

Report
of the
Examination of
Humana Wisconsin Health Organization Insurance Corporation
Louisville, Kentucky
As of December 31, 2010

TABLE OF CONTENTS

| | Page |
|--|-------------|
| I. INTRODUCTION | 1 |
| II. HISTORY AND PLAN OF OPERATION | 3 |
| III. MANAGEMENT AND CONTROL..... | 7 |
| IV. AFFILIATED COMPANIES..... | 10 |
| V. REINSURANCE..... | 15 |
| VI. FINANCIAL DATA | 17 |
| VII. SUMMARY OF EXAMINATION RESULTS..... | 24 |
| VIII. CONCLUSION..... | 27 |
| IX. SUMMARY OF COMMENTS AND RECOMMENDATIONS..... | 28 |
| X. ACKNOWLEDGMENT..... | 29 |
| XI. ADDENDUM I – PHYSICIAN HOSPITAL ORGANIZATIONS, INDEPENDENT PROVIDER ASSOCIATIONS, AND GROUPS..... | 30 |
| XII. ADDENDUM II – HOSPITALS..... | 31 |



State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Scott Walker, Governor
Theodore K. Nickel, Commissioner

Wisconsin.gov

January 20, 2012

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:

HUMANA WISCONSIN HEALTH ORGANIZATION INSURANCE CORPORATION
Louisville, Kentucky

and this report is respectfully submitted.

I. INTRODUCTION

The previous examination of Humana Wisconsin Health Organization Insurance Corporation (the company, Humana WHO, or the HMO) was conducted in 2006 as of December 31, 2005. The current examination covered the intervening period ending December 31, 2010, and included a review of such 2011 transactions as deemed necessary to complete the examination.

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

estimates made by management, as well as an evaluation of the overall financial statement presentation and management's compliance with statutory accounting principles, annual statement instructions, and Wisconsin laws and regulations.

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

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

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

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

II. HISTORY AND PLAN OF OPERATION

The Humana Wisconsin Health Organization Insurance Corporation is 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, Wis. Stat., or issued a certificate of authority under ch. 618, Wis. Stat., 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 HMO provides care through contracts with clinics and otherwise independent physicians operating out of their separate offices. HMOs compete with traditional fee-for-service and preferred provider plan health insurance delivery systems.

The HMO was incorporated on June 4, 1985, under the provisions of ch. 611, Wis. Stat. It commenced business under its former name, Wisconsin Health Organization Insurance Corporation, in September of 1985. Humana WHO is a wholly owned subsidiary of CareNetwork, Inc., a Wisconsin corporation which is a wholly owned subsidiary of Humana Inc. Humana WHO became an affiliate in the insurance holding company system on December 20, 1994, when CareNetwork, Inc., was purchased and merged into HWS, Inc., a wholly owned subsidiary of Humana Inc. CareNetwork, Inc., was the survivor of the merger. The name change to Humana Wisconsin Health Organization Insurance Corporation was effective June 1, 1995.

The HMO contracts with Physician Hospital Organizations (PHOs), Independent Provider Associations (IPAs) and groups for the provision of physician services, including specialty services (groups). Under these contracts, the PHOs, IPAs and groups are reimbursed on a fee schedule or discounted fee-for-service basis.

The initial terms of the PHO, IPA and group provider contracts vary in length from one to five years. The agreements may be terminated by either party for breach of material provision with 30 days' prior written notice, following a 30-day period to cure breach. Also, the agreement may be terminated by either party upon 90 to 120 days' written notice prior to the effective date of such termination. The contracts include hold-harmless provisions for the protection of enrollees.

In addition to contracted PHOs, IPAs and groups, the HMO contracts with approximately 3,000 individual physicians to provide covered health care services to eligible enrollees. All such direct contracted physicians are reimbursed on a fee schedule or discounted fee-for-services basis. The contracts have one-year initial terms and automatically renew for additional one-year terms. The agreements may be terminated upon a 90-day written notice. The contracts also contain hold-harmless provisions for the protection of enrollees.

The HMO currently contracts with 37 PHOs, IPAs and groups. A listing of the PHOs, IPAs and groups the HMO currently has contracts with is included in Addendum I to this report.

The HMO contracts with 68 hospitals to provide inpatient services. Hospitals are reimbursed on a negotiated DRG, per diem, case rate, discounted fee-for-service or fee schedule basis. The contracts include hold-harmless provisions for the protection of enrollees. A listing of the hospitals in which the participating physicians have admitting privileges is included in Addendum II of this report. All hospitals have contracts with the HMO.

The HMO's service area is comprised of the following counties: Brown, Calumet, Dodge, Door, Douglas, Dunn, Eau Claire, Fond du Lac, Green, Green Lake, Jefferson, Kenosha, Kewaunee, Manitowoc, Marinette, Menominee, Milwaukee, Oconto, Outagamie, Ozaukee, Pierce, Polk, Racine, Rock, Shawano, Sheboygan, St. Croix, Walworth, Washington, Waukesha, Waupaca, Waushara, and Winnebago.

The HMO offers comprehensive health care coverage, subject to riders for 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--\$5.00 copayment

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

There are no day limits for inpatient mental health, AODA coverage is limited to 10 days per calendar year, outpatient mental health and AODA coverage is limited to 30 visits per calendar year, transitional treatment arrangement coverage is limited to 14 visits per calendar year, home health care is limited to 60 visits per calendar year, and skilled nursing care is limited to 100 days per confinement. Emergency room co-pay is waived upon admission into an inpatient facility. Plan coverage is contingent on nonemergency services being provided by participating physicians and hospitals or on the referral of participating physicians.

