

Report
of the
Examination of
The Medical Associates Clinic Health Plan of Wisconsin
Dubuque, Iowa
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

Wisconsin.gov

December 18, 2014

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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:

THE MEDICAL ASSOCIATES CLINIC HEALTH PLAN OF WISCONSIN
Dubuque, Iowa

and this report is respectfully submitted.

I. INTRODUCTION

The previous examination of The Medical Associates Clinic Health Plan of Wisconsin (the company or the HMO) was conducted in 2011 as of December 31, 2010. 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 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 Medical Associates Clinic Health Plan of Wisconsin is described as a nonprofit group 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 group model, the company contracts with a sponsoring clinic to provide primary and specialist services. HMOs compete with traditional fee-for-service health care delivery.

The company was incorporated October 25, 1983, and commenced business on January 1, 1985. The company is controlled by Medical Associates Clinic Professional Corporation (the Clinic), an Iowa Professional Corporation which is the HMO's sponsoring clinic and founder.

The HMO contracts with the Medical Associates Clinic, P.C., to provide primary and specialty health care services to its members. These services are provided to the HMO's members through physicians affiliated with the Clinic. The Clinic, in turn, contracts with participating providers (hospitals, clinics, and other participating providers) for services not available through the Clinic and to ensure provider access in other parts of the HMO's service area. As compensation for these services, the company pays the Clinic a percentage of the premium it receives, which effectively transfers most of the risk to the Clinic. Further details of this agreement are discussed in the "Affiliated Companies" section of this report. In addition, the Clinic currently contracts with the following participating clinics for primary care physicians on behalf of the company:

- Argyle Clinic
- Upland Hills Health Clinic (Dodgeville, Highland and Montfort)
- Family Health of Lafayette County
- Crossing Rivers Health Clinic (Prairie du Chien and Fennimore)
- Lancaster Family Medical Center
- Mineral Point Medical Center
- Gundersen Boscobel Area Hospital and Clinics
- Dodgeville Medical Center
- Family Medicine Associates
- High Point Family Medicine
- Drs. Maski & Maski
- Regional Family Health
- Women's Wellness Center

Provider contracts include hold-harmless provisions for the protection of policyholders. After the initial term, the contracts are automatically renewable and may be terminated without cause upon 90 days' prior notice or with cause upon 30 - 60 days' prior written notice.

The provider network for the HMO consists of 153 primary care physicians and 181 specialty care physicians providing care on a 24-hour basis. Members may go to any physician on the provider list, including specialists. If the member has to see a physician outside of the HMO's network, an authorized referral is needed. In many instances, the referring physician will obtain the referral for the subscriber. However, it is the subscriber's responsibility to ensure that a referral is obtained.

The Clinic contracts with 15 hospitals to provide inpatient services. Hospitals are typically reimbursed on a discounted fee-for-service basis. The contracts include hold-harmless provisions for the protection of policyholders. The following is a listing of hospitals the Clinic contracts with:

Central Community Hospital	Mercy Medical Center – Dyersville
Finley Hospital	Memorial Hospital of Lafayette County
Grant Regional Health Center	Midwest Medical Center
Gundersen Boscobel Area Hospital and Clinics	Prairie du Chien Memorial Hospital
Guttenberg Municipal Hospital	Regional Medical Center
Jackson County Regional Health Center	Southwest Health Center
Jones Regional Medical Center	Upland Hills Health
Mercy Medical Center – Dubuque	

According to its business plan, the company's service area is comprised of the following counties: Crawford, Grant, Iowa, and Lafayette.

The HMO 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—various copayments
- 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 alcohol and other drug abuse (AODA) coverage requires Prior Approval from the HMO. Medication management services do not require prior approval with a network provider. Emergency services have a copayment, which is waived upon admission into an inpatient facility. Skilled nursing care is limited to 100 days per confinement. All inpatient mental health and AODA services, except emergencies, require prior approval to receive treatment (including durable medical equipment, prosthetic appliances, and artificial limb purchases or rentals that exceed \$500). Coverage is contingent on nonemergency services being provided by in-network physicians and hospitals or on the referral of in-network physicians. The company also has various benefit plans in which inpatient services have copayments, coinsurance and deductibles subject to various out-of-pocket maximums.

