

Report
of the
Examination of
UnitedHealthcare of Wisconsin, Inc.
Wauwatosa, 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

Wisconsin.gov

May 14, 2014

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Honorable Theodore K. Nickel
Commissioner of Insurance
State of Wisconsin
125 South Webster Street
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Commissioner:

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

UNITEDHEALTHCARE OF WISCONSIN, INC.
Wauwatosa, Wisconsin

and this report is respectfully submitted.

I. INTRODUCTION

The previous examination of UnitedHealthcare of Wisconsin, Inc. (herein referred to as the company or the HMO) was conducted in 2008 as of December 31, 2007. 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 UnitedHealthcare of Texas, 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.

Independent Actuary's Review

An independent actuarial firm was engaged under a contract with the Office of the Commissioner of Insurance. The actuary reviewed the adequacy of the unpaid claims liability. The actuary's results were reported to the examiner-in-charge. As deemed appropriate, reference is made in this report to the actuary's conclusion.

II. HISTORY AND PLAN OF OPERATION

UnitedHealthcare of Wisconsin, Inc., is described as a for-profit network 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 network model, the company provides care through contracts with two or more clinics. HMOs compete with traditional fee-for-service health care delivery.

The HMO was incorporated on May 8, 1986, and commenced business on June 6, 1986, as the Heritage Health Plan of Wisconsin, Inc. Simultaneously, the HMO acquired all of the assets and assumed all of the liabilities of the PrimeCare Health Plan of Wisconsin, pursuant to an Asset Purchase Agreement dated May 8, 1986. By shareholder consent dated May 11, 1987, the name of the HMO was changed to PrimeCare Health Plan, Inc. On March 1, 1990, UnitedHealthcare Corporation (United), a Minnesota managed care holding company, acquired Heritage Holding Company, Inc. (HHC) through purchase of all outstanding shares of common stock. HHC, which owned 100% of the HMO's outstanding common stock at the time of the purchase, was subsequently dissolved, and the ownership interest in the HMO was transferred to UHC Management Company (UMC). UMC is a wholly owned subsidiary of United. UMC subsequently changed its name to United HealthCare Services, Inc. (UHS). On August 1, 1991, the HMO merged with an affiliate, Samaritan Health Plan (Samaritan), which was also a wholly owned subsidiary of UMC. Samaritan, which was the surviving corporation, changed its name to PrimeCare Health Plan, Inc., pursuant to the merger. On July 17, 1996, the HMO merged with an affiliate, MetraHealth Care Plan of Wisconsin, Inc. The HMO (PrimeCare Health Plan, Inc.) was the surviving corporation. On June 30, 2000, the HMO became a wholly owned subsidiary of UnitedHealthcare, Inc. (UHC) pursuant to a transfer of 100% of the HMO's outstanding shares to UHC by UHS. UHC is a Delaware corporation and wholly owned subsidiary of UHS, designed to be the holding company for all of the HMOs that are part of the UnitedHealth

Group. UnitedHealth Group Incorporated (United or UHG) is the ultimate controlling affiliate in the insurance holding company system. United had changed its name from United Healthcare Corporation effective March 6, 2000. On October 9, 1999, the HMO's board amended the Articles of Incorporation to change the corporate name to its current name, UnitedHealthcare of Wisconsin, Inc., effective December 31, 1999. On March 25, 2004, UnitedHealthcare of Wisconsin, Inc., entered into an asset purchase agreement with Touchpoint Health Plan and acquired certain intangible assets, assigned contracts, and select physical assets.

The HMO provides primary health care through physicians who either contract directly with the HMO, or contract with an independent practice association (IPA) or clinic that has a contractual relationship with the HMO. The only exception to this is a lease arrangement with the physicians in the Marshfield Clinic, which is accessed through a partnership agreement with Medica Health Plans of Wisconsin. The HMO contracts directly with over 11,043 physicians (primary and specialist).

Under the Participating Physician Agreement, the physician agrees to provide health services in accordance with the benefit plans offered by the HMO. Pursuant to that agreement, the physician agrees to provide health services to all members as the physician's patient load permits, and to accept members as new patients on the same basis that the physician is accepting non-members as new patients, in accordance with local, state and federal laws. In addition, if the physician is a primary care physician, the physician agrees to provide or arrange for the provision of advice and assistance to members in emergency situations 24 hours/day, 7 days/week.

Pursuant to the Participating Physician Agreement, physicians are compensated in accordance with approved fee schedules. The agreement precludes physicians from billing members for the difference between customary charges and the amount that the physician has agreed to accept as full reimbursement under the agreement. That agreement specifically states: "A health care provider who is subject to the statutory hold-harmless provisions is prohibited from seeking to recover health care costs from an enrollee. The provider may not bill, charge, collect a deposit from, seek remuneration or compensation from, file or threaten to file with a credit

reporting agency or have any recourse against an enrollee or any person acting on the enrollee's behalf, for health care costs for which the enrollee is not liable.”

The HMO currently contracts with the following large IPAs and Clinics, in addition to several smaller medical groups:

- Aurora/Advanced Health Care
- Agnesian Healthcare
- All Saints Medical Group
- Aspirus Network
- Aurora Medical Group
- Bay Area Medical Center Physicians
- Bellin Health
- Children's Medical Group
- Columbia/St. Mary's Medical Group
- Divine Savior Physicians
- Fort Health Care
- Franciscan Skemp Medical Group
- Medical Associates Health Centers
- Medical College of Wisconsin
- Mercy Health System Physicians
- Ministry Health Care
- Monroe Clinic
- Prevea Clinic
- Thedacare Physicians
- United Hospital System Medical Group
- Watertown Physicians
- Waukesha/Elmbrook Health Care, S.C.
- West Bend Clinic
- Wheaton Franciscan Medical Group
- Wilkinson Medical Clinic

The HMO contracts with 133 hospitals to provide inpatient services. Hospitals are reimbursed on a negotiated per diem, per case, per visit and discounted fee-for-service basis.

