

Report  
of the  
Examination of  
Managed Health Services Insurance Corporation  
Milwaukee, Wisconsin  
As of December 31, 2012

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# State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

**Scott Walker**, Governor  
**Theodore K. Nickel**, Commissioner

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February 7, 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:

MANAGED HEALTH SERVICES INSURANCE CORPORATION  
Milwaukee, Wisconsin

and this report is respectfully submitted.

## I. INTRODUCTION

The previous examination of Managed Health Services Insurance Corporation (hereinafter MHSIC, the HMO, or the company) was conducted in 2010 as of December 31, 2009. The current examination covered the intervening period ending December 31, 2012, and included a review of such 2013 transactions as deemed necessary to complete the examination.

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

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

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

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

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

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

## II. HISTORY AND PLAN OF OPERATION

Managed Health Services 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 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 has a delivery system consisting of clinics and/or independent contracting physicians operating out of their separate offices. HMOs compete with traditional fee-for-service health care delivery.

MHSIC was incorporated August 31, 1990, as a wholly owned stock insurer subsidiary of Managed Health Services, Inc. (MHSI), a Wisconsin non-stock, not-for-profit corporation. The HMO commenced business on December 17, 1990. On September 8, 1993, Coordinated Care Corporation (CCC), a Wisconsin stock corporation, acquired 100% of the outstanding common stock of MHSIC from MHSI. On November 20, 1996, the name of Coordinated Care Corporation was changed to Centene Corporation (CC).

The company has undergone several mergers since its acquisition by Coordinated Care Corporation. On September 1, 1997, MHSIC purchased Genesis Health Plan Insurance Corporation (GHPIC). The operations of MHSIC and GHPIC were merged with MHSIC as the surviving company. On October 1, 1998, MHSIC acquired Maxicare Health Insurance Company (Maxicare Health). Maxicare Health continued to exist as a separate company under a new name, Coordinated Care Health Plan, Inc. (CCHP), until December 31, 1999, when it was merged into MHSIC. On February 1, 2001, MHSIC purchased the Medicaid/BadgerCare line of business from Humana Wisconsin Health Organization Insurance Corporation. Approximately 35,000 Medicaid enrollees were transferred to MHSIC.

MHSIC derives all of its revenue from the Wisconsin Title XIX Medical Assistance BadgerCare and Supplemental Security Income (SSI) Programs and from Medicare as a Medicare Advantage Special Needs Plan. The HMO contracts directly with the Wisconsin Department of Health Services (DHS) to provide health care benefits to eligible Medical

Assistance (Medicaid) recipients. In addition, the HMO provides benefits to the Medicaid enrollees of another HMO, Network Health Plan (NHP), through a subcontract under which MHSIC accepts all financial risk in exchange for a percentage of the capitation payments received by NHP from DHS. The current BadgerCare and SSI contracts with DHS, for all participating HMOs, expired on December 31, 2013. The 2014/2015 contract received from DHS is now in effect. The initial term of the contract with NHP will expire on December 31, 2015. The NHP contract automatically renews for successive five-year terms, unless notice is provided two years prior to the termination date. MHSIC also contracts directly with the Centers for Medicare and Medicaid Services (CMS) for its Special Needs Plan. That contract is for a one-year term on a calendar basis, with application made annually for a subsequent year. The 2014 contract has been executed. See the table below for a revenue and enrollment breakout.

	<b>Revenue</b>	<b>Enrollment</b>
Managed Health Services BC+	\$ 68,890,791	32,577
Managed Health Services SSI	41,623,692	5,813
Medicare	7,555,167	822
Network Health Plan BC+	66,783,251	30,679*
Network Health Plan SSI	17,096,850	2,514*
<b>Total</b>	<b>\$201,949,751</b>	<b>461,217</b>

\*NHP enrollment is not reported on MHSIC's annual statement

The HMO provides primary and specialty health services to Medicaid/BadgerCare and Medicare enrollees through contractual arrangements with physicians, independent practice associations (IPAs), group practices, physician-hospital organizations (PHOs), and clinics. Physician services are reimbursed on either a capitated or fee schedule basis.

The contracts include hold-harmless provisions for the protection of policy holders, have a one-year term, and automatically renew unless terminated by either party giving written notice to the other party at least 90 days prior to the end of the initial or renewed term. In addition, the contracts require physicians to participate in and contribute information for the company's quality improvement and utilization management programs and abide by applicable provisions of the contract with DHS and CMS.