The company currently markets to groups for non-Medicare coverage and to individuals for coverage under its Medicare cost contract. The company uses internal sales staff and outside agencies and pays a commission on new and renewal business. Commission payments for new and renewal business are as follows:

New Groups:

Small (50 or less eligible enrollees)

3 or less contracts enrolled: 4% of first \$200,000; 1.5% above \$200,000

4 or more contracts enrolled: 6% of first \$200,000; 1.5% above \$200,000

Large (51 or more eligible enrollees)

5% for the first \$200,000; 3% above \$200,000

Renewal Groups:

Small and Large

4% of first \$200,000 and 1.5% of premium above \$200,000

Medicare:

Members that are New to Medicare (paid lump sum the first effective month and no additional commissions are paid in subsequent months)

	2013 - 2014
All Plans	\$216.00

New Members from other plans for first year (paid per month and year defined as calendar year – 2013 change)

	2013 - 2014	2010 - 2012	2009	2008
WI Smart	\$18.00	\$16.17	\$15.98	\$14.10
WI CHP	18.00	18.67	18.53	16.35
WI Freedom	18.00	20.42	20.23	17.85

Transferring (Renewal) Members/New Members after first year (paid per month)

	2013 - 2014	2010 - 2012	2009	2008
WI Smart	\$9.00	\$ 8.09	\$ 7.99	\$15.98
WI CHP	9.00	9.34	9.27	16.35
WI Freedom	9.00	10.21	10.12	17.85

2013 change: All transfers for Medicare are considered elections so the commission changes to the renewal rate for the year the transfer was made.

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

III. MANAGEMENT AND CONTROL

Board of Directors

The board of directors consists of nine members. Directors are elected to serve a three-year term. Officers are elected by the board of directors annually. Members of the company's board of directors may also be members of other boards of directors in the holding HMO group. The board members currently receive \$300 per meeting for serving on the board. The Chairman of the board is paid \$5,000 annually.

Executive Committee members receive \$300 per meeting, while Investment Committee and Audit Committee members are paid \$200 per meeting. Grievance Committee members are paid \$50 per meeting, except for physicians who are paid \$100 per meeting.

Currently the board of directors consists of the following persons:

Name and Residence	Principal Occupation	Term Expires
Andrea Ries, M.D. Dubuque, IA	Physician - Medical Associates Clinic, P.C.	3/31/2015
Mark Janes, M.D. Dubuque, IA	Physician - Medical Associates Clinic, P.C.	3/31/2015
Patrick Dillon East Dubuque, IL	Retired Laborer	3/31/2015
Brad McClimon, M.D. Dubuque, IA	Physician	3/31/2017
Ryan Stille, M.D. Asbury, IA	Physician	3/31/2017
Laurie Garms, M.D. Dubuque, IA	Physician - Medical Associates Clinic, P.C.	3/31/2017
Lawrence Kukla, M.D. Dubuque, IA	Physician - Medical Associates Clinic, P.C.	3/31/2016
Joann Lueken Dubuque, IA	Retired Dubuque Community Schools	3/31/2017
Jan Hess Dubuque, IA	Retired County Employee	3/31/2016

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 Salary¹
Andrea Ries, M.D.	Chairman	\$5,000
Mark Janes, M.D.	Vice Chairman	2,200
Patrick Dillon	Secretary/Treasurer	2,500

Committees of the Board

The company's bylaws allow for the formation of certain committees by the board of directors. The committees at the time of the examination are listed below:

Executive Committee

Andrea Ries, M.D., Chairman
Mark Janes, M.D.
Patrick Dillon

Investment Committee

Mark Janes, M.D., Chair
Brad McClimon, M.D.
Jan Hess

Audit Committee

Lawrence Kukla, M.D., Chair
Laurie Garms, M.D.
Patrick Dillon

Nominating Committee

Andrea Ries, M.D., Chair
Laurie Garms, M.D.
Joann Lueken

Grievance Committee

Laura Boge, Chair
Member Services Manager

The Grievance Committee has eleven voting members and one nonvoting member who is the chair of the committee. Only the Chief Operating Officer of the HMO and two committee members are needed for a hearing.