The contracts include hold-harmless provisions for the protection of policyholders. See Addendum I for a listing of hospitals in which the HMO holds direct contracts.

According to its business plan at December 31, 2012, the HMO's service area was comprised of the following 57 counties:

Ashland	Douglas	Manitowoc	Polk	Vilas
Barron	Florence	Marathon	Portage	Walworth
Bayfield	Fond du Lac	Marinette	Price	Washburn
Brown	Forest	Marquette	Racine	Washington
Burnett	Green Lake	Menominee	Rock	Waukesha
Calumet	Jackson	Milwaukee	Sawyer	Waupaca
Chippewa	Jefferson	Monroe	Shawano	Waushara
Clark	Kenosha	Oconto	Sheboygan	Winnebago
Crawford	Kewaunee	Oneida	St. Croix	Wood
Dane	La Crosse	Outagamie	Taylor	
Dodge	Langlade	Ozaukee	Trempealeau	
Door	Lincoln	Pierce	Vernon	

The HMO offers comprehensive health care coverage through its commercial HMO product, which may be changed by riders to include deductibles and copayments. The following basic health care coverage is provided:

- Ambulance Services
- Chiropractic Treatment
- Clinical Trials
- Dental/Anesthesia Services – Hospital or Ambulatory Surgery
- Dental Services – Accident only
- Diabetes Treatment
- Emergency Services
- Home Health Care
- Hospice
- Hospital – Inpatient Services
- Kidney Disease Treatment
- Lab, X-Ray, Diagnostic Services
- Maternity Services
- Mental Health and Substance Abuse Services – Outpatient, Inpatient and Transitional Care
- Ostomy Supplies
- Outpatient Pharmaceutical Products
- Outpatient Surgery, Diagnostic Therapeutic Services
- Physician's Office Services
- Preventive Care Services
- Professional Fees for Surgical and Medical Services
- Prosthetic Devices & Durable Medical Equipment
- Reconstructive Procedures
- Rehabilitation Services – Outpatient Therapy
- Skilled Nursing Facility/Inpatient Rehabilitation Facility Services
- Temporomandibular Joint Disorders
- Transplantation Services
- Urgent Care Services
- Vision Exam

In addition, outpatient prescription drug coverage is added to many of the policies through a rider.

Inpatient mental health and AODA coverage is limited to \$7,000, outpatient mental health and AODA coverage is limited to \$2,000 per year, emergency services have a copayment range from \$5 to \$500, and skilled nursing care can range from 30-180 days. Plan coverage is contingent on non-emergency services being provided by participating physicians and hospitals.

The HMO also offers a point-of-service (POS) product called Choice Plus. This product provides comprehensive benefits similar to the commercial HMO product; however, policyholders are not restricted to participating providers and are not required to obtain primary care physician referrals for specialist or out-of-network care. This product is jointly offered through an affiliate, UnitedHealthCare Insurance Company (UHIC). As described in the certificates of coverage, the HMO retains the risk for in-network care, out-of-network emergency and urgent care, and out-of-network care pursuant to participating physician referral. UHIC is responsible for the risk for all out-of-network self-referral claims with the exception of emergency or urgent care services. In return for this coverage, UHIC receives 8% of premiums received pursuant to a Premium Allocation Agreement dated January 1, 1998. In addition, the HMO has an aggregate excess of loss reinsurance agreement with UHIC effective August 1, 1990, to cover in-network POS claims in excess of a fixed percentage of in-network premiums. The benefits for the POS products may be changed by riders to include various levels of deductibles, copayments, and out-of-pocket ceilings.

The HMO entered into a Medicare Advantage (f/k/a Medicare+Choice) contract with the Health Care Financing Administration (HCFA) in 1995, now called the Centers for Medicare and Medicaid Services (CMS). The Medicare Advantage program was established pursuant to the Balanced Budget Act of 1997 and further modified by the Medicare Modernization Act of 2003, and replaced the existing Medicare risk program. In general, beneficiaries under the Medicare Advantage contract must use the HMO's network of providers, with the exception of medically necessary emergency health services and health services provided in an urgent care center outside of the service area. A POS benefit has been added that allows beneficiaries to

obtain specified services outside of the network within a defined service area. Under the contract, the HMO agrees to provide enrollees with Medicare Part A and Part B benefits, Medicare Part D outpatient prescription drug benefits as well as supplemental benefits based on the annual bid and approval process established by CMS. CMS reimburses the HMO in accordance with a capitated rate, which is adjusted primarily on individual beneficiary hierarchical health conditions (HHC) as well as demographic risk factors such as a beneficiary's age, disability status, sex, institutional status, and other factors as CMS deems appropriate. The current contract period runs from January 1, 2014, to December 31, 2014.

The HMO derives approximately 23% of its revenues from Wisconsin's Medicaid/Badgercare Program. The HMO contracts directly with the Wisconsin Department of Health Services (DHS) to provide specified health care benefits to eligible Medicaid Assistance/Badgercare recipients. In exchange for these services, the HMO is paid a monthly capitation rate, which is designed to be less than the cost of providing the same services covered under the contract to a comparable Medicaid population on a fee-for-service basis. The current contract with DHS will expire on December 31, 2015.

The HMO currently markets its commercial HMO product to groups only. The HMO uses external brokerage agencies and pays commissions ranging from \$0 to \$21 per employee per month on new and renewal business for groups with 51-99 eligible employees, and uses broker service fee agreements for groups with 100+ eligible employees. For small employer groups, agents are paid according to a predetermined per employee per month rate, ranging from \$10 to \$38 depending on the number of subscribers.