The following is a list of the IPAs, group practices, PHOs, and clinics which serve the Medicaid/BadgerCare and Medicare enrollees:

**Clinics**

Aspirus Network, Inc.  
Beloit Area Community Health Center  
Community Health Network  
Community Memorial Hospital – Oconto Falls  
Dilip K. Tannan, MD  
Family Health Medical & Dental Center  
Fox Cities Community Clinic  
Kaukauna Clinic SC  
Marshfield Clinic  
Meade Medical Clinic  
Medical College of Wisconsin  
Memorial Health Center  
Memorial Hospital  
Milwaukee Health Services  
New Community Clinic  
Nicolet Medical and Dental Clinic  
Oneida Community Health Center  
Procure Medical Group  
Progressive Community Health Centers  
ProHealth Care  
Riverview Primary Care Physicians  
Sami Roumani, MD  
Sixteenth Street Community Health Center  
Turke Family Medicine SC  
United Hospital System Medical Group  
Vincent G. Lubsey, MD SC  
Wausau Family Practice Center

**IPAs**

Columbia St. Mary's Physician Network  
Physicians Health Network (PHN)  
OakLeaf Medical Network  
North Shore Health Network  
Watertown PHO Medical Services

**PHOs**

Affinity Health System  
Agnesian Health  
Aurora (for Medicare)  
Bellin Health  
Beloit PHO  
Essentia  
Fort Health Care, Inc.  
Holy Family Memorial Hospital  
Ministry Health Care  
Prevea HSHS  
ThedaCare, Inc.  
Wheaton Franciscan Healthcare

Inpatient services to Medicaid enrollees are provided through contracts with 89 hospitals. The hospitals are paid on a DRG or per diem basis. The contracts include hold-harmless provisions for the protection of policyholders, automatically renew for one-year terms, and may be terminated by either party upon 120 days' written notice prior to the next termination date of the contract between the HMO and DHS or CMS. The following is a list of hospitals serving Medicaid/BadgerCare/BadgerCare Plus enrollees:

Appleton Medical Center	Oakleaf Surgical Hospital
Aspirus Wausau Hospital	Oconomowoc Memorial Hospital
Aurora BayCare Medical Center	Oconto Medical Center
Aurora Lakeland Medical Center	Orthopedic Hospital of Wisconsin
Aurora Medical Center – Grafton	Osceola Medical Center
Aurora Medical Center – Kenosha	Our Lady of Victory Hospital Inc.
Aurora Medical Center – Summit	Rehabilitation Hospital of Wisconsin
Aurora Medical Center of Manitowoc	Ripon Medical Center
Aurora Memorial Hospital – Burlington	Riverside Medical Center
Aurora Sinai Medical Center	Riverview Hospital
Aurora West Allis Medical Center	Rusk County Memorial Hospital
Bay Area Medical Center	Sacred Heart Hospital – Eau Claire
Beaver Dam Community Hospitals	Sacred Heart Hospital – Tomahawk
Bellin Memorial Hospital	Sacred Heart Rehabilitation Institute
Beloit Memorial Hospital	Sacred Heart St. Mary's – Rhinelander
Berlin Memorial Hospital	Select Specialty Hospital – Madison
Calumet Medical Center	Select Specialty Hospital – Milwaukee (West Allis & St. Luke's Campus)
Children's Hospital of Wisconsin	Shawano Medical Center
Children's Hospital of Wisconsin – Fox Valley	Sheboygan Memorial Medical Center
Columbia Center – Mequon	Spooner Health System
CSM Hospital – Milwaukee	St. Agnes Hospital
Community Memorial Hospital Oconto Falls	St. Clare's Hospital
Divine Savior Hospital – Portage	St. Elizabeth Hospital
Door County Memorial Hospital	St. Francis Hospital
Eagle River Memorial Hospital	St. Joseph's and The Heart Hospital
Edgerton Hospital	St. Joseph's Hospital – Milwaukee
Elmbrook Memorial Hospital	St. Joseph's Hospital – Chippewa Falls
Essentia Health Duluth	St. Joseph's Hospital – Marshfield
Essentia Health Sandstone	St. Luke's Medical Center
Essentia St. Mary's Medical Center	St. Luke's – St. Luke's South Shore
Flambeau Hospital	St. Mary's Hospital – Rhinelander
Fort Health Care Inc.	St. Mary's Hospital – Green Bay
Froedtert Memorial Lutheran Hospital	St. Michael's Hospital
Good Samaritan Health Center	St. Nicholas Hospital
Hayward Area Memorial Hospital	St. Vincent Hospital
Holy Family Memorial Medical Center	Theda Clark Medical Center
Howard Young Medical Center	UHS – St. Catherine's Medical Center
Lakeview Rehabilitation Center	UHS – Kenosha Medical Center
Langlade Memorial Hospital	Waukesha Memorial Hospital
Memorial Health Center Medford	Waupun Memorial Hospital
Memorial Hospital Neilsville	Wausau Hospital
Memorial Medical Center Ashland	Wheaton Franciscan Healthcare All Saints
Mercy Medical Center	Wheaton Franciscan Healthcare Franklin
Midwest Orthopedic Specialty Hospital	Wild Rose Community Memorial Hospital
New London Family Medical Center	