The HMO also has a co-payment plan in which inpatient services have co-payments ranging from \$100 to \$500 per day for the first three days per admission. Office visits have co-payments ranging from \$5 to \$40 and emergency room visits have co-payments ranging from \$75 to \$150. Prescription drug coverage with specified amount of co-payments for generic and name brands can be added by rider. In addition, vision and hearing aid coverage can also be attached by rider. Members are required to choose a primary care physician from the listing of participating physicians available.

The HMO offers a national point-of-service (NPOS) product jointly with an affiliate, Humana Insurance Company (HIC). The HMO covers the direct in-network claims for a share of the products' direct premium. Beginning January 1, 2006, the HMO had ceded, on a 100% coinsurance basis, its direct portion to HIC through a reinsurance contract. As a result of the contract, 100% of the NPOS business was ultimately recorded on the financial statements of HIC. The reinsurance contract was terminated, effective October 1, 2010, when the two parties entered into a commutation agreement. Under the terms of the commutation agreement, the HMO received cash for taking back reserves previously ceded to HIC. Also, with the commutation in place, both the HMO and HIC retain their own proportionate share of the dual-party NPOS contracts. As a result, the HMO's financial results for the year ended December 31, 2010, include the impact of one full quarter of underwriting activity which was previously ceded.

The HMO currently markets to groups only using outside, independent agencies and pays first-year and renewal commissions based on Humana's Producer Partnership Plan which is in place at the effective date of the sale.

The HMO uses an actuarially determined base as a beginning point in premium determination. This rate is adjusted to reflect the age, sex, occupation, and coverage characteristics for new groups. Experience is reviewed for renewal groups and, based on the review, a recommendation is made regarding adjusting the rate or canceling the group (large groups with more than 51 employees only). The base rate is adjusted monthly for inflation and other trending factors.

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. Each member of the company's board of directors is a senior executive of the parent, Humana Inc., and is also a member of other boards of directors in the holding company group. The board members currently do not receive compensation for serving on the board.

Currently the board of directors consists of the following persons:

| Name and Residence | Principal Occupation | Term Expires |
|--|--|---------------------|
| Michael B. McCallister Louisville, KY | President & Chief Executive Officer, Humana Inc. | 2012 |
| James E. Murray Louisville, KY | Senior Vice President, Chief Operating Officer, Humana Inc. | 2012 |
| James H. Bloem Louisville, KY | Senior Vice President, Chief Financial Officer, Humana Inc. | 2012 |

Officers of the Company

Each senior executive officer of the company is also a senior executive officer of Humana Inc. and also serves as an officer in other legal entities within the holding company group. The company's executive officers are compensated by Humana Inc. and do not receive direct compensation remitted by the company. A portion of the executive officer compensation remitted by Humana Inc. to the company's executive officers is allocated to Humana Wisconsin Health Organization Insurance Corporation pursuant to intercompany expense allocation agreements. The company's senior executive officers serving at the time of this examination are as follows:

| Name | Office | 2010 Compensation |
|------------------------|--|------------------------------|
| Michael B. McCallister | President & Chief Executive Officer | \$2,891,673 |
| James H. Bloem | Senior VP, Chief Financial Officer and Treasurer | 1,244,378 |
| Joan O. Lenahan | Vice President & Corporate Secretary | 553,309 |
| Frank Amrine* | Appointed Actuary | 310,931 |

*Frank Amrine retired on June 30, 2011. Jonathan Canine is the current appointed actuary.

Committees of the Board

The company's bylaws allow for the formation of certain committees by the board of directors. There were no board member only committees at the time of the examination. The committees of the parent company, Humana Inc., perform comprehensive corporate governance oversight on behalf of each Humana Inc. operating subsidiary including Humana Wisconsin Health Organization Insurance Corporation. The Humana Inc. board of directors has the following committees: Audit, Executive, Investment, Nominating & Corporate Governance, and Organization & Compensation. Only directors meeting the Securities and Exchange Commission's (SEC) and the New York Stock Exchange's (NYSE) director independence standards may serve on the Audit Committee, the Nominating & Corporate Governance Committee and the Organization & Compensation Committee. Each member of the Audit Committee is an "audit committee financial expert" as defined by the SEC, and each is "financially literate" as defined by the NYSE.

The company does have a Quality Improvement Committee (QIC) consisting of members of management. The committee reports directly to the board of directors. The voting members of the QIC at the time of the examination are listed below:

- Phil Painter, Corporate Medical Director
- Thomas James, Medical Director, National Accounts
- Karen Feldkamp, Director, Corporate Quality & Accreditation
- Darlene Holzbach, Manager Corporate Quality
- Emilie Sims, Manager Accreditation
- Marla Sanders, Director Delegation Compliance
- Mike Funk, Director Provider Operations
- Shari Dillon, Director CIT
- Karen Wooldridge, Consultant Corporate Quality
- Lynne Schifreen, Manager Pharmacy Quality
- Sondra Harp, Manager, Grievances & Appeals
- Stilla McMahon, Director Provider Communications
- Mary Jane Branch, Regional Quality Director South
- Mary Weiss, Regional Quality Director West
- Susan Hoffman, Regional Quality Director South Florida
- Nancy Walsh, Regional Quality Director East
- Patrice Thor, Regional Quality Director Central
- Sue Suchan, Director Corporate Compliance