For large groups, the HMO looks at a combination of actual claims experience and medical trend to determine premium rates. Experience is reviewed for renewal groups and, based on the review, a recommendation is made regarding adjusting the rate or canceling the group. For small groups, the HMO uses an actuarially determined base as a beginning point in premium determination. This rate is adjusted by various rating factors, such as age, location, and effective date, as filed and as allowed by law. Medicaid/Badgercare and Medicare rates are

negotiated between the HMO and the sponsoring state agency (DHS for Medicaid/Badgercare), or sponsoring federal agency (CMS for Medicare).

III. MANAGEMENT AND CONTROL

Board of Directors

The board of directors consists of five members. All directors are elected annually to serve a one-year term. Officers are appointed by the board of directors. Members of UnitedHealthcare of Wisconsin, Inc.'s board of directors may also be members of other boards of directors in the holding company group. The board members currently receive no compensation for serving on the board.

Currently the board of directors consists of the following persons:

Name and Residence	Principal Occupation	Term Expires
Christopher M. Abbott Menomonee Falls, WI	Regional Vice President of UnitedHealthcare Medicare & Retirement	2014
Wendy D. Arnone Menomonee Falls, WI	President - Commercial Business of UnitedHealthcare of Wisconsin	2014
Donna D. Davidoff Mequon, WI	Chief Medical Officer of UnitedHealthcare of Wisconsin	2014
Bror O. Hultgren Golden, CO	Senior Vice President of Complex Care	2014
Jeffrey J. Nohl Oconomowoc, WI	President of UnitedHealthcare Community Plan of Wisconsin	2014

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	2012 Salary
Jeffrey Nohl	President, CEO	\$559,393*
Christopher Buel	Chief Financial Officer	179,143*
Robert Oberrender	Treasurer	15,656*

* This amount is the part of their total compensation that is allocated to UnitedHealthcare of Wisconsin, Inc.

The company has no employees. Necessary staff is provided through a management agreement with United HealthCare Services, Inc. Under the agreement, effective March 1, 2011, UHS agrees to negotiate employer, provider, subscriber, and other contracts; advises the board; maintains accounting and financial records; recruits marketing, utilization

review, and claims processing personnel; provides or contracts for claims processing, and MIS. UHS receives a monthly fee, calculated as 8.5% of gross revenues, as compensation for services rendered. The term of the agreement is continuous. The company may terminate the agreement upon 60 days' written notice to the other party.

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:

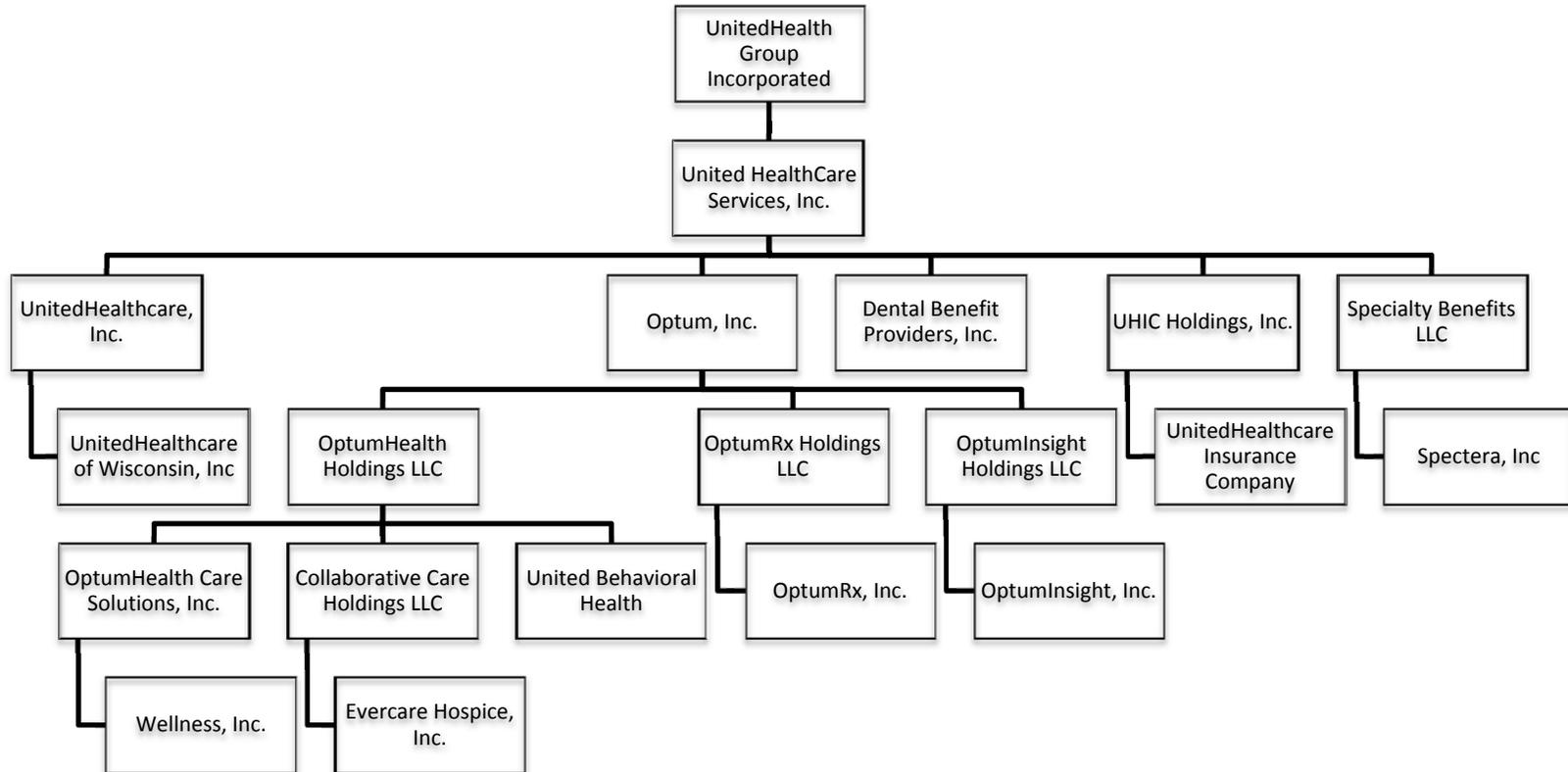
1. Enrollees hospitalized on the date of insolvency will be covered until discharged; and
2. Enrollees will be entitled to similar, alternate coverage which does not contain any medical underwriting or preexisting limitation requirements.

