company's board of directors manage the business and affairs of the corporation, including quarterly review of financial results, in accordance with s. 611.51 (6), Wis. Stat.

Action—Compliance.

2. Management and Control—It is again recommended that the company file biographical affidavits for all directors and officers in accordance with s. Ins 6.52, Wis. Adm. Code.

Action—Compliance.

3. Management and Control—It is recommended that the company perform a formal review of its subcontractor's performance at least once a year in accordance with its BadgerCare Plus Contract with the Wisconsin Department of Health Services.

Action—Compliance.

4. Bylaws—It is again recommended that the company comply with its bylaws in regard to the date the annual shareholder's meeting is to be held.

Action—Compliance.

5. Corporate Records—It is again recommended that the company maintain a glossary of corporate contracts pursuant to s. 601.42, Wis. Stat.

Action—Compliance.

6. Corporate Records—It is recommended that the company report all remuneration to executives, which includes deferred compensation and other retirement compensation fully-funded or awarded by the company, for those executives whose remuneration meets the requirements to be reported to the Commissioner of Insurance in accordance with s. 611.63, Wis. Stat. It is further recommended that the company retain sufficient documentation to support the balances reported on the Report on Executive Compensation in order for this office to determine compliance with s. 611.63, Wis. Stat., which would include a detailed listing of plans and associated balances that create what is reported in the "All Other Compensation" portion of the report.

Action—Partial Compliance.

7. Investment Limitations—It is recommended that the company adjust its assets as part of the calculation of its compulsory and security surplus requirements to reflect investment holdings that exceed limitations governed by s. 620.22, Wis. Stat.

Action—Compliance.

Summary of Current Examination Results

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

Corporate Records

The examination team reviewed the Report on Executive Compensation for Compcare filed with the Commissioner for year-end 2013 to verify that this supplemental annual report included and disclosed all compensation given to executives included in that report, such as 401(k) and deferred compensation contributions, exercised stock options under a stock incentive plan, payments made on executive incentive plans, etc. It was discovered as part of the review that the report did not include contributions made by the company or affiliates to individuals under a 401(k) or deferred compensation plan. It is again recommended that the company report all remuneration to executives, which includes deferred compensation and other retirement compensation fully-funded or awarded by the company, for those executives whose remuneration meets the requirements to be reported to the Commissioner of Insurance in accordance with s. 611.63, Wis. Stat.

Actuarial Memoranda Detail

The NAIC Annual Statement Instructions - Health requires that the Actuarial Memorandum include a technical component that contains detail such that, "This technical component must show the analysis from the basic data, (e.g., claim lags) to the conclusions." The Actuarial Memorandum of the company did not include claim lag triangles. While the technical component of the Actuarial Memorandum did include a significant amount of information and exhibits, it was not indexed or organized in a way that one could follow the analysis from data to conclusions. Therefore, the Actuarial Memorandum prepared by the appointed actuary did not include the required technical component detail as required by the NAIC Annual Statement Instructions - Health.

The examiners recognize that due to the size and complexity of the company's analysis, the volume of information necessary to demonstrate the appointed actuary's strict

compliance with the requirements of the annual statement instructions regarding content of the Actuarial Memorandum could be significant. In the case where the volume of technical documentation is so large that its inclusion in the document is not practical (the lag triangles in this case), it is acceptable that the technical documentation be included in the Actuarial Memorandum by reference to separate electronic file(s). Such reference should state that the file has been prepared, describe the information contained therein, and indicate that the file is available on request to any party to whom the Actuarial Memorandum is made available. Both the file name and the date it was saved should be stated in the Actuarial Memorandum. Notwithstanding this compromise position, in those instances where the information would not be too voluminous, consideration should be given to including all of the required information within the Memorandum. It is recommended that the appointed actuary's technical component include the analysis from the basic data (e.g., claim lags) to the conclusions as well as organize the technical appendices in a manner such that the analysis can be followed from data to conclusions in future Actuarial Memoranda as is required by the NAIC Annual Statement Instructions - Health.

Actuarial Memoranda Exhibit

The 2013 NAIC Annual Statement Instructions - Health requires that the Actuarial Memorandum include "An exhibit which ties to the Annual Statement and compares the actuary's conclusions to the carried amounts." The required exhibit was not included in the Actuarial Memorandum of the company. The company provided a response that, "The actuarial team does currently perform the checks via notes in our reconciliations, but that information isn't currently included in the memo itself." It is recommended that the appointed actuary include an exhibit which ties to the annual statement and compares the actuary's conclusions to the carried amounts in future Actuarial Memoranda as is required by the NAIC Annual Statement Instructions - Health.

VII. CONCLUSION

Compcare Health Services Insurance Corporation has reported favorable financial results over the period under examination. RBC ratios of 522%, 541%, 588%, and 513% for 2013 through 2010, respectively, show that the company had capital well in excess of the action level. Compulsory and security surplus excesses in 2013 were \$68,661,269 and \$64,597,024, respectively. Compcare's total capital increased to \$103.9 million in 2013 from \$86.0 million compared to the prior year-end. The company paid dividends to its parent company totaling \$100.0 million over the examination period. Net income averaged \$30.1 million per year over the examination period. Membership increased 18% in 2013. Utilization appeared stable with an average length of hospitalization of approximately 3.9 days over the examination period.