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:

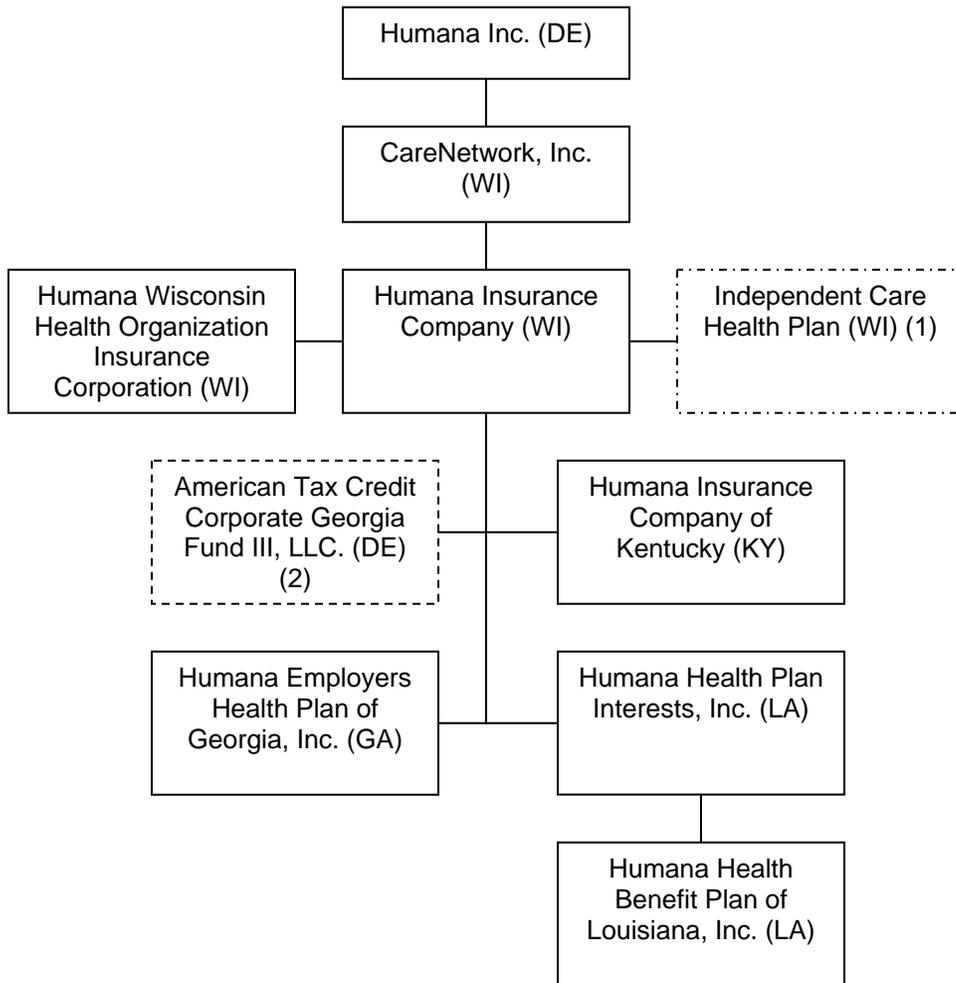
1. Enrollees hospitalized on the date of insolvency will be covered until discharged; and
2. Enrollees will be entitled to similar, alternate coverage which does not contain any medical underwriting or preexisting limitation requirements.

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

IV. AFFILIATED COMPANIES

The company is a member of a holding company system. As previously stated, its ultimate parent is Humana Inc. The abbreviated organizational chart below depicts the relationships among the affiliates in the direct succession of control of the company. A brief description of affiliates deemed significant follows the organizational chart.

**Holding Company Chart
As of December 31, 2010**



- (1) Ownership is 50% by CareNetwork, Inc., and 50% by New Health Services, Inc., an affiliate of Milwaukee Center for Independence, Inc., an unaffiliated entity.
- (2) Ownership is 58.1736% by Humana Insurance Company, 1.6029% by The Savannah Bank N.A., an unaffiliated entity, and 40.2133% by GMAC investment fund, organized for the purpose of investing in apartment complexes generating Georgia state low income housing tax credits.

Humana Inc.

Humana Inc. is an insurance holding company which provides indemnity insurance, managed health care insurance, and specialty service products through the operations of its subsidiary companies. Humana Inc. was incorporated on July 27, 1964, and is a Delaware corporation. Humana products are offered primarily through subsidiary life and health indemnity insurers, health maintenance organizations, and preferred provider organizations, and are marketed for employer groups, government benefit programs, and individuals.

As of December 31, 2010, the GAAP basis audited financial statements of Humana Inc. reported total assets of \$16.1 billion, total liabilities of \$9.2 billion, and total stockholders' equity of \$6.9 billion. Operations for 2010 produced net income of \$1.1 billion.

CareNetwork, Inc.

CareNetwork, Inc., is a non-operating intermediate holding company domiciled in Wisconsin which holds the assets of various Humana operating subsidiaries. CareNetwork, Inc., holdings include the Wisconsin-domiciled insurers Humana Insurance Company and Humana Wisconsin Health Organization Insurance Corporation.

As of December 31, 2010, the GAAP basis unaudited financial statements of CareNetwork, Inc., reported total assets of \$1,599,408,170, total liabilities of \$4,386,911, and total stockholders' equity of \$1,595,021,259. Operations for 2010 produced net income of \$1,139,210.