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 UnitedHealth Group Incorporated. There were 373 legal entities in the UHG system. The abbreviated organizational chart below depicts the relationships among the affiliates in the group that interact with the company. A brief description of the significant affiliates of the company follows the organizational chart.

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



Note: Not all subsidiaries of UHG have been included in this organizational chart. UHG had 373 subsidiaries, including the company, at December 31, 2012.

UnitedHealth Group Incorporated

UnitedHealth Group Incorporated, the ultimate controlling entity in the insurance holding company system, is a diversified health and well-being company serving approximately 70 million members throughout the United States. Through its affiliated companies, UHG offers a broad spectrum of health care products and services. As of December 31, 2012, the company's consolidated audited financial statement reported assets of \$80.9 billion, liabilities of \$47.6 billion, and shareholders' equity of \$31.2 billion. Operations for 2012 produced net income of \$5.5 billion on revenues of \$110.6 billion. UHG is traded over the New York Stock Exchange under the symbol "UNH."

United HealthCare Services, Inc.

United HealthCare Services, Inc., a wholly owned subsidiary of UHG, provides administrative and other services to various member companies in the holding company group. As of December 31, 2012, the company's consolidated audited financial statement reported assets of \$58.9 billion, liabilities of \$23.4 billion, and shareholder's equity of \$35.3 billion. Operations for 2012 produced net income of \$5.2 billion on revenues of \$96.9 billion.

UnitedHealthcare Insurance Company

UnitedHealthcare Insurance Company is a wholly owned subsidiary of UHIC Holdings, Inc. The company is licensed to sell life and accident and health insurance in most states and primarily issues group accident and health insurance contracts to employers and associations. As of December 31, 2012, the company's audited financial statement reported assets of \$14.1 billion, liabilities of \$9.4 billion, and capital and surplus of \$4.7 billion. Operations for 2012 produced net income of \$2.5 billion on revenues of \$43.1 billion.

Agreements with Affiliates

Effective August 1, 2012, the HMO entered into an amended and restated Revolving Credit Agreement with UHG. Under this agreement, UHG will provide the HMO with a short-term borrowing facility. The HMO may borrow funds upon demand from United, up to a maximum of \$50 million, at an interest rate equal to the LIBOR rate plus 50 base points. The agreement may be terminated with 60 days' prior written notice by either party. This agreement replaced the

Participating Addendum for the Subordinated Revolving Credit Agreement with UHG that was effective from December 1, 1999, to July 31, 2012.

Effective August 1, 1991, the HMO entered into a Tax-Sharing Agreement with UHG. The Tax-Sharing Agreement establishes a formal method for the allocation and payment of federal, state and local income tax liabilities related to the consolidated federal income tax returns filed each year. Quarterly federal tax estimates are paid to UHG each quarter, with over and underpayments due within 60 days of UHG filing the return. An addendum effective October 1, 1996, clarified the treatment of member losses and credits related to the consolidated federal income tax returns filed each year. The agreement will continue until terminated as long as the HMO is owned by UHG.

Effective March 1, 2012, the HMO entered into an agreement with United Behavioral Health (UBH). Under this agreement, UBH is responsible for arranging for the provision of certain mental health and substance abuse treatment services for the HMO's commercial, Medicare, and Medicaid customers. The HMO shall pay a monthly fee for each service rendered on a per member per month (PMPM) basis. The agreement may be terminated with 60 days' prior written notice by either party. This agreement replaces and supersedes the Agreement for the Provision of Services between UBH and Primecare Health Plan, Inc., effective January 1, 1998.

Effective April 1, 2010, the HMO is a participant in an existing agreement between UHIC, UHS and PacifiCare Health Plan Administrators, Inc. (PHPA), entered into on December 1, 2006. UHS will utilize UHIC as a common lockbox for premium collection and zero balance disbursement account for paying certain bills, allowing for more administrative ease when servicing customers who purchase products or services from more than one affiliate. The agreement will continue until terminated by mutual agreement or with 60 days' notice. The agreement will continue indefinitely unless terminated at any time by the consent of all related parties. Any participant can terminate their participation on demand, and will terminate if they are no longer an affiliate of the service providers.

Effective February 1, 2012, the HMO entered into an agreement with Dental Benefit Providers, Inc. (DBP). Under this agreement, DBP is responsible for developing, contracting, and

managing a network of dental providers to provide dental health care services for the HMO's insureds. This includes establishing and maintaining a credentialing process, having a quality management program, setting requirements for providers, providing appropriate geographic access to providers, and performing certain claims administration services. The HMO shall pay a monthly fee per service provided per customer to DBP. The agreement will continue until terminated by mutual agreement or with 60 days' prior written notice by either company.