The company has no employees. Necessary staff is provided through a management agreement with Medical Associates Clinic. Under the agreement, effective January 1, 2012, the Executive Director of the company, with concurrence of the Board of Directors, shall establish the yearly budget setting forth the personnel required to staff the HMO. The personnel under this agreement will maintain accounting and financial records, recruits, marketing, utilization review, claims processing personnel, member services, and IT. Medical Associates Clinic receives 135% of the combined compensation or percentage of base salary attributable to all persons assigned to the HMO, which approximately covers employee benefits

¹ Andrea Ries and Mark Janes are paid and employed by the Medical Associates Clinic, P.C.

and payroll taxes in addition to salary. The detail of this agreement is discussed in the “Affiliated Companies” section of this report. The agreement is continuous and may be terminated by either party upon 60 days' prior written notice to the other.

Insolvency Protection for Policyholders

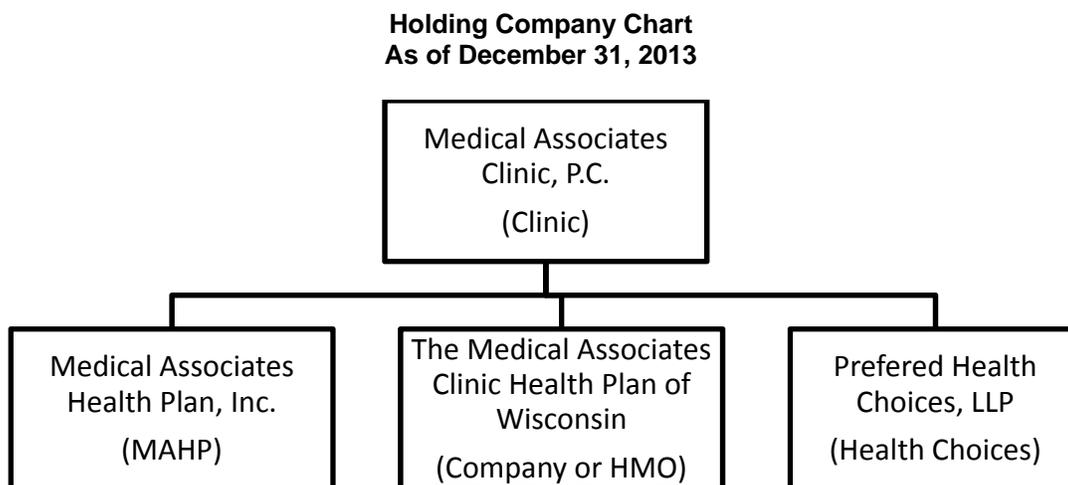
Under s. Ins 9.04 (6), Wis. Adm. Code, HMOs are required to either maintain compulsory surplus at the level required by s. Ins 51.80, Wis. Adm. Code, or provide for the following in the event of the company's insolvency:

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. Its ultimate parent is Medical Associates Clinic, P.C. The organizational chart below depicts the relationships among the affiliates in the group. A brief description of the significant affiliates of the company follows the organizational chart.



Medical Associates Clinic, P.C.

Medical Associates Clinic, P.C. (the Clinic) is an Iowa professional service corporation operating as a private multi-specialty and family practice medical group. As of December 31, 2013, the company's audited financial statement reported assets of \$50,040,584, liabilities of \$15,024,867, and equity of \$35,015,717. Operations for 2013 produced net income of \$2,878,194 on revenues of \$140,897,466.

The Clinic received or accrued approximately \$28,423,791 in capitation revenue in 2013, under the service agreement with the company as discussed below in "Affiliated Agreements." The company uses the management services of the Clinic and shares administrative services with the Medical Associates Health Plan, Inc. For the year-ended 2013, the total revenue for reimbursement of indirect expenses and management fees from the company was approximately \$1,234,467.

Medical Associates Health Plan, Inc.

Medical Associates Health Plan, Inc. (MAHP) is an Iowa corporation organized as a for-profit company for the purpose of providing comprehensive health care services to subscribers on a prepaid basis. As of December 31, 2013, the company's audited financial statement reported assets of \$31,103,921, liabilities of \$9,863,602, and capital and surplus of \$21,240,319. Operations for 2013 produced net income of \$3,104,969 on revenues of \$117,009,050.