The HMO's service area for BadgerCare Plus and Medicaid SSI populations is comprised of the following 46 counties:

Ashland	Green Lake	Milwaukee	Sheboygan
Bayfield	Iron	Oconto	Taylor
Brown	Jefferson	Oneida	Vilas
Calumet	Kenosha	Outagamie	Walworth
Chippewa	Kewaunee	Ozaukee	Washburn
Clark	Langlade	Portage	Waukesha
Dodge	Lincoln	Price	Waupaca
Door	Manitowoc	Racine	Waushara
Douglas	Marathon	Rock	Winnebago
Eau Claire	Marinette	Rusk	Wood
Fond du Lac	Marquette	Sawyer	
Forest	Menominee	Shawano	

Benefits for its BadgerCare/Medicaid SSI members are provided for in the contract between MHSIC and DHS. Coverage must be consistent with coverage specified in the State Plan; however, the HMO retains the right to determine the medical necessity of a covered service and to require prior authorization of certain services which it identifies.

The HMO's service area for the Medicare Advantage Special Needs Plan is comprised of the following 25 counties:

Adams	Outagamie
Brown	Ozaukee
Calumet	Portage
Kenosha	Racine
Kewaunee	Shawano
Langlade	Sheboygan
Lincoln	Taylor
Marathon	Washington
Marinette	Waukesha
Marquette	Waupaca
Menominee	Waushara
Milwaukee	Wood
Oconto	

Benefits for its Medicare members are provided for in the contract between MHSIC and CMS. Coverage must be consistent with coverage specified in the Medicare coverage rules; however, the HMO retains the right to determine the medical necessity of a covered service and to require prior authorization of certain services which it identifies.

### III. MANAGEMENT AND CONTROL

#### Board of Directors

The board of directors consists of 11 members. All directors are elected annually to serve a one-year term. Officers are elected by the board of directors. Members of the HMO's board of directors may also be members of other boards of directors in the holding group. The board members currently receive \$500 per meeting for serving on the board.

Currently the board of directors consists of the following persons:

<b>Name and Residence</b>	<b>Principal Occupation</b>	<b>Term Expires</b>
John Finerty, Jr., Chair Milwaukee, WI	Attorney Michael Best & Friedrich, LLP	2014
Michael Grebe Milwaukee, WI	Attorney/Partner Quarles & Brady	2014
Corey Hoze Milwaukee, WI	Senior Vice President Associated Banc-Corp	2014
Sherry Husa Milwaukee, WI	President, Chief Executive Officer Managed Health Services Ins. Corp.	2014
Tito Izard, MD Milwaukee, WI	CEO Milwaukee Health Services	2014
David Karst Greenfield, WI	Director of Business Partnerships MRA/The Management Association	2014
Daniel Parietti St. Louis, MO	Senior Vice President, Health Plan Business Unit, Centene Corporation	2014
Antonio Perez Milwaukee, WI	Director Housing Authority of the City of Milwaukee	2014
Joan Prince, MD Milwaukee, WI	Vice Chancellor University of Wisconsin-Milwaukee	2014
John Waeltz, MD Glendale, WI	OB/GYN Glen Point OB/GYN	2014
Sheldon Wasserman, MD Milwaukee, WI	OB/GYN Columbia-St. Mary's	2014
Keith Williamson St. Louis, MO	Senior Vice President, Secretary/ General Counsel, Centene Corporation	2014

## Officers of the Company

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

<b>Name</b>	<b>Office</b>	<b>2012 Salary*</b>
Sherry Husa	President and CEO	\$350,129
Sandra Tunis	SVP Government Relations and Compliance	256,321
Christopher Scott	VP of Finance	172,494
Keith Williamson	Secretary	54,253
Mark Eggert	Vice President	81,709
Paul Sabin	VP Network Management	229,440
Danielle Brazee	VP Operations	113,522

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

## 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:

### **Strategic Planning Committee**

John Finerty, Jr., Chair\*  
Michael Grebe\*  
Corey Hoze\*  
Sherry Husa\*  
David Karst\*  
Sandi Tunis  
Sheldon Wasserman\*

\* Indicates committee member is on the board of directors.