Effective May 1, 2008, the HMO entered into an agreement with OptumRx, Inc. (OptumRx), formerly known as Rx Solutions, Inc., and United Healthcare Products, LLC. Under this agreement, OptumRx is responsible for covering pharmacy medications covered under the HMO's medical benefits. The HMO shall pay for covered services at the lesser of the eligible charges or a contract rate. The agreement had a three-year term and will automatically renew for one year at a time until terminated by mutual agreement or with 180 days' prior written notice by either company.

Effective January 1, 2012, the HMO entered into an agreement with OptumRx. Under this agreement, OptumRx is responsible for covering Durable Medical Equipment (DME) Services and Hearing Aids for the HMO's members. This agreement is available to be used by all products that the HMO offers. The HMO shall pay for covered services at the lesser of OptumRx's customary charges or United's DME/orthotics and prosthetics fee schedule. The agreement had a three-year term and will automatically renew for one year at a time until terminated by mutual agreement or with 180 days' prior written notice by either company.

Effective October 1, 2010, the HMO entered into an agreement with Wellness, Inc. (Wellness). Under the agreement, Wellness provides influenza and pneumococcal vaccination services to the HMO's commercial and Medicare members. The fees are to be charged per vaccination given and are the same for Wellness customers. The agreement had a three-year term and will automatically renew for one year at a time until terminated by mutual agreement or with 180 days' notice.

Effective January 1, 2009, the HMO is a participant in an existing agreement between UHS and OptumRx. Under the agreement, OptumRx will provide the HMO's AmeriChoice and

Ovations Medicare members with catalogues to “purchase” items (including over-the-counter drugs, canes, and other DME) either outright or using accumulated points.

Effective March 1, 2011, the HMO has a management agreement with UHS, whereby UHS will provide administrative and management services to the company, until termination upon written agreement of both parties. The HMO pays UHS a monthly management fee, equal to UHS’s expenses for services and use of assets provided to the HMO and the portion of UHS’s expenses allocated to the HMO, for the given month. The agreement will continue until terminated by mutual agreement or with 60 days’ notice.

Effective February 1, 2009, the HMO is a participant in an existing agreement between UHS and OptumRx, entered into on January 1, 2009. Under this agreement, OptumRx provides the HMO’s Medicare members with durable medical equipment and supplies, specifically diabetic test strips, the reading instrument and any equipment related to the testing of blood glucose levels. The HMO shall pay for covered services at the lesser of the usual and customary charge or the contracted rate. The agreement had a one-year term and will automatically renew for one year at a time until terminated with 45 (if terminated by UHS) or 180 (if terminated by OptumRx) days’ prior written notice.

Effective July 1, 2011, the HMO entered into a Service Agreement with Ingenix, Inc., now known as OptumInsight, Inc. (OptumInsight). Under this agreement, OptumInsight provides the HMO with services relating to claim analytics and recovery services, retrospective fraud, waste and abuse services and subrogation services. The HMO shall pay for each service on a monthly basis at assorted rates based on services rendered PMPM or gross amount avoided/recovered, as appropriate. The agreement will continue until terminated. This replaces the Retrospective Fraud and Abuse Services Agreement, effective April 1, 2009, and the Subrogation Services Agreement, amended once effective January 1, 2009. The agreement will continue until terminated by mutual agreement or with 60 days’ prior written notice by either company.

Effective January 1, 2012, the HMO entered into an agreement with Spectera, Inc. (Spectera). Under this agreement, Spectera is responsible for managing a network of vision

providers to provide vision services and/or products (frames and contact lenses), claims processing and other administrative functions related to its vision services to the HMO's commercial and Medicare members. The HMO shall pay a monthly fee for each service rendered PMPM. The agreement may be terminated with 60 days' prior written notice by either party.

Effective August 1, 2009, the HMO is a participant in the Evercare Hospice, Inc. (Evercare) agreement with UHIC, entered into on July 1, 2007. Under this agreement, Evercare maintains a network of providers to provide the HMO's commercial and Medicaid customers with covered services for hospice care. Evercare does not currently have a location in Wisconsin, and this agreement is currently anticipated to have no financial impact on the HMO. If fees are incurred, the HMO shall pay for coverable services at the lesser of the eligible charges or a contract rate. The agreement had a three-year term and will automatically renew for one year at a time until terminated by mutual agreement or with 180 days' prior written notice by either company.

The HMO has a premium allocation agreement with UHIC with respect to the point-of-service product that is offered jointly by the two insurers. The agreement commenced on January 1, 1998, and will continually renew each January 1st, unless terminated by either party upon 180 days' prior written notice to the other party. Under the agreement, UHIC receives a percentage of the POS premiums in return for providing out-of-network coverage for this product. Under the current agreement, UHIC receives 8% of the premium for its obligations under the contract.

V. REINSURANCE

The HMO has reinsurance coverage under the contract outlined below:

1. Reinsurer: UnitedHealthcare Insurance Company, Inc.
Type: Specific Excess of Loss Reinsurance
Effective date: July 1, 1991
Lines covered: All Lines
Retention: Commercial Members - \$400,000/member/year; 20% coinsurance
Medicaid Members - \$200,000/member/year; 10% coinsurance
Medicare Members - \$450,000/member/year; 10% coinsurance
Coverage: Maximum annual coverage of \$2,000,000 for eligible inpatient services, after deductible and coinsurance
Premium: \$0.54 per commercial member per month
\$0.35 per Medicaid member per month
\$0.66 per Medicare member per month
Termination: The contract took effect on July 1, 1991, and shall continue in full force until terminated by either party giving at least 90 days' written notice prior to the anniversary of the effective date

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

1. The reinsurer will continue the Plan benefits as defined in the Membership Service Agreements for Commercial and Medicaid members who are receiving non-custodial care while confined in an inpatient facility on the date of the insolvency, until their discharge.