Humana Insurance Company

Humana Insurance Company, the largest insurance subsidiary of the group, is a Wisconsin-domiciled life and health insurer authorized to conduct insurance business pursuant to ch. 611, Wis. Stat. The company was initially organized December 18, 1968, under the name Classified Life Insurance Company (CLIC). After various changes in ownership and names, the company is now called Humana Insurance Company and directly owned by CareNetwork, Inc.

As of December 31, 2010, the statutory basis audited financial statements of Humana Insurance Company reported total admitted assets of \$4.9 billion, total liabilities of

\$2.3 billion, and policyholders' surplus of \$2.6 billion. Operations for 2010 produced net income of \$680.5 million.

Independent Care Health Plan

Independent Care Health Plan (I-Care) commenced business as a separate entity on June 18, 2003. CareNetwork, Inc., owns 50% and New Health Services, a subsidiary of Milwaukee Center for Independence, a 501(c)(3) nonprofit, owns 50%. I-Care members are all covered under Title XVIII (Medicare) or Title XIX (Medicaid) with a special emphasis on dual-eligible members.

As of December 31, 2010, the statutory basis audited financial statements of I-Care reported total admitted assets of \$68,780,512, total liabilities of \$50,532,073, and policyholders' surplus of \$18,248,439. Operations for 2010 produced net income of \$2,356,995.

Agreements with Affiliates

Indemnity Agreement between Humana WHO and Humana Inc.

Humana Wisconsin Health Organization Insurance Corporation and Humana Inc. entered into an indemnity agreement on June 30, 1995. Under the indemnity agreement, Humana Inc., the indemnitor, agrees to indemnify Humana WHO from any and all liability, loss, or damage. Humana WHO may suffer as a result of its failure to perform its obligations arising under certificates of coverage issued to its subscribers should the HMO become insolvent or financially incapable of furnishing such health care services. The indemnitor further guarantees continuation of coverage to subscribers for the duration of the contract period for which payment has been made, and continuation of benefits to the HMO's members who are confined on the date of insolvency in an inpatient facility until their discharge.

Tax Allocation Agreement between Humana WHO and Humana Inc.

Humana Wisconsin Health Organization Insurance Corporation is party to a Tax Allocation Agreement with Humana Inc. It became effective December 31, 1995. The agreement provides that Humana Inc. will file consolidated tax returns for all of the legal entities in the Humana Inc. holding company group, including Humana WHO. The consolidated tax liability for each year shall be apportioned to Humana Inc. and its subsidiaries based on applicable

provisions of the Internal Revenue Code, based on the ratio which the portion of consolidated tax liability attributable to each respective member of the group bears to the consolidated tax liability. Humana Inc. shall credit to each respective affiliate 100% of the excess of the affiliate's separate return tax liability over its allocated consolidated tax return liability. Humana Inc. is responsible for the preparation and filing of all consolidated tax return and any other returns or documents required to be filed with the Internal Revenue Service.

Corporate Service Agreement between Humana WHO and Humana Inc.

Humana Wisconsin Health Organization Insurance Corporation is party to a Corporate Service Agreement effective January 3, 2007. It has been amended May 14, 2009, June 1, 2009, and January 1, 2011, for regulatory compliance purposes. Humana Inc. provides services supporting the business operations of Humana WHO. Humana provides Humana WHO with services such as payroll, trade accounts payments, broker commissions, medical and product management, executive management, information systems, financial and legal services, human resource and sales distribution management, and related services. Humana Inc. receives a direct reimbursement for services with direct costs and a pro rata share of costs of shared services and overhead based upon weighted membership. The agreement provides that Humana Inc. collects funds due Humana WHO in the operation of its business and performs any necessary banking and accounting administrative duties to accomplish collections and disbursements of funds on behalf of Humana WHO.

Service Center Service Agreements between Humana WHO, HIC, and Humana Inc.

Humana Wisconsin Health Organization Insurance Corporation has established a service center service agreement with Humana Insurance Company and Humana Inc. as a repository effective January 3, 2007. It has been amended May 14, 2009, June 1, 2009, and January 1, 2011, for regulatory compliance purposes. The agreements provide that HIC will provide Humana WHO with claims processing, customer service, front-end operations, billing and enrollment, utilization review, and other support activities. HIC expenses allocated to Humana WHO include general business expenses incurred by HIC in performance of the services. Humana Inc. serves as the repository under the service center agreement, pursuant to which

Humana Inc. disburses and collects management fees that are required by the agreements, and performs any necessary banking and administrative duties required to accomplish its repository duties. The 2011 amendment also integrated some previously separate affiliate agreements into this agreement.