The company has no employees. Necessary staff is provided through a management agreement with Centene Management Company LLC (CMC), a wholly owned subsidiary of Centene Corporation. Under the agreement, effective January 1, 1997, CMC agrees to provide the company with administrative and financial services necessary to manage its business operations, and agrees to assume responsibility for all costs associated therewith. Areas/systems for which CMC assumes responsibility, under the terms of the agreement, include the following: program planning and development, management information systems, financial systems and services, claims administration, provider and enrollee services and records, utilization and peer review, quality assurance/quality improvement, and marketing services. CMC

receives a management fee of 12% of gross monthly revenues (payable on the first day of the month based on estimated gross revenue). The term of the agreement is five years and shall automatically renew for additional five-year terms. The company may terminate the agreement upon 30 days' written notice if default of standards of performance continues 60 days after notice of such default.

### **Insolvency Protection for Policyholders**

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

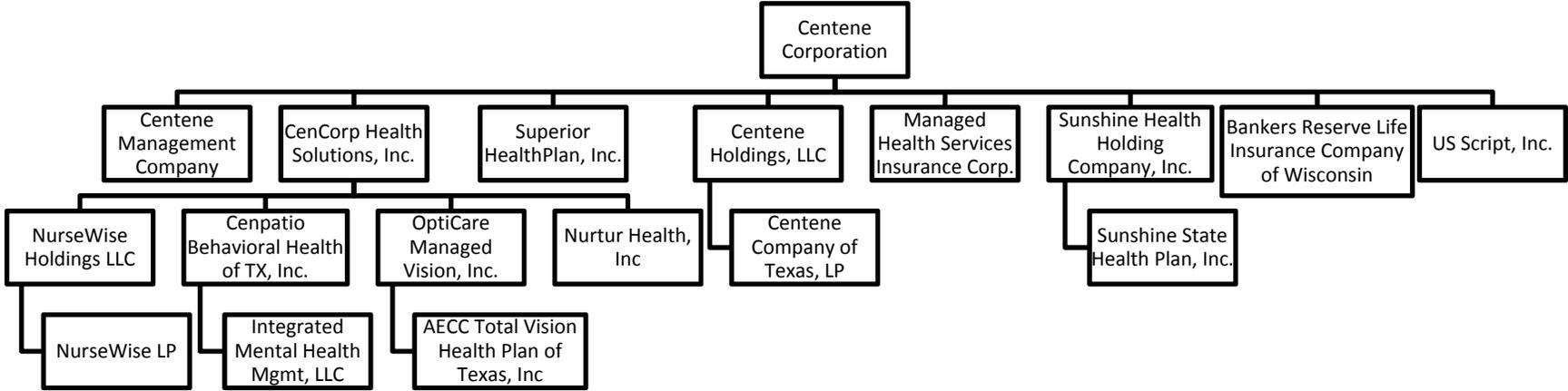
1. Enrollees hospitalized on the date of insolvency will be covered until discharged; and
2. Enrollees will be entitled to similar, alternate coverage which does not contain any medical underwriting or preexisting limitation requirements.

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 Centene Corporation. 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.

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



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

### **Centene Corporation**

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

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

### **Centene Management Company LLC**

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

### **Bankers Reserve Life Insurance Company of Wisconsin**

Bankers Reserve Life Insurance Company of Wisconsin is licensed in 41 states and only directly writes business in the state of Texas. The company was incorporated under the laws of Wisconsin on January 5, 1961, and commenced business on July 29, 1964. The company became a member of the holding group on March 1, 2002, when it was purchased by

the Centene Corporation. The company primarily provides managed care services to individuals receiving benefits under the state of Texas Children's Health Insurance Program (CHIP) and Foster Care Program. The company provides these services under separate contracts with the Texas Health and Human Services Commission. The company assumes reinsurance from 11 Centene affiliates, including MHSIC, and retrocedes to external reinsurers.

As of December 31, 2012, the company's audited financial statements reported assets of \$409 million, liabilities of \$211 million, and capital and surplus of \$198 million. Operations for 2012 produced a net loss of \$126 million on revenues of \$1.7 billion.

**Sunshine State Health Plan, Inc.**

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

**Superior HealthPlan, Inc.**

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

## Agreements with Affiliates

The company has entered into numerous affiliated agreements. These agreements are described below:

- Effective December 31, 2002, the company entered into a tax-sharing agreement with Centene Corporation (Centene). Under this agreement, Centene will file a consolidated tax return for member companies; member companies in turn agree to make quarterly payments to Centene in an amount equal to the full separate federal, state and local income tax liability attributable to the net taxable income of each member that would have been paid if such member had filed separate federal, state and local tax returns.
- Effective January 1, 1997, the company entered into an administrative service agreement with Centene Management Company LLC (CMC). This agreement is discussed in the section of the report captioned "Management and Control."
- Effective March 1, 2006 (last amended October 1, 2010), the company entered into a pharmacy benefit management agreement with US Script, Inc. Under the agreement US Script, Inc., provides the company's members with access to their pharmacy network. This agreement automatically renews in one-year periods, unless either party gives 90 days' written notice.
- Effective January 1, 2008 (last amended February 17, 2010), the company entered into a service agreement with NurseWise, LP. Under this agreement, NurseWise, LP, has established a toll-free bilingual care line. Professional nurses employed by NurseWise, LP, respond to inquiries on matters for eligible individuals and their eligible dependents that are enrolled in MHSIC's covered plans.
- Effective July 1, 2007 (last amended January 1, 2010), the company entered into an agreement with OptiCare Vision Company d/b/a/ OptiCare Managed Vision (Vision Network). MHSIC is responsible for administrative activities necessary to fulfill the obligations such as quality improvement process, utilization management, marketing, customer service, claims processing, benefits and eligibility verification, accounts receivable collection, maintenance of provider directory and records, and development of contracts with providers of covered

services. Vision Network is responsible for ongoing network development and network maintenance, including: provision for covered services, credentialing criteria, determination of covered person eligibility, emergency care, compliance with policies, acceptance of new patients, referrals, drug formulary, network provider responsibilities, non-discrimination, medical records, advance directives, quality improvement, utilization management program, grievance and appeals procedures, encounter data, financial records, non-solicitation, new or modified product attachments, provider listings, compliance with laws, and information systems. This agreement shall automatically renew for successive one-year periods, unless either party gives 180 days' written notice.

- Effective January 1, 2008 (last amended January 1, 2011), the company entered into a behavioral health services agreement with Cenpatico Behavioral Health LLC (Behavior Network). The Behavior Network is engaged in the business of arranging for the provision of covered behavioral health services. Behavior Network shall be responsible for ongoing network development and network maintenance, including: provision for covered services, credentialing criteria, determination of covered person eligibility, emergency care, compliance with policies, acceptance of new patients, referrals, drug formulary, network provider responsibilities, non-discrimination, medical records, advance directives, quality improvement, utilization management program, grievance and appeals procedures, encounter data, financial records, non-solicitation, new or modified product attachments, provider listings, compliance with laws, and information systems. This agreement shall automatically renew for successive one-year periods, unless either party gives 180 days' written notice.
- Effective February 1, 2008 (last amended November 1, 2009), the company entered into a disease management program services agreement with Nurtur Health, Inc. (f.k.a. Air Logix). MHSIC arranges for provisions of health care services, including disease prevention services and chronic disease management services to members. Nurtur Health, Inc., entered into a disease management program services agreement with MHSIC to provide disease management services to members enrolled in the BadgerCare, BadgerCare Plus and SSI

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

## V. REINSURANCE

The company has reinsurance coverage under the contract outlined below:

### Affiliated Ceded Reinsurance

1. Reinsurer: Bankers Reserve Life Insurance Company of Wisconsin  
Type: Specific Excess of Loss Reinsurance  
Effective date: January 1, 2013  
Retention: Specific deductible per covered person per agreement term: \$200,000  
Covered business: Medicaid, Badger Care, SSI, and BadgerCare Plus  
Coverage: 90% of covered expenses excess of specific deductible. Claims must be received by November 1, 2014. Organ Transplant Services: If performed at a Non-Approved Transplant Provider 50%.  
Maximum coverage: All services: \$2,000,000 in excess of the retention  
Limitations: Hospital inpatient services as defined by the membership services agreement: the lesser of the amount paid, the contracted rate, the applicable Wisconsin Medicaid fee schedule where contracted rates do not exist or an average per diem per discharge of \$10,000 for allowable expenses over \$1,000,000  
Premium: \$0.51 per member per month  
Termination: January 1, 2014

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

1. Reinsurer will continue plan benefits for members who are confined in an acute-care hospital on the date of insolvency until their discharge.
2. Reinsurer will continue plan benefits for any member insured plan until the end of the contract period for which premiums have been paid to plan by that member or on his behalf.