A substantial portion of MAHP's operations are transacted with the Clinic. As discussed below in "Affiliated Agreements," MAHP contracts with the Clinic for the provision of certain health care services to its members. The total amount of capitation paid and accrued to the Clinic during the years 2013 and 2012 was \$42,765,467 and \$39,991,653, respectively. MAHP also has entered into contracts with the Clinic to provide management services. The total amounts paid in 2013 and 2012 for these services were \$4,631,052 and \$4,724,183, respectively.

Preferred Health Choices, LLP

Preferred Health Choices, LLP (Health Choices) is a third-party administrator (TPA) established to provide dental and short-term disability claims, COBRA and flexible spending for self-funded clients. As of December 31, 2013, the company's audited financial statement reported assets of \$1,020,341, liabilities of \$412,686, and members' equity of \$607,655. Operations for 2013 produced net income of \$36,973 on revenues of \$1,207,052.

MAHP arranges for all of the staff necessary to carry out the functions of the TPA. Expenses that are directly related to Health Choices or its programs are charged directly to Health Choices. All other costs are allocated based upon the ratio of persons covered by the plans administered by Health Choices to the total number of persons enrolled by MAHP and Health Choices. Settlement of these expenses is to be on a monthly basis. MAHP participates with the company and Health Choices in sharing indirect administrative costs. Costs not directly attributable to an entity are charged to each based on agreed-upon cost allocation ratios. For the years ended December 31, 2013 and 2012, the net indirect expenses paid under the cost allocation agreements were \$1,607,556 and \$1,694,712, respectively.

Affiliated Agreements

Below is a summary of affiliated agreements in effect at the time of the examination.

Administrative Agreement between the Clinic and MAHP

MAHP has an administrative agreement with the Clinic whereby the Clinic provides all necessary staff to carry out the operations of MAHP and the company. Under the agreement, originally effective August 1, 1996, as amended on January 1, 2012, the Clinic provides all the staff necessary to carry out the administration of the company consisting of bookkeeping, payroll, accounting, and other functions for the company and the effective operations of MAHP. The agreement between the Clinic and MAHP allocates 100% of these costs to MAHP whereas the company has an administrative services (cost allocation) agreement with MAHP for the sharing of these costs. As compensation for these services, the Clinic is reimbursed a sum equal to 135% of the combined base compensation of all persons assigned to MAHP, as well as a specified percentage of the salaries of key positions that have significant portions of their time attributable to HMO business (i.e., CEO, CFO, Director of Human Resources, Medical Director, IT Director, etc.). This agreement is continuous and may be terminated by either party upon 60 days' prior written notice to the other.

Administrative (Cost Allocation) Agreement between the Company and MAHP

The company and MAHP are both staffed by the same personnel (employed by the Clinic) and share common administrative costs (pursuant to the administrative services agreement between the Clinic and MAHP, as discussed above). The purpose of this agreement is to equitably allocate these common administrative costs, as well as shared facilities/overhead costs, between the two HMOs. The agreement allocates these shared costs between the two HMOs based on the percentage of gross premium revenue of each plan to the total combined gross premium revenue for each month. The agreement is continuous and may be terminated by either party upon 60 days' prior written notice to the other.

AMISYS System Agreement between the Company and MAHP

MAHP owns the AMISYS computer system software. The company owns the AMISYS system hardware. The purpose of this agreement is to allocate the cost of the hardware and software equitably between the two HMOs. The agreement allocates the amortization and depreciation costs of the AMISYS system between the two HMOs based on the percentage of gross premium revenue of each HMO to the total combined gross premium revenue for each month.

Service Agreement between the Company and the Clinic

The company has a service agreement with the Clinic whereby the Clinic provides or arranges for all authorized medical services to the company's enrollees through Clinic physicians and other contracted participating providers. As compensation for these services, the company pays the Clinic a percentage of the monthly premium it receives from employer groups, individuals, and the Centers for Medicare and Medicaid Services (CMS). The percentage of premium is calculated annually, based on the prior year's actual claims experience with anticipated medical trend and projected premiums. The premium used in the calculation is the company's retained portion of the risk, per the Reinsurance Agreement discussed below, and projected administrative costs. The percentage of premium may be adjusted quarterly if the actual claims experience varies by more than 5% of estimated claims experience on a Per Member/ Per Month (PMPM) basis. As of November 1, 2011, the Self-Insurance agreement between the company and the Clinic was terminated.