V. REINSURANCE

The company has reinsurance coverage under the contracts outlined below:

1. Reinsurer: Westport Insurance Corporation
- Type: Individual/Hospital Only/Other - Excess of Loss
- Effective date: January 1, 2010 (contracts are one year in length and are renewed annually)
- Retention: \$550,000 per member and agreement period plus excess retention of 10%, except for:
 - Transplant Services-Unscheduled which are subject to retention if they are in excess of the established limits per Schedule B
 - Inpatient Hospital Services consisting in transplant services will be subject to 10% retention if the average charge a day is \$3,000 or less, and 40% retention over the average charge a day
- Coverage: Hospital Services only (Inpatient Hospital Services, subacute facility services, skilled nursing facility services, hospice services, inpatient rehabilitation facility services, and home health care agency services) up to \$1,000,000 per member and lifetime in excess of \$550,000; plus 90% in excess of the company's retention of 10%, except for:
 - Transplant Services-Unscheduled which are subject to coverage if the charges are equal or less than the limits per Schedule B
 - Inpatient Hospital Services consisting in transplant services will be subject to 90% coverage if the average charge a day is \$3,000 or less, and 60% coverage over the average charge a day
- Limitations: \$2,000 average daily maximum for Inpatient Hospital Services
\$750 per day for subacute facility services and inpatient rehabilitation facility services
\$500 per day for skilled nursing facility services, hospice services and home health care agency services for a maximum of 30 days per agreement period
- Premium: \$0.11 per member and per month subject to a minimum of \$225,000 per agreement period
- Termination: December 31, 2010, or at any time with 30 days' advance notice

The reinsurance policy has an endorsement containing the following insolvency provisions:

The reinsurer will indemnify the reinsured, its liquidator, receiver or other statutory successor for loss pertaining to each commercial member:

1. whose health care premium applicable to a period of time after the reinsured's insolvency date was paid to the reinsured before the insolvency date, but only with respect to benefits incurred for services rendered after the insolvency date and prior to expiration of

- the period of time for which the member's premium was paid to the reinsured, not to exceed sixty (60) days from the date of insolvency;
2. who is confined to an inpatient facility as of the reinsured's insolvency date, but only with respect to benefits incurred for services rendered after the insolvency date and prior to whichever of the following takes place first:
 - a. the member is discharged from the inpatient facility;
 - b. the member becomes entitled to other health insurance coverage;
 - c. 60 days from the date of insolvency.

2. Reinsurer: White Mountains Reinsurance Company of America

Type: Commercial Excess of Loss – 3 contracts:

- a.) Fully-Insured Excess of Loss
- b.) Stop-Loss Excess of Loss
- c.) Stand-Alone Stop-Loss Excess of Loss

Effective date: October 1, 2010

Retention: \$2,000,000

Coverage: The company retains all risk on individual members up to the \$2 million attachment point. Risk transfers to White Mountains above the \$2 million attachment point, on an unlimited basis.

Premiums: The company pays a monthly reinsurance premium calculated on a MPPM basis, by contract, by reinsurance layer.

| | Fully-Insured | ASO | Stand-Alone |
|---------------------------------|----------------------|------------|--------------------|
| Layer 1 (\$3M XS of \$2M) | \$ 0.20 | \$ 0.22 | \$ 0.22 |
| Layer 2 (\$5M XS of \$3M) | 0.06 | 0.08 | 0.08 |
| Layer 3 (Unlimited XS of \$10M) | 0.05 | 0.05 | 0.05 |

Term: Effective until September 30, 2011.

VI. FINANCIAL DATA

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

Humana Wisconsin Health Organization Insurance Corporation
Assets
As of December 31, 2010

| | Assets | Nonadmitted Assets | Net Admitted Assets |
|---|----------------------------|-------------------------------|------------------------------------|
| Bonds | \$41,399,888 | \$ | \$41,399,888 |
| Cash, cash equivalents and short-term investments | 13,605,849 | | 13,605,849 |
| Securities lending reinvested collateral assets | 375,960 | | 375,960 |
| Investment income due and accrued | 372,802 | | 372,802 |
| Uncollected premiums and agents' balances in the course of collection | 541,520 | 5,564 | 535,956 |
| Current federal and foreign income tax recoverable and interest thereon | 2,483,365 | | 2,483,365 |
| Net deferred tax asset | 638,341 | 638,341 | 0 |
| Guaranty funds receivable or on deposit | | | |
| Electronic data processing equipment and software | 159,389 | 9,797 | 149,592 |
| Furniture and equipment, including health care delivery assets | 320,332 | 320,332 | 0 |
| Health care and other amounts receivable | 891,800 | | 891,800 |
| Aggregate write-ins for other than invested assets | <u>246,258</u> | <u>246,258</u> | <u>0</u> |
| Total Assets | <u>\$61,035,504</u> | <u>\$1,220,292</u> | <u>\$59,815,212</u> |

Humana Wisconsin Health Organization Insurance Corporation
Liabilities and Net Worth
As of December 31, 2010

| | | |
|--|---------------------|----------------------------|
| Claims unpaid | | \$18,023,100 |
| Unpaid claims adjustment expenses | | 146,722 |
| Aggregate health policy reserves | | 30,000 |
| Aggregate health claim reserves | | 23,000 |
| Premiums received in advance | | 902,840 |
| General expenses due or accrued | | 567,796 |
| Ceded reinsurance premiums payable | | 25,993 |
| Amounts due to parent, subsidiaries and affiliates | | 5,957,874 |
| Payable for securities lending | | 429,771 |
| Liability for amounts held under uninsured plans | | <u>3</u> |
| Total liabilities | | 26,107,099 |
| Common capital stock | \$ 13,635,500 | |
| Gross paid in and contributed surplus | 53,410,000 | |
| Unassigned funds (surplus) | <u>(33,337,387)</u> | |
| Total capital and surplus | | <u>33,708,113</u> |
| Total Liabilities, Capital and Surplus | | <u>\$59,815,212</u> |