2. Reinsurer: Celtic Insurance Company  
Type: Medical Expense Conversion Program  
Effective date: January 1, 2002  
Covered business: Wisconsin Medicaid managed care contract (HMO Plans), which are fully insured covering Medicaid and BadgerCare recipients and dependent members

Coverage: In consideration of subscription fees paid by HMO, reinsured will make available to eligible members the privilege of obtaining without evidence of insurability, through the conversion program; subject to the other limitations and provisions and may be considered eligible if:

- a) the member moves out of the state of HMO
- b) the member loses Medicaid eligibility because their earned income exceeds the Medicaid program's stated maximum income level for the state of Wisconsin and he or she still resides in state of the HMO

Eligible member shall lose or have his or her coverage terminated for any of following reasons:

- a) discontinuance of a plan or withdrawal of a plan or plans by the HMO
- b) failure of the member to pay any required contribution under the plan
- c) the member's commission of fraud
- d) immediately prior to termination, the eligible member was not continuously covered under applicable plan at least three consecutive months
- e) the eligible member is or could be covered by Medicare
- f) the eligible member is covered by or eligible for similar benefits under any group, individual, pre-payment government or any other plan or program
- g) HMO fails to pay subscription fee when due
- h) the Conversion Program terminates in the state of Wisconsin
- i) the member moves outside the state of Wisconsin.

Limitations: Hospital inpatient services-Acute care services: the lesser of the amount paid, the contracted rate, Medicare allowable, or a maximum average per diem per discharge of \$10,000. Extended Care Facility/Skilled Nursing Facility/Sub-Acute Care Facility/Home Health Care Rehabilitation: the lesser of the amount paid, the contracted rate, Medicare allowable, or a \$1,000 per diem and further limited to 90 days in total for the combination of all categories.

Subscription fee: HMO state of Wisconsin conversion coverage \$.05 per member per month

Termination: No set termination date. If the required subscription fee is not paid within 90 days of due date; 60 days' advance notice to the HMO.

### **Non-Affiliated Ceded Reinsurance**

- 3. Reinsurer: Ace American Insurance Company
- Type: Specific Excess of Loss Reinsurance
- Effective date: January 1, 2013
- Retention: Specific deductible per covered person per agreement term: \$1,250,000  
Maximum payable per covered person: \$2,500,000
- Covered business: WI Medicare Dual Eligible

Coverage: 80% of covered expenses excess of specific deductible. Claims must be received by the reinsurer no later than November 1, 2014.

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

Limitations: Hospital inpatient services-Acute care services: the lesser of the amount paid, the contracted rate, Medicare allowable, or a maximum average per diem per discharge of \$10,000. Extended Care Facility/Skilled Nursing Facility/Sub-Acute Care Facility/Home Health Care Rehabilitation: the lesser of the amount paid, the contracted rate, Medicare allowable, or a \$1,000 per diem and further limited to 90 days in total for the combination of all categories.

Premium: Provisional premium rate: \$0.04 per member per month  
Maximum premium rate: \$0.06 per member per month

Termination: January 1, 2014

## **VI. FINANCIAL DATA**

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

**Managed Health Services Insurance Corporation**  
**Assets**  
**As of December 31, 2012**

	<b>Assets</b>	<b>Nonadmitted Assets</b>	<b>Net Admitted Assets</b>
Bonds	\$20,825,355	\$	\$20,825,355
Cash, cash equivalents and short-term investments	25,022,384		25,022,384
Other invested assets	487,191		487,191
Investment income due and accrued	278,923		278,923
Uncollected premiums and agents' balances in the course of collection	4,695,516		4,695,516
Amounts recoverable from reinsurers	153,515		153,515
Net deferred tax asset	770,817	20,572	750,245
Receivables from parent, subsidiaries and affiliates	72,693		72,693
Health care and other amounts receivable	1,167,511	558,032	609,479
Aggregate write-ins for other than invested assets	<u>343,348</u>	<u>109,511</u>	<u>233,837</u>
<b>Total Assets</b>	<b><u>\$53,817,253</u></b>	<b><u>\$688,115</u></b>	<b><u>\$53,129,138</u></b>

**Managed Health Services Insurance Corporation**  
**Liabilities and Net Worth**  
**As of December 31, 2012**

Claims unpaid		\$15,307,207
Accrued medical incentive pool and bonus payments		701,858
Unpaid claims adjustment expenses		290,000
General expenses due or accrued		10,286,561
Current federal and foreign income tax payable and interest thereon		1,410,802
Amounts due to parent, subsidiaries and affiliates		6,860,365
Aggregate write-ins for other liabilities [including \$(1) current]		<u>26,423</u>
<b>Total liabilities</b>		<b>34,883,216</b>
Common capital stock	\$ 750,000	
Gross paid in and contributed surplus	1,250,000	
Unassigned funds (surplus)	<u>16,245,919</u>	
<b>Total capital and surplus</b>		<b><u>18,245,919</u></b>
<b>Total Liabilities, Capital and Surplus</b>		<b><u>\$53,129,135</u></b>