Reinsurance Agreement between the Company and the Clinic

The company entered into an agreement with the Clinic that requires the HMO to enter into a reinsurance contract with an established insurance carrier for provision of reinsurance coverage for inpatient hospital claims incurred by enrollees of the plan which are in excess of the specified deductible amount. In conjunction with the company's Service Agreement with the Clinic, the Clinic has requested the company to provide reinsurance for inpatient hospital claims incurred by the company's non-Medicare enrollees. This agreement requires the company to purchase reinsurance for the benefit of the Clinic, which will pay up to 90% of the amount paid by

the Clinic for inpatient hospital services provided to any non-Medicare enrollee of the company in excess of \$300,000 for any contract year.

CMS Over/Underpayment Agreement between the Company and the Clinic

The Clinic has entered into a service agreement to provide medical services to the company's enrollees (discussed above). The company administers a Medicare cost-reimbursement program under a contract with CMS. Payments made by CMS are based on actual costs relating to such medical care and treatment. When payments are made by CMS, it is not always possible to ascertain whether the payments are greater or less than the actual cost of the services provided. The purpose of this agreement is to clarify each party's obligations with respect to CMS over/underpayments, as discussed below:

1. In the event that CMS has made excess payments to the company for medical and hospital services provided by the Clinic to the company's Medicare enrollees, the Clinic agrees to reimburse CMS for any excess payments and to indemnify and hold the company harmless for any excess payments.
2. In the event that CMS has underpaid the company for medical and hospital services provided by the Clinic to the company's Medicare enrollees, the company will promptly reimburse the Clinic for reimbursements of underpayments made by CMS to the company.

V. REINSURANCE

The company has reinsurance coverage under the contract outlined below:

Reinsurer:	HM Life Insurance Company
Type:	Specified Excess of Loss Reinsurance
Effective date:	January 1, 2014, through December 31, 2014
Retention:	\$300,000 Per Member Per Agreement Year, plus 10% of any excess
Coverage:	The reinsurer pays 90% of eligible expenses after retention
Eligible expenses:	Incurred during the agreement year Paid and reported by the company within six months following the agreement year Submitted within seven months following the agreement year
Retention:	\$300,000 Per Member Per Agreement Year
Reinsurance limits:	None
Coinsurance:	The amount paid by the reinsurer for eligible expenses, after retention, and subject to the reinsurance limits: <ul style="list-style-type: none">• 90% for services other than transplant• 90% for approved transplants• 50% for non-approved transplants
Premium:	\$3.92 Per Commercial HMO and POS Member Per Month
Termination:	Reinsurer may terminate the agreement upon occurrence of: <ol style="list-style-type: none">a) nonpayment of premium,b) the company acquiring the assets and liabilities of any other company, corporation or foundation, or is acquired, come under the control of, or merged with any other company, corporation or foundation,c) the company is ordered by the department of insurance or other legal authority to cease writing business that is reinsured under this agreement,d) the company is placed into liquidation or receivership,e) the number of members has declined by 50% or more from the number that was in effect at the inception of the agreement, orf) the date of Insolvency

The reinsurance policy has an endorsement containing the following insolvency provisions, subject to an aggregate maximum liability of \$5,000,000 and in no case will less than \$500,000 be available to the company.

Insolvency Provision

In the event of insolvency, the company or its legal representative shall notify member(s), and/or health care providers of this provision obligating the reinsurer to reimburse expenses incurred by member(s) on the basis of the terms and conditions of the policies of coverage without limitation of the reinsurance agreement