In addition, the reinsurer will continue the Plan benefits as defined in the Member Service Agreements for Medicare members who are receiving non-custodial care while confined in an inpatient facility, skilled nursing facility or rehabilitation facility on the date of the insolvency, until their discharge.
2. The reinsurer will continue the Plan benefits as defined in the Membership Service Agreement for any member until the end of the contract period for which premium was paid to the Plan by or on behalf of the member.
3. Each member for himself and covered dependents shall have the right to convert within 30 days of the date of insolvency, without evidence of insurability, to coverage then being offered by the reinsurer to other insureds eligible for conversion under its group insurance policies with the same benefits and at the same rates as offered to such other insureds.

2. Reinsurer: UnitedHealthcare Insurance Company, Inc.
- Type: Aggregate Excess of Loss Reinsurance
- Effective date: August 1, 1990
- Lines covered: Point of Service
- Retention: 90% of gross earned premium for the POS product
- Coverage: The reinsurer is liable for the amount by which the HMO's ultimate net loss exceeds its retention
- Premium: 1% of gross earned premium
- Termination: The contract shall automatically be renewed each January 1, unless mutually terminated by the parties to the contract

In addition, the HMO is provided with corporate insurance coverage under the contracts listed below:

Type of Coverage	Policy Limits
Professional Liability	\$25,000,000
General Liability	1,000,000/Occurrence; 3,000,000/Aggregate
Directors' and Officers' Liability	25,000,000
Automobile Liability	1,000,000
Crime	25,000,000
Property	25,000,000/Location
Umbrella	25,000,000

The above coverages were obtained through various insurers which are licensed in Wisconsin.

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.

UnitedHealthcare of Wisconsin, Inc.
Assets
As of December 31, 2012

	Assets	Nonadmitted Assets	Net Admitted Assets
Bonds	\$231,689,478	\$	\$231,689,478
Cash, cash equivalents and short-term investments	36,340,624		36,340,624
Investment income due and accrued	1,837,480		1,837,480
Uncollected premiums and agents' balances in the course of collection	34,368,940	104,508	34,264,432
Accrued retrospective premiums	1,165,063		1,165,063
Amounts receivable relating to uninsured plans	7,909,524	360,720	7,548,804
Net deferred tax asset	6,734,288		6,734,288
Receivables from parent, subsidiaries and affiliates	1,426,749	1,426,749	
Health care and other amounts receivable	14,560,104	10,801,802	3,758,302
Aggregate write-ins for other than invested assets	<u>338,105</u>	<u>338,105</u>	<u> </u>
Total Assets	<u>\$336,370,354</u>	<u>\$13,031,884</u>	<u>\$323,338,471</u>

UnitedHealthcare of Wisconsin, Inc.
Liabilities and Net Worth
As of December 31, 2012

Claims unpaid			\$139,601,135
Accrued medical incentive pool and bonus payments			961,731
Unpaid claims adjustment expenses			2,564,532
Aggregate health policy reserves			4,630,278
Aggregate health claim reserves			596,346
Premiums received in advance			1,814,935
General expenses due or accrued			9,112,864
Current federal and foreign income tax payable and interest thereon			2,081,734
Ceded reinsurance premiums payable			148,753
Remittance and items not allocated			1,207
Amounts due to parent, subsidiaries and affiliates			16,984,139
Liability for amounts held under uninsured accident and health plans			1,997,587
Aggregate write-ins for other liabilities (including \$3,123,347 current)			<u>3,132,887</u>
Total liabilities			183,628,128
Common capital stock	\$	1,000	
Gross paid in and contributed surplus		50,289,807	
Unassigned funds (surplus)		<u>89,419,536</u>	
Total capital and surplus			<u>139,710,343</u>
Total Liabilities, Capital and Surplus			<u>\$323,338,471</u>

UnitedHealthcare of Wisconsin, Inc.
Statement of Revenue and Expenses
For the Year 2012

Net premium income		\$1,432,141,956
Change in unearned premium reserves and reserve for rate credits		<u>(1,457,447)</u>
Total revenues		1,430,684,509
Medical and hospital:		
Hospital/medical benefits	\$ 998,931,116	
Other professional services	15,178,991	
Prescription drugs	40,606,607	
Aggregate write-ins for other medical and hospital	179,389,321	
Incentive pool and withhold adjustments	<u>(174,409)</u>	
Subtotal	1,233,931,626	
Less		
Net reinsurance recoveries	<u>694,673</u>	
Total medical and hospital	1,233,236,953	
Non-health claims		
Claims adjustment expenses	65,075,948	
General administrative expenses	110,530,889	
Increase in reserves for life and accident and health contracts	<u>(9,395,000)</u>	
Total underwriting deductions		<u>1,399,448,790</u>
Net underwriting gain or (loss)		31,235,719
Net investment income earned	5,423,065	
Net realized capital gains or (losses)	<u>505,646</u>	
Net investment gains or (losses)		5,928,711
Net gain or (loss) from agents' or premium balances charged off		(108,892)
Aggregate write-ins for other income or expenses		<u>(103,980)</u>
Net income or (loss) before federal income taxes		36,951,558
Federal and foreign income taxes incurred		<u>9,899,225</u>
Net Income (Loss)		<u>\$ 27,052,333</u>

UnitedHealthcare of Wisconsin, Inc.
Capital and Surplus Account
As of 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:

Capital and surplus prior reporting year		\$132,506,077
Net income or (loss)	\$27,052,333	
Change in net deferred income tax	(472,005)	
Change in nonadmitted assets	(4,847,695)	
Dividends to stockholders	(13,000,000)	
Aggregate write-ins for gains or (losses) in surplus	<u>(1,528,367)</u>	
Net change in capital and surplus		<u>7,204,266</u>
Capital and Surplus End of Reporting Period		<u>\$139,710,343</u>