**Managed Health Services Insurance Corporation**  
**Statement of Revenue and Expenses**  
**For the Year 2012**

Net premium income		\$118,069,650
Risk revenue (Network Health Plan subcontract)		<u>83,880,101</u>
Total revenues		201,949,751
Medical and hospital:		
Hospital/medical benefits	\$109,001,207	
Other professional services	13,031,429	
Outside referrals		
Emergency room and out-of-area	12,637,888	
Prescription drugs	1,883,397	
Aggregate write-ins for other medical and hospital	43,972,275	
Incentive pool and withhold adjustments	<u>382,887</u>	
Subtotal	180,909,083	
Less		
Net reinsurance recoveries	<u>417,659</u>	
Total medical and hospital	180,491,424	
Claims adjustment expenses	4,638,657	
General administrative expenses	12,456,889	
Increase in reserves for life and accident and health contracts	<u>(3,271,934)</u>	
Total underwriting deductions		<u>194,315,036</u>
Net underwriting gain or (loss)		7,634,715
Net investment income earned		<u>799,967</u>
Net income or (loss) before federal income taxes		8,434,682
Federal and foreign income taxes incurred		<u>1,303,402</u>
Net Income (Loss)		<u>\$ 7,131,280</u>

**Managed Health Services Insurance Corporation**  
**Analysis of Surplus**  
**For the Three-Year Period Ending December 31, 2012**

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

	<b>2012</b>	<b>2011</b>	<b>2010</b>
Capital and surplus, beginning of year	\$27,050,638	\$31,221,094	\$51,892,624
Net income or (loss)	7,131,280	6,865,135	(1,600,857)
Change in net unrealized capital gains and losses	(34,330)	(22,076)	(26,669)
Change in net deferred income tax	(1,393,441)	(4,648,792)	4,644,932
Change in nonadmitted assets	491,771	635,277	1,311,064
Dividends to stockholders	(15,000,000)	(7,000,000)	(25,000,000)
Net change in capital and surplus	<u>(8,804,720)</u>	<u>(4,170,456)</u>	<u>(20,671,530)</u>
Capital and Surplus, End of Year	<u>\$18,245,918</u>	<u>\$27,050,638</u>	<u>\$31,221,094</u>

**Managed Health Services Insurance Corporation**  
**Statement of Cash Flows**  
**As of December 31, 2012**

Premiums collected net of reinsurance		\$112,963,663
Net investment income		1,331,479
Miscellaneous income		<u>83,880,101</u>
Total		<u>198,175,243</u>
Less:		
Benefit- and loss-related payments	\$174,444,398	
Commissions, expenses paid and aggregate write-ins for deductions	10,933,405	
Federal and foreign income taxes paid (recovered)		
\$0 net tax on capital gains (losses)	<u>(3,529,069)</u>	
Total		<u>181,848,734</u>
Net cash from operations		16,326,509
Proceeds from investments sold, matured or repaid:		
Bonds	\$15,364,134	
Miscellaneous proceeds	<u>5,001</u>	
Total investment proceeds		15,369,135
Cost of investments acquired—long-term only:		
Bonds	10,864,760	
Other invested assets	<u>247,500</u>	
Total investments acquired		<u>11,112,260</u>
Net cash from investments		4,256,875
Cash provided/applied:		
Dividends to stockholders	15,000,000	
Other cash provided (applied)	<u>12,150,424</u>	
Net cash from financing and miscellaneous sources		<u>(2,849,576)</u>
Net change in cash, cash equivalents, and short-term investments		17,733,808
Cash, cash equivalents, and short-term investments:		
Beginning of year		<u>7,288,576</u>
End of Year		<u>\$ 25,022,384</u>

### Growth of Managed Health Services Insurance Corporation

Year	Assets	Liabilities	Capital and Surplus	Premium Earned	Medical Expenses Incurred	Net Income
2012	\$ 53,129,138	\$34,883,216	\$18,245,919	\$201,949,751	\$180,491,424	\$ 7,131,280
2011	51,618,004	24,567,366	27,050,638	201,008,122	184,783,737	6,865,135
2010	105,197,471	73,976,375	31,221,096	299,624,447	261,872,272	(1,600,857)
2009	77,993,314	26,100,691	51,892,624	378,719,307	332,633,955	9,695,881

Year	Profit Margin	Medical Expense Ratio	Administrative Expense Ratio	Change in Enrollment
2012	3.8%	89.4%	6.8%	-3.3%
2011	1.2	91.9	6.9	7.1
2010	1.1	87.4	11.5	-54.2
2009	3.7	87.8	8.5	6.4

### Enrollment and Utilization

Year	Enrollment	Hospital Days/1,000	Average Length of Stay
2012	476,943	411.17	3.9
2011	489,427	398.52	3.8
2010	832,891	520.59	3.5
2009	961,393	305.53	3.5