The prior examination noted seven examination recommendations for which the company has complied on six and partially complied on one. The current examination noted one repeat examination recommendation and two new examination recommendations, with no examination adjustments or reclassifications.

VIII. SUMMARY OF COMMENTS AND RECOMMENDATIONS

1. Page 30 - Corporate Records—It is again recommended that the company report all remuneration to executives, which includes deferred compensation and other retirement compensation fully-funded or awarded by the company, for those executives whose remuneration meets the requirements to be reported to the Commissioner of Insurance in accordance with s. 611.63, Wis. Stat.
2. Page 31 - Actuarial Memoranda Detail—It is recommended that the appointed actuary's technical component include the analysis from the basic data (e.g., claim lags) to the conclusions as well as organize the technical appendices in a manner such that the analysis can be followed from data to conclusions in future Actuarial Memoranda as is required by the NAIC Annual Statement Instructions - Health.
3. Page 31 - Actuarial Memoranda Exhibit—It is recommended that the appointed actuary include an exhibit which ties to the annual statement and compares the actuary's conclusions to the carried amounts in future Actuarial Memoranda as is required by the NAIC Annual Statement Instructions - Health.

IX. 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
Shelly Bueno	Insurance Financial Examiner
John Pollock	Insurance Financial Examiner
Thomas Hilger	Insurance Financial Examiner
Dave Jensen, CFE	IT Specialist
Jerry DeArmond, CFE	Reserve Specialist

Respectfully submitted,

Gene M. Renard, CFE
Examiner-in-Charge

X. SUBSEQUENT EVENTS

There were two significant events that took place after the end date of the examination but prior to the examination report issuance. These are non-recognized events that provide evidence with respect to conditions that did not exist at the balance sheet date.

The first significant event involved a change to Compcare's operations in southeastern Wisconsin. Compcare has a risk agreement with Group Health Cooperative of Eau Claire for its Medicaid HMO business in western Wisconsin and in the rest of the state Compcare manages its own Medicaid provider network. Effective July 1, 2014, Compcare terminated the administrative services only arrangement, covering southeastern Wisconsin enrollees, with Group Health Cooperative of Eau Claire; however, the risk contract covering western Wisconsin enrollees remains in place.

The second significant event involved a cyber-attack/data breach on Anthem's systems, which was announced in early February 2015. Anthem, Inc., included the following disclosure on its 2015 Form 10-Q first quarter filing (Filing Date - April 29, 2015) concerning this event.

Cyber Attack Incident

In February 2015, we reported that we were the target of a sophisticated external cyber attack. The attackers gained unauthorized access to certain of our information technology systems and obtained personal information related to many individuals and employees, such as names, birthdays, health care identification/social security numbers, street addresses, email addresses, phone numbers and employment information, including income data. To date, there is no evidence that credit card or medical information, such as claims, test results or diagnostic codes, were targeted, accessed or obtained, although no assurance can be given that we will not identify additional information that was accessed or obtained.

Currently, we are in the process of addressing the cyber attack and supporting federal law enforcement efforts to identify the responsible parties. Upon discovery of the cyber attack, we took immediate action to remediate the security vulnerability and retained a cybersecurity firm to evaluate our systems and identify solutions based on the evolving landscape. We will provide credit monitoring and identity protection services to those who have been affected by this cyber attack. While the cyber attack did not have an impact on our business, cash flows, financial condition and results of operations for the year ended December 31, 2014, we have incurred expenses subsequent to the cyber attack to investigate and remediate this matter and expect to continue to incur expenses of this nature in the foreseeable future. Although we are unable to quantify the ultimate magnitude of such expenses and any other impact to our business from this incident at this time, they may be significant. We will recognize these expenses in the periods in which they are incurred.

Actions have been filed in various federal and state courts and other claims have been or may be asserted against us on behalf of current or former members, current or former employees, other individuals, shareholders or others seeking damages or other related relief, allegedly arising out of the cyber attack. State and federal agencies, including state insurance regulators, state attorneys general, the Health and Human Services Office of Civil Rights and the Federal Bureau of Investigations, are investigating events related to the cyber attack, including how it occurred, its consequences and our responses. Although we are cooperating in these investigations, we may be subject to fines or other obligations, which may have an adverse effect on how we operate our business and our results of operations. With respect to the civil actions, a motion to transfer was filed with the Judicial Panel on Multidistrict Litigation on February 10, 2015 and will be heard by the Panel on May 28, 2015.

We have contingency plans and insurance coverage for certain expenses and potential liabilities of this nature, however, the coverage may not be sufficient to cover all claims and liabilities. While a loss from these matters is reasonably possible, we cannot reasonably estimate a range of possible losses because our investigation into the matter is ongoing, the proceedings remain in the early stages, alleged damages have not been specified, there is uncertainty as to the likelihood of a class or classes being certified or the ultimate size of any class if certified, and there are significant factual and legal issues to be resolved.

The cyber-attack/data breach announcement by Anthem was made during the ongoing financial examination. On March 14, 2015, the IDOI called a multi-state targeted market conduct/financial examination to investigate the aftermath of the cyber-attack/data breach on Anthem. Wisconsin is participating in the multi-state targeted examination. The outcome of the targeted examination, including the financial impact of the data breach, cannot be reasonably estimated and, therefore, no liability has been included in this report.