1. Reinsurer will continue benefits covered under the applicable reinsured policy(ies) of coverage with respect to expenses incurred by member(s) confined in a hospital or any other eligible inpatient facility on the date of insolvency until the earliest of:
 - I. The member(s) discharge from the hospital; or
 - II. The date member(s) becomes covered for health coverage or benefits under another group or blanket policy or plan or any federal, state, or local governmental plan or program. The reinsurer shall pursue any coordination of benefits, subrogation or any other right of recovery that may be available to reinsurer as a result of member(s) being covered under two or more health care policies or plans; or
 - III. Three hundred and sixty five (365) days from the date of insolvency.
2. Reinsurer will continue benefits for members with respect to expenses incurred for medical services or treatment received after the date of insolvency (including services rendered to members who were confined on the date of insolvency but subsequently discharged from the hospital) until the end of the period for which premium was received by the company for members prior to the date of insolvency but not to extend beyond the end of the calendar month in which the insolvency occurs as long as such expenses are payable by the company. In no event will the coverage extend beyond the end of the period of time for which premium prepayments were received for affected members whether prepayments were made on a monthly, quarterly or other period of time, as long as such expenses are payable by members.
3. Reinsurer will make available to all members for a period of 365 days, without evidence of insurability, replacement coverage of the same benefit schedule and rates as then being offered by reinsurer to other prospective insureds within the state.

VI. 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."

**The Medical Associates Clinic Health Plan of Wisconsin
Assets
As of December 31, 2013**

	Assets	Nonadmitted Assets	Net Admitted Assets
Bonds	\$ 812,311	\$ 0	\$ 812,311
Stocks:			
Preferred stocks	8,839	0	8,839
Common stocks	1,280,186	0	1,280,186
Cash, cash equivalents and short-term investments	1,598,999	0	1,598,999
Investment income due and accrued	7,207	0	7,207
Uncollected premiums and agents' balances in the course of collection	4,005	0	4,005
Health care and other amounts receivable	222,500	0	222,500
Aggregate write-ins for other than invested assets	<u>54,699</u>	<u>54,699</u>	<u>0</u>
Total Assets	<u>\$3,988,746</u>	<u>\$54,699</u>	<u>\$3,934,047</u>

**The Medical Associates Clinic Health Plan of Wisconsin
Liabilities and Net Worth
As of December 31, 2013**

Premiums received in advance	\$ 555,756
General expenses due or accrued	41,071
Amounts due to parent, subsidiaries and affiliates	234,734
Aggregate write-ins for other liabilities [including \$(1) current]	<u>65,012</u>
Total liabilities	896,573
Unassigned funds (surplus)	<u>3,037,474</u>
Total Liabilities, Capital and Surplus	<u>\$3,934,047</u>

**The Medical Associates Clinic Health Plan of Wisconsin
Statement of Revenue and Expenses
For the Year 2013**

Net premium income		\$21,370,466
Fee-for-service (net of \$9,253,870 medical expenses)		292,462
Aggregate write-ins for other health care related revenues		<u>12,299</u>
Total revenues		21,675,227
Medical and hospital:		
Hospital/medical benefits	\$17,722,176	
Prescription drugs	<u>1,447,745</u>	
Total medical and hospital		19,169,921
Claims adjustment expenses		611,296
General administrative expenses		<u>1,827,948</u>
Total underwriting deductions		21,609,165
Net underwriting gain or (loss)		66,062
Net investment income earned	64,129	
Net realized capital gains or (losses)	<u>12,192</u>	
Net investment gains or (losses)		76,321
Net gain or (loss) from agents' or premium balances charged off		<u>(3,185)</u>
Net Income (Loss)		<u>\$ 139,198</u>

**The Medical Associates Health Plan of Wisconsin
Capital and Surplus Account
For the Three-Year Period Ending December 31, 2013**

	2013	2012	2011
Capital and surplus, beginning of year	\$2,967,049	\$2,646,156	\$2,571,107
Net income (loss)	139,198	168,000	189,267
Change in net unrealized capital gains/losses	<u>(14,074)</u>	<u>60,889</u>	<u>(89,377)</u>
Surplus, End of Year	<u>\$3,037,474</u>	<u>\$2,967,049</u>	<u>\$2,646,156</u>