Humana Wisconsin Health Organization Insurance Corporation
Statement of Revenue and Expenses
For the Year 2010

| | | |
|---|-------------------|---------------------|
| Net premium income | | \$176,843,655 |
| Total revenues | | |
| Medical and hospital: | | |
| Hospital/medical benefits | \$170,947,928 | |
| Other professional services | 1,819,067 | |
| Emergency room and out-of-area | 6,483,732 | |
| Prescription drugs | <u>14,794,882</u> | |
| Subtotal | 194,045,609 | |
| Less | | |
| Net reinsurance recoveries | <u>39,910,058</u> | |
| Total medical and hospital | 154,135,551 | |
| Claims adjustment expenses | 6,151,588 | |
| General administrative expenses | 14,576,755 | |
| Increase in reserves for life and accident and health contracts | <u>30,000</u> | |
| Total underwriting deductions | | <u>174,893,894</u> |
| Net underwriting gain or (loss) | | 1,949,761 |
| Net investment income earned | 1,505,353 | |
| Net realized capital gains or (losses) | <u>(48,439)</u> | |
| Net investment gains or (losses) | | <u>1,456,914</u> |
| Net income or (loss) before federal income taxes | | 3,406,675 |
| Federal and foreign income taxes incurred | | <u>(2,684,018)</u> |
| Net Income (Loss) | | <u>\$ 6,090,693</u> |

Humana Wisconsin Health Organization Insurance Corporation
Capital and Surplus Account
As of December 31, 2010

| | | |
|--|--------------|---------------------|
| Capital and surplus prior reporting year | | \$31,603,717 |
| Net income or (loss) | \$ 6,090,693 | |
| Net unrealized capital gains and losses | (23,483) | |
| Change in net deferred income tax | (3,729,629) | |
| Change in nonadmitted assets | (235,540) | |
| Aggregate write-ins for gains or (losses) in surplus | <u>2,355</u> | |
| Net change in capital and surplus | | <u>2,104,396</u> |
| Capital and Surplus End of Reporting Year | | <u>\$33,708,113</u> |

Humana Wisconsin Health Organization Insurance Corporation
Statement of Cash Flows
As of December 31, 2010

| | | |
|--|--------------------|----------------------|
| Premiums collected net of reinsurance | | \$175,068,744 |
| Net investment income | | <u>1,662,660</u> |
| Total | | 176,731,404 |
| Less: | | |
| Benefit- and loss-related payments | \$156,231,185 | |
| Commissions, expenses paid and aggregate write-ins for deductions | 14,793,678 | |
| Federal and foreign income taxes paid (recovered) | | |
| \$0 net tax on capital gains (losses) | <u>(2,710,100)</u> | |
| Total | | <u>168,314,763</u> |
| Net cash from operations | | 8,416,641 |
| Proceeds from investments sold, matured or repaid: | | |
| Bonds | \$ 7,286,192 | |
| Net gains (losses) on cash, cash equivalents, and short-term investments | <u>(438)</u> | |
| Total investment proceeds | | 7,285,754 |
| Cost of investments acquired - long-term only: | | |
| Bonds | <u>11,178,459</u> | |
| Total investments acquired | | <u>11,178,459</u> |
| Net cash from investments | | (3,892,705) |
| Cash provided/applied: | | |
| Capital and paid in surplus, less treasury stock | 2,355 | |
| Other cash provided (applied) | <u>(6,106,438)</u> | |
| Net cash from financing and miscellaneous sources | | <u>(6,104,083)</u> |
| Net change in cash, cash equivalents, and short-term investments | | (1,580,147) |
| Cash, cash equivalents, and short-term investments: | | |
| Beginning of year | | <u>15,185,996</u> |
| End of year | | <u>\$ 13,605,849</u> |

Growth of Humana Wisconsin Health Organization Insurance Corporation

| Year | Assets | Liabilities | Capital and Surplus | Premium Earned | Medical Expenses Incurred | Net Income |
|-------------|---------------|--------------------|----------------------------|-----------------------|----------------------------------|-------------------|
| 2010 | \$59,815,212 | \$26,107,099 | \$33,708,113 | \$176,843,655 | \$154,135,551 | \$ 6,090,693 |
| 2009 | 57,935,621 | 26,331,904 | 31,603,717 | 151,625,446 | 136,464,344 | 223,373 |
| 2008 | 56,450,641 | 24,676,021 | 31,774,620 | 145,349,096 | 114,598,957 | 755,184 |
| 2007 | 42,866,926 | 31,246,473 | 11,620,453 | 242,098,006 | 236,587,503 | (7,750,865) |
| 2006 | 43,303,692 | 17,982,570 | 25,321,122 | 173,760,235 | 154,219,434 | 6,611,255 |
| 2005 | 67,744,800 | 27,830,088 | 39,914,712 | 240,694,705 | 207,093,228 | 9,979,814 |

| Year | Profit Margin | Medical Expense Ratio | Administrative Expense Ratio | Change in Enrollment |
|-------------|----------------------|------------------------------|-------------------------------------|-----------------------------|
| 2010 | 3.4% | 87.2% | 11.7% | (17.8)% |
| 2009 | 0.1 | 90.0 | 13.4 | 11.6 |
| 2008 | 0.5 | 78.8 | 16.9 | (18.2) |
| 2007 | (3.2) | 97.7 | 7.5 | 58.9 |
| 2006 | 3.8 | 88.8 | 7.4 | (30.8) |
| 2005 | 5.4 | 86.0 | 8.5 | (29.8) |