UnitedHealthcare of Wisconsin, Inc.
Statement of Cash Flows
As of December 31, 2012

Premiums collected net of reinsurance		\$1,435,164,295
Net investment income		<u>7,063,497</u>
Total		1,442,227,791
Less:		
Benefit- and loss-related payments	\$1,245,257,299	
Commissions, expenses paid and aggregate write-ins for deductions	186,674,596	
Federal and foreign income taxes paid (recovered) \$294,545 net tax on capital gains (losses)	<u>13,078,070</u>	
Total		<u>1,445,009,964</u>
Net cash from operations		(2,782,173)
Proceeds from investments sold, matured or repaid:		
Bonds	46,750,034	
Cost of investments acquired - long-term only:		
Bonds	<u>93,849,186</u>	
Net cash from investments		(47,099,152)
Cash provided/applied:		
Dividends to stockholders	13,000,000	
Other cash provided (applied)	<u>21,282,444</u>	
Net cash from financing and miscellaneous sources		<u>8,282,444</u>
Net change in cash, cash equivalents, and short-term investments		(41,598,881)
Cash, cash equivalents, and short-term investments:		
Beginning of year		<u>77,939,505</u>
End of Year		<u>\$ 36,340,624</u>

Growth of UnitedHealthcare of Wisconsin, Inc.

Year	Assets	Liabilities	Capital and Surplus	Premium Earned	Medical Expenses Incurred	Net Income
2012	\$323,338,471	\$183,628,128	\$139,710,343	\$1,430,684,509	\$1,233,236,953	\$27,052,333
2011	312,975,271	180,469,194	132,506,077	1,402,997,813	1,210,599,557	31,487,879
2010	389,233,858	282,094,941	107,138,917	1,215,847,496	1,024,893,885	39,837,244
2009	228,486,705	134,741,427	93,745,278	1,308,085,650	890,252,812	45,617,273
2008	208,869,682	98,719,819	110,149,863	696,979,553	575,125,545	41,805,740

Year	Profit Margin	Medical Expense Ratio	Administrative Expense Ratio	Change in Enrollment
2012	1.89%	86.11%	8.96%	(42.25)%
2011	2.24	86.37	7.47	12.00
2010	3.25	84.97	8.80	23.35
2009	4.39	85.78	7.76	24.12
2008	6.00	83.55	10.40	14.50

Enrollment and Utilization

Year	Enrollment	Hospital Days/1,000	Average Length of Stay
2012	220,617	762.16	5.8
2011	382,013	705.55	5.9
2010	341,074	668.38	5.6
2009	276,510	637.47	5.3
2008	222,783	783.48	4.3

Per Member Per Month Information

	2012	2011	Percentage Change
Premiums:			
Commercial	\$454.65	\$477.11	(4.7)%
Medicare	735.78	718.55	2.4
Medicaid	<u>208.64</u>	<u>209.77</u>	(0.5)
	332.01	313.11	6.0
Expenses:			
Hospital/medical benefits	231.58	208.39	11.1
Other professional services	3.52	5.81	(39.5)
Outside referrals			
Emergency room and out-of-area			
Prescription drugs	9.41	8.39	12.2
Other medical and hospital	41.59	47.45	(12.4)
Incentive pool and withhold adjustments	(0.04)	0.40	(110.2)
Less: Net reinsurance recoveries	<u>0.16</u>	<u>0.64</u>	(75.0)
Total medical and hospital	285.90	269.79	6.0
Claims adjustment expenses	15.09	13.85	8.9
General administrative expenses	25.62	20.20	26.9
Increase in reserves for accident and health contracts	<u>(2.18)</u>	<u>2.09</u>	(204.0)
 Total Underwriting Deductions	 <u>\$324.43</u>	 <u>\$305.94</u>	 6.0

The large increase in assets and liabilities in 2010 was due to the company receiving a \$143 million capitation payment from the state of Wisconsin, which was made in December 2010 for the first quarter of 2011. This payment resulted in large increases in assets (cash and short-term investments) and liabilities (advance premium).

The HMO has been profitable over the examination period posting a net income during all five years under examination. The company's membership increased from 2008-2011 due to growth in the Medicare and Medicaid business lines. The large membership decrease in 2012 was due to the termination of BadgerCare Plus agreements in two regions of the state. Subsequently the company has re-entered one of the regions. The company paid dividends to its parent of \$13 million in 2012, \$44.3 million in 2010, \$47 million in 2009, and \$42.7 million in 2008. Over that same period surplus increased from \$110 million in 2008 to \$139 million in 2012.

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 four 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. Cash—It is recommended that the HMO show all active cash accounts on the Schedule E – Part 1, Cash, in accordance with the NAIC Annual Statement Instructions – Health.
Action—Compliance.
2. Health Care Receivables—It is recommended that the HMO value its pharmaceutical rebates and other receivables from affiliates in accordance with s. Ins 9.10, Wis. Adm. Code.
Action—Compliance.
3. HIRSP Assessment—It is recommended that the HMO accrue an appropriate expense and liability for its HIRSP Assessment Payable on a monthly basis.
Action—Compliance.
4. Premium Deficiency Reserve—It is recommended that the HMO comply with the guidelines set forth in SSAP No. 54, paragraph 18, and evaluate its methodology for calculating Premium Deficiency Reserves as it concerns the allocation of indirect expenses and make appropriate changes that will result in consistency between the Annual Statement and PDR calculations.
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:

	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, 2012, is as follows:

Assets	\$ 323,338,471	
Less:		
Special deposit	8,012,641	
Liabilities	<u>183,628,128</u>	
Assets available to satisfy surplus requirements		\$131,628,128
Net premium earned	1,251,295,188	
Compulsory factor	<u>6%</u>	
Compulsory surplus		<u>75,077,711</u>
Compulsory Surplus Excess/(Deficit)		<u>\$ 56,619,991</u>
Assets available to satisfy surplus requirements		\$131,628,128
Compulsory surplus	\$ 75,077,711	
Security factor	<u>110%</u>	
Security surplus		<u>82,585,482</u>
Security Surplus Excess/(Deficit)		<u>\$ 49,112,220</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 2012 with a deposit of \$8,012,641 with the State Treasurer.