**The Medical Associates Clinic Health Plan of Wisconsin
Statement of Cash Flows
As of December 31, 2013**

Premiums collected net of reinsurance		\$21,877,982
Net investment income		71,510
Miscellaneous income		<u>630,020</u>
Total		22,579,512
Less:		
Benefit- and loss-related payments	\$19,169,921	
Commissions, expenses paid and aggregate write-ins for deductions	<u>2,625,405</u>	
Total		<u>21,795,326</u>
Net cash from operations		784,186
Proceeds from investments sold, matured or repaid:		
Bonds	\$559,193	
Stocks	414,024	
Miscellaneous proceeds	<u>1</u>	
Total investment proceeds		973,218
Cost of investments acquired—long-term only:		
Bonds	427,635	
Stocks	<u>619,338</u>	
Total investments acquired		<u>1,046,973</u>
Net cash from investments		(73,755)
Cash provided/applied:		
Other cash provided (applied)		<u>(157,189)</u>
Net change in cash, cash equivalents, and short-term investments		553,242
Cash, cash equivalents, and short-term investments:		
Beginning of year		<u>1,045,757</u>
End of Year		<u>\$ 1,598,999</u>

Growth of The Medical Associates Clinic Health Plan of Wisconsin

Year	Assets	Liabilities	Capital and Surplus	Premium Earned	Medical Expenses Incurred	Net Income
2013	\$3,934,047	\$896,573	\$3,037,474	\$21,370,466	\$19,169,921	\$139,198
2012	3,431,877	464,828	2,967,049	29,971,787	27,558,696	168,000
2011	2,917,018	270,862	2,646,156	31,273,065	28,564,893	189,267

Year	Profit Margin	Medical Expense Ratio	Administrative Expense Ratio	Change in Enrollment
2013	0.7%	89.7%	9.5%	(1.4)%
2012	0.6	91.9	7.0	(3.7)
2011	0.6	91.3	7.8	2.4

Enrollment and Utilization

Year	Enrollment	Hospital Days/1,000	Average Length of Stay
2013	6,577	1,428	8.5
2012	6,670	1,609	9.8
2011	6,923	1,096	7.3

Per Member Per Month Information

	2013	2012	Percentage Change
Premiums:			
Commercial	\$400	\$371	7.7%
Medicare	<u>384</u>	<u>367</u>	4.7
Expenses:			
Hospital/medical benefits	224	319	(29.7)
Prescription drugs	<u>18</u>	<u>21</u>	(14.3)
Total medical and hospital	242	340	(28.7)
Claims adjustment expenses	8	5	57.2
General administrative expenses	<u>23</u>	<u>24</u>	(3.4)
Total underwriting deductions	<u>\$273</u>	<u>\$369</u>	(25.9)

The company's operations have been profitable over the three-year period under examination. Premiums decreased by 28.7% in 2013. Despite the slight decline in enrollment, medical expenses have steadily decreased. Total medical and hospital expenses per member per month declined by 98, with a percentage change of 28.7%. The reinsurance agreement with

the company will pay up to 90% of the amount paid by the Clinic for inpatient hospital claims in excess of \$50,000 and under \$300,000 per enrollee.

The company has had increases in assets and in liabilities from 2011 to 2013. The change in assets was mainly due to a recorded receivable from the Centers for Medicare and Medicaid Services (CMS) for Medicare cost reimbursements. The receivable was recorded as an offset to affiliated payables. The change in liabilities, especially in 2013 compared to 2012, was due to an increase of 93% in premiums received in advance, due primarily to premium payment received in December 2013 for January 2014 coverage. There had been no Claims Unpaid at December 31 of each of the three years under examination.

Medical and administrative expense ratios were stable in two of the three years under examination. It should be noted that medical loss ratio has not varied much over the years because the company is 100% capitated. In addition, the company's Medicare business, which represents approximately 44% of premiums written, is virtually risk-free (as the company's Medicare contract with CMS is a cost-reimbursement contract). Moreover, the company's cost allocation agreement with MAHP ensures that company's administrative costs are in line with gross premiums written. As a result of these contracts, the company's medical and administrative expenses have been fairly predictable, allowing the company to post reasonably steady operating results over the last several years.

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:

Assets	\$ 3,934,047	
Less:		
Special deposit	240,000	
Liabilities	<u>896,573</u>	
Assets available to satisfy surplus requirements		\$2,797,474
Net premium earned	21,370,466	
Compulsory factor	<u>3%</u>	
	641,114	
Compulsory surplus		<u>750,000</u>
Compulsory Surplus Excess/(Deficit)		<u>\$2,156,360</u>
Assets available to satisfy surplus requirements		\$2,797,474
Compulsory surplus	\$ 750,000	
Security factor	<u>140%</u>	
Security surplus		<u>1,050,000</u>
Security Surplus Excess/(Deficit)		<u>\$1,747,474</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 2013 with a deposit of \$240,000 with the State Treasurer.