### Per Member Per Month Information

	2012	2011	Percentage Change
<b>Premiums:</b>			
Medicare	1,168	1,210	(3.5)%
Medicaid	<u>235</u>	<u>231</u>	2.2
Aggregate Total	<u>248</u>	<u>231</u>	7.6
<b>Expenses:</b>			
Hospital/medical benefits	138	130	6.0
Other professional services	16	15	3.0
Emergency room and out-of-area	16	13	21.7
Prescription drugs	4	0	
Other medical and hospital	51	54	(6.4)
Incentive pool and withhold adjustments	1	1	65.4
Less: Net reinsurance recoveries	<u>1</u>	<u>(1)</u>	(169.0)
Total medical and hospital	<u>224</u>	<u>213</u>	5.0
Claims adjustment expenses	10	9	2.5
General administrative expenses	26	23	12.1
Increase in reserves for accident and health contracts	<u>(7)</u>	<u>(4)</u>	65.5
Total underwriting deductions	<u>\$253</u>	<u>\$242</u>	4.5

The company's enrollment decreased 54% in 2011 to 489,427 members from 832,891 members at year-end 2010. The large decrease in enrollment from 2010 to 2011 is due to the fact that the company no longer serves BadgerCare Plus Standard and Benchmark members in Milwaukee, Washington, Ozaukee, Waukesha, and Kenosha counties.

The decrease in enrollment caused total assets to decrease to \$53 million at year-end 2012 from a high of \$105 million at year-end 2010. Capital and surplus decreased to \$18 million at year-end 2012 from \$52 million at year-end 2009. The decrease in capital and surplus is largely from \$47 million in dividends paid to the parent company over the examination period. The company's leverage decreased due to a decrease in premium related to the loss of business in the southeastern part of the state. The company has posted positive financial results in three of the four years under examination.

#### **Reconciliation of Capital and Surplus per Examination**

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

## VII. SUMMARY OF EXAMINATION RESULTS

### Compliance with Prior Examination Report Recommendations

There were two 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. Unclaimed Funds—It is recommended that the company shall report to the Office of the State Treasurer all intangible property that remains unclaimed by the owner for more than five years and considered abandoned property pursuant to ch. 177, Wis. Stat.

Action—Compliance.

2. HIRSP Assessment—It is recommended that the company accrue for the HIRSP assessment in accordance with SSAP No. 35.

Action—Compliance.

## Summary of Current Examination Results

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

## Financial Requirements

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

	<b>Amount Required</b>
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, 2012, as modified for examination

adjustments is as follows:

Assets	\$ 53,129,136	
Less:		
Liabilities	<u>34,883,217</u>	
Assets available to satisfy surplus requirements		\$18,245,919
Net premium earned	201,949,750	
Compulsory factor	<u>3%</u>	
Compulsory surplus		<u>6,058,492</u>
Compulsory Surplus Excess/(Deficit)		<u>\$12,187,427</u>
Assets available to satisfy surplus requirements		\$18,245,919
Compulsory surplus	\$ 6,058,492	
Security factor	<u>135%</u>	
Security surplus		<u>8,178,964</u>
Security Surplus Excess/(Deficit)		<u>\$10,066,955</u>

## VIII. CONCLUSION

Managed Health Services Insurance Corporation is a wholly owned subsidiary of Centene Corporation. The company was organized under the laws of Wisconsin on August 31, 1990, as a network model health maintenance organization (HMO) and provides managed care services to individuals receiving benefits under Medicaid. The company provides these services under a contract with the Wisconsin Department of Health Services (DHS) and a subcontract of another entity's contract with DHS. The company contracts directly with health care providers on a fee-for-service, per diem, diagnostic rate grouping and capitation basis.

The company's enrollment decreased 54% in 2011 to 489,427 members from 832,891 members at year-end 2010. The large decrease in enrollment from 2010 to 2011 is because the company no longer serves BadgerCare Plus Standard and Benchmark members in Milwaukee, Washington, Ozaukee, Waukesha, and Kenosha counties.

The decrease in enrollment caused total assets to decrease to \$53 million at year-end 2012 from a high of \$105 million at year-end 2010. Capital and surplus decreased to \$18 million at year-end 2012 from \$52 million at year-end 2009. The decrease in capital and surplus is largely from \$47 million in dividends paid to the parent company over the examination period. The company has posted positive financial results in three of the four years under examination.

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

## **IX. SUMMARY OF COMMENTS AND RECOMMENDATIONS**

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

**X. ACKNOWLEDGMENT**

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

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

<b>Name</b>	<b>Title</b>
Holly Poore	Insurance Financial Examiner
Richard Janosik	Insurance Financial Examiner
Thomas Houston	IT Specialist

Respectfully submitted,

Terry J. Lorenz  
Examiner-in-Charge