Enrollment and Utilization

| Year | Enrollment | Hospital Days/1,000 | Average Length of Stay |
|-------------|-------------------|----------------------------|-------------------------------|
| 2010 | 44,595 | 198.42 | 3.5 |
| 2009 | 54,270 | 229.08 | 3.8 |
| 2008 | 48,635 | 212.71 | 3.5 |
| 2007 | 59,422 | 240.69 | 3.5 |
| 2006 | 37,399 | 233.00 | 3.5 |
| 2005 | 54,053 | 245.20 | 3.7 |

Per Member Per Month Information

| | 2010 | 2009 | Percentage Change |
|--|------------------------|------------------------|----------------------|
| Premiums: | | | |
| Commercial | \$322.11 | \$229.02 | 40.6% |
| Expenses: | | | |
| Hospital/medical benefits | 311.37 | 298.65 | 4.3 |
| Other professional services | 3.31 | 3.92 | -15.5 |
| Emergency room and out-of-area | 11.81 | 11.72 | 0.8 |
| Prescription drugs | 26.95 | 25.42 | 6.0 |
| Less: Net reinsurance recoveries | <u>72.69</u> | <u>133.58</u> | -45.6 |
| Total medical and hospital | 280.75 | 206.12 | 36.2 |
| | | | |
| Claims adjustment expenses | 11.20 | 4.47 | 150.5 |
| General administrative expenses | 26.55 | 26.11 | 1.7 |
| Increase in reserves for accident and health contracts | <u>0.05</u> | <u>(9.56)</u> | -100.6 |
| Total Underwriting Deductions | <u>\$318.56</u> | <u>\$227.14</u> | 40.2 |

During the period under examination, the HMO's admitted assets decreased 12%, premiums earned decreased 27%, and surplus decreased by 16%.

The decline in enrollment during 2006 was a result of renewing member groups electing to enroll in consumer-choice Preferred Provider Organization projects as well as ASO products offered by an affiliated insurer. The increase in enrollment in 2007 was due to increase in commercial membership and increase in premium rates.

The 2007 medical loss ratio was unusually high due to a final hospital stay of a single patient which resulted in significant incurred expenses during the fourth quarter of 2007.

Change in surplus was a result of dividends of \$31 million paid to Humana Insurance Company during the examination period and poor underwriting results in 2007, primarily offset by capital contributions of \$20 million by Care Network, Inc., in 2008 and positive underwriting results in years other than 2007.

The HMO writes predominantly short tailed health business; as such, the HMO's investment portfolio is conservatively managed with an emphasis on high-quality, liquid holdings which provide a reasonable return.

Reconciliation of Capital and Surplus per Examination

No adjustments were made to surplus as a result of the examination. The amount of surplus reported by the company as of December 31, 2010, is accepted.

VII. SUMMARY OF EXAMINATION RESULTS

Compliance with Prior Examination Report Recommendations

There were three 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 recommended that the board of directors review the financial performance of the corporation and maintain meeting minutes to document the board's active governance in accordance with s. 611.51 (6), Wis. Stat.

Action—Compliance

2. Agent Listing—It is recommended that the HMO establish and implement procedures to ensure that its agent listing is complete and accurate.

Action—Compliance

3. Claims Unpaid—It is again recommended that the HMO correctly fill out Exhibit 4 – Claims Unpaid and Incentive Pool, Withhold and Bonus (Reported and Unreported) according to NAIC Annual Statement Instructions – Health.

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.

Security Lending

The company participates in Humana's security lending program. The review determined that the collateral descriptions in Schedule DL – Part 1 are incorrect and do not properly report the CUSIP numbers for each security. It is recommended that the company provide an accurate description and properly report CUSIP numbers for each security on Schedule DL – Part 1.

Financial Requirements

The financial requirements for an HMO under s. Ins 9.04, Wis. Adm. Code, are as follows:

| | Amount Required |
|---|--|
| 1. Minimum capital or permanent surplus | Either: \$750,000, if organized on or after July 1, 1989 or \$200,000, if organized prior to July 1, 1989 |
| 2. Compulsory surplus | The greater of \$750,000 or: If the percentage of covered liabilities to total liabilities is less than 90%, 6% of the premium earned in the previous 12 months; If the percentage of covered liabilities to total liabilities is at least 90%, 3% of the premium earned in the previous 12 months |
| 3. Security surplus | The greater of: 140% of compulsory surplus reduced by 1% of compulsory surplus for each \$33 million of additional premiums earned in excess of \$10 million or 110% of compulsory surplus |

Covered liabilities are those due to providers who are subject to statutory hold-harmless provisions.

The company's calculation as of December 31, 2010, as modified for examination

adjustments is as follows:

| | | |
|--|---------------|---------------------|
| Assets | \$ 59,815,212 | |
| Less: | | |
| Special deposit | 3,013,553 | |
| Liabilities | 26,107,099 | |
| Examination adjustments | <u>0</u> | |
| Assets available to satisfy surplus requirements | | \$30,694,560 |
| Net premium earned | 176,843,655 | |
| Compulsory factor | <u>3%</u> | |
| Compulsory surplus | | <u>5,305,310</u> |
| Compulsory Surplus Excess/(Deficit) | | <u>\$25,389,250</u> |
| Assets available to satisfy surplus requirements | | \$30,694,560 |
| Compulsory surplus | \$ 5,305,310 | |
| Security factor | <u>140%</u> | |
| Security surplus | | <u>7,427,434</u> |
| Security Surplus Excess/(Deficit) | | <u>\$23,267,126</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 written in this state in the preceding calendar year;
2. One-third of 1% of premium written in this state in the preceding calendar year.