Reconciliation of Capital and Surplus per Examination

No adjustments were made to surplus as a result of the examination. The amount of capital and surplus reported by the company as of December 31, 2013, is accepted.

Examination Reclassifications

There were no examination reclassifications as a result of this examination.

VII. SUMMARY OF EXAMINATION RESULTS

Compliance with Prior Examination Report Recommendations

There were eight 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. Affiliated Agreements – Administrative Services Agreements—It is recommended that the company complete a study to determine the reimbursement in accordance with reasonableness standards set forth in SSAP 25.

Action—Compliance.

2. Affiliated Agreements – Administrative Services Agreements—It is recommended the company file an amendment to this agreement with this office that includes a settlement provision in accordance with SSAP 96.

Action—Compliance.

3. Annual Statement Reporting – EDP Equipment and Software—It is again recommended that the company implement procedures to ensure that all future EDP equipment and operating system software purchases are depreciated over the lesser of its useful life, or three years, in accordance with SSAP No. 79, paragraph 3, of the NAIC Accounting Practices and Procedures Manual.

Action—Compliance.

4. Capitation Agreements – Reserving Methodology—It is recommended that the health plan establish adequate reserves in accordance with SSAP No. 54 (23).

Action—Compliance.

5. Information Systems – Disaster Recovery Plan Testing—It is again recommended that the company perform annual testing to validate its disaster recovery plan is executable, both from a network restoration and critical function perspective. Table-top walkthroughs may be used to satisfy the testing requirement.

Action—Compliance.

6. Information Systems – Access Review—It is again recommended that the company perform periodic reviews of IDs with access to the Plan's network resources to ensure that all active IDs are authorized and the assigned rights are appropriate.

Action—Compliance.

7. Management and Control – Board Minutes Review—It is recommended that the company review member attendance of the board of directors meetings in accordance with Article II, Section 13, of the bylaws.

Action—Compliance. A director who had attended less than 50% of the meetings is no longer a director. Attendance is noted in the minutes of each meeting.

8. Management and Control – Biographical Sketches—It is recommended that the company report biographical affidavits relating to officers and directors in accordance with the provisions of s. Ins 6.52 (5), Wis. Adm. Code.

Action—Compliance.

Summary of Current Examination Results

The current examination resulted in no adverse or material findings.

VIII. CONCLUSION

The Medical Associates Clinic Health Plan of Wisconsin is a nonprofit group model health maintenance organization (HMO) insurer that was incorporated on October 25, 1983, and commenced business on January 1, 1985. The company is controlled by Medical Associates Clinic Professional Corporation, which is the HMO's sponsoring clinic and founder.

The company offers commercial group and individual Medicare cost policies in the following Wisconsin counties: Crawford, Grant, Iowa and Lafayette. As of December 31, 2013, the HMO generated approximately 56% of its premium revenues from its commercial group business. The remaining 44% of premium revenues were generated by its Medicare business.

The company's operations have been profitable over the three-year period under examination. Despite the slight decline in enrollment, medical expenses have steadily decreased.

The company purchased reinsurance for the benefit of the Clinic, which will pay up to 90% of the amount paid by the Clinic for inpatient hospital services provided to any non-Medicare enrollee of the company which is in excess of \$300,000 for any contract year, up to a maximum of \$5,000,000 in the enrollee's lifetime. In 2014 the maximum per enrollee was removed in the reinsurance contract. The company's service agreement with the Clinic and cost-sharing agreement with MAHP has allowed the company to equitably allocate common administrative costs, as well as shared facilities/overhead costs, allowing the company reasonably steady operating results.

IX. SUMMARY OF COMMENTS AND RECOMMENDATIONS

The current examination resulted in no comments or recommendations.

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
Diana Havitz	Insurance Financial Examiner
David Jensen	IT Specialist

Respectfully submitted,

Vickie Ostien
Examiner-in-Charge