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VIII. CONCLUSION

UnitedHealthcare of Wisconsin, Inc., is a for-profit network model HMO serving 57 counties in Wisconsin. The HMO commenced business in June 1986 and subsequently underwent a number of mergers, acquisitions, and name changes. The HMO became a wholly owned subsidiary of UnitedHealthcare, Inc., on June 30, 2000, and acquired its current name, UnitedHealthcare of Wisconsin, Inc. (formerly PrimeCare Health Plan, Inc.) pursuant to an amendment to the Articles of Incorporation effective December 31, 1999.

The HMO has been profitable over the examination period posting a net income during all five years under examination. The company's membership increased from 2008-2011 due to growth in the Medicare and Medicaid business lines. The large membership decrease in 2012 was due to the termination of BadgerCare Plus agreements in two regions of the state. The company paid dividends to its parent of \$13 million in 2012, \$44.3 million in 2010, \$47 million in 2009, and \$42.7 million in 2008. Over that same period surplus increased from \$110 million in 2008 to \$139 million in 2012.

The company complied with all four of the prior recommendations. There were no recommendations as a result of this examination.

IX. SUMMARY OF COMMENTS AND RECOMMENDATIONS

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

X. ACKNOWLEDGMENT

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

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

Name	Title
Diana Havitz	Insurance Financial Examiner
Thomas Houston	IT Specialist

Respectfully submitted,

Terry Lorenz
Examiner-in-Charge

Addendum I

Amery Regional Medical Center
Appleton Medical Center
Aspirus Wausau Hospital
Aurora Baycare Medical Center
Aurora Health Care Metro (Sinai)
Aurora Health Care Metro (St Lukes)
Aurora Lakeland Medical Center
Aurora Medical Center Grafton
Aurora Medical Center Kenosha
Aurora Medical Center Manitowoc
Aurora Medical Center Of Washington
Aurora Medical Center Oshkosh
Aurora Medical Center Summit
Aurora Memorial Burlington
Aurora Sheboygan Memorial Medical Center
Aurora St Lukes South Shore
Aurora West Allis Medical Center
Baldwin Area Medical Center Inc
Bay Area Medical Center
Beaver Dam Community Hospital
Bellin Memorial Hospital
Beloit Memorial Hospital
Berlin Memorial Hospital
Black River Mem Hospital
Boscobel Area Health Care
Burnett Medical Center
Calumet Medical Center
Childrens Hospital Of Wisconsin
Chippewa Valley Hospital
Columbia Center
Columbia St Marys Hospital Milwaukee
Community Memorial Hospital Of Menomonee Falls
Community Memorial Hospital
Cumberland Memorial Hospital
Divine Savior Healthcare
Door County Memorial Hospital
Eagle River Memorial Hospital
Edgerton Hospital Health Services
Flambeau Hospital
Fort Healthcare
Froedtert Memorial Lutheran Hospital
Good Samaritan Health Center
Grant Regional Health Center
Gundersen Lutheran Medical Center
Hayward Area Memorial Hospital
Holy Family Memorial
Howard Young Medical Center
Hudson Hospital and Clinics
Indianhead Medical Center
Kindred Hospital Milwaukee
Lakeview Medical Center Inc Of Rice Lake
Lakeview Specialty Hospital
Langlade Hospital
Lifecare Hospital Of Wisconsin
MCHS Chippewa Valley
MCHS Eau Claire Luther Campus
MCHS Medical Center La Crosse
MCHS Medical Center Sparta
MCHS Northland
MCHS Oakridge
MCHS Red Cedar
Memorial Health Center
Memorial Hospital Lafayette County
Memorial Medical Center Inc
Mercy Hospital Of Janesville
Mercy Medical Center
Mercy Walworth Hospital and Medical Center
Midwest Orthopedic Speciality Hospital
Monroe Clinic
Moundview Memorial Hospital and Clinics
New London Family Medical Center
Oakleaf Surgical Hospital
Oconomowoc Memorial Hospital - Prohealth Care
Oconto Hospital and Medical Center
Orthopaedic Hospital Of Wisconsin
Osceola Medical Center
Our Lady Of Victory Hospital
Reedsburg Area Medical Center
Rehabilitation Hospital Of Wisconsin
Richland Hospital
Ripon Medical Center
River Falls Area Hospital
Riverside Medical Center
Riverview Hospital Association
Rusk County Memorial Hospital
Sacred Heart Hospital
Sacred Heart Rehab Hospital
Sauk Prairie Memorial Hospital
Select-Milwaukee St Lukes
Shawano Medical Center
Southwest Health Center
Spooner Health System
SSH Madison
St Agnes Hospital
St Clare Hospital and Health Services
St Clare's Hospital Of Weston
St Croix Regional Medical Center
St Elizabeth Hospital
St Elizabeth Medical Center
St Joseph's Community Hospital West Bend
St Joseph's Health Services
St Joseph's Hospital
St Mary's Hospital and Medical Center Madison
St Mary's Hospital
St