The company has satisfied this requirement for 2010 with a deposit of \$3,013,553 with the State - Controller.

VIII. CONCLUSION

Humana WHO is a wholly owned subsidiary of CareNetwork, Inc., a Wisconsin corporation which is a wholly owned subsidiary of Humana Inc. The company offers coordinated health and pharmacy insurance products, primarily to employer groups, through a variety of product options including HMO and preferred provider organizations.

During the period under examination, the HMO's admitted assets decreased 12%, premiums earned decreased 27%, and surplus decreased by 16%. Change in surplus was a result of dividends of \$31 million paid to Humana Insurance Company during the examination period and poor underwriting results in 2007, primarily offset by capital contributions of \$20 million by Care Network, Inc., and positive underwriting results in years other than 2007.

The examination determined that the company was in compliance with all of the recommendations made by the previous examination. The current examination resulted in one recommendation. No adjustments were made to surplus as a result of the examination. The amount of surplus reported by the company as of December 31, 2010, is accepted.

IX. SUMMARY OF COMMENTS AND RECOMMENDATIONS

1. Page 25 - Security Lending—It is recommended that the company provide an accurate description and properly report CUSIP numbers for each security on Schedule DL – Part 1.

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 |
|------------------|------------------------------|
| Russell Lamb | Insurance Financial Examiner |
| David Jensen | Insurance Financial Examiner |
| Sheena Basra | Insurance Financial Examiner |
| Amanda Schroeder | Insurance Financial Examiner |
| Randy Milquet | IT Specialist |
| Jerry DeArmond | Reserve Specialist |

Respectfully submitted,

Rick Anderson
Examiner-in-Charge

**XI. ADDENDUM I – PHYSICIAN HOSPITAL ORGANIZATIONS,
INDEPENDENT PROVIDER ASSOCIATIONS, AND GROUPS**

Affinity Medical Group
Agnesian Health System
Aurora Advanced
Aurora Health Care
Baycare Clinic LLP
Bellin Medical Group
Beloit PHO
Children’s Health System
Columbia St. Mary’s
Community Health Network
Fort Healthcare
Froedtert Health Medical Group
Holy Family Memorial Clinics
Lakeshore Medical Clinic
Marshfield Clinic
Mayo Health System
Medical College of WI
Mercy Health System
Ministry Medical Group
Monroe Clinic
NEWHVN
North Shore Health Network
Oakleaf Medical Network
Physician’s Health Network
Prevea Clinic
Progressive Physician Network
ProHealth Care Medical Associates
St. Croix Regional
St. Mary’s Duluth Clinic
ThedaCare Physicans
United Hospital System Clinics
Watertown PHO
Waukesha Elmbrook Health Care
West Bend Clinic
Western Wisconsin Medical Association
Wheaton Medical Group
Wisconsin Health Fund

XII. ADDENDUM II - HOSPITALS

Amery Regional Medical Center
Appleton Medical Center
Aurora BayCare Medical Center
Aurora Burlington
Aurora Kenosha
Aurora Lakeland
Aurora Medical Center – Manitowac City
Aurora Medical Center – Washington County
Aurora Medical Center of Oshkosh
Aurora Sheboygan Memorial Medical Center
Aurora St. Luke's
Aurora Summit
Baldwin Area Medical Center
Bay Area Medical Center
Beaver Dam Community Hospital
Bellin Memorial Hospital
Beloit Memorial Hospital
Berlin Memorial Hospital
Calumet Medical Center
Children's Hospital of Wisconsin
Columbia Center
Columbia St. Mary's Hospital Milwaukee
Columbia St. Mary's Hospital Ozaukee
Community Memorial Hospital
Door County Memorial Hospital
Fort Atkinson Memorial Hospital
Froedtert Memorial Luthern Hospital
Holy Family Memorial
Hudson Hospital and Clinics
Luther Hospital – Mayo Health System
Mercy Hospital Janesville
Mercy Medical Center of Oshkosh
Midwest Orthopedic Specialty Hospital
Monroe Clinic
New London Family Medical Center
Oak Leaf Surgical Hospital
Oconomowoc Memorial Hospital
Oconto Hospital and Medical Center
Orthopedic Hospital of Wisconsin
Osceola Medical Center
Red Cedar Medical Center – Mayo Health System
Ripon Medical Center
River Falls Area Hospital
Riverside Medical Center
Sacred Heart Hospital
Sacred Heart Rehabilitation Institute
Shawano Medical Center
St. Agnes Hospital
St. Croix Regional Medical Center
St. Elizabeth Hospital
St. Joseph's Hospital
St. Mary's Hospital of Superior

St. Nicholas Hospital
St. Vincent Hospital
Theda Clark Medical Center
UHS Kenosha Medical Center Campus
Watertown Regional Medical Center
Waukesha Memorial Hospital
Waukesha Rehabilitation Hospital
Waupun Memorial Hospital
West Allis Memorial Hospital
Westfields Hospital
Wheaton Franciscan Healthcare – All Saints
Wheaton Franciscan Healthcare – Elmbrook Memorial
Wheaton Franciscan Healthcare – Franklin
Wheaton Franciscan Healthcare – St. Francis
Wheaton Franciscan Healthcare – St. Joseph
Wild Rose Community Memorial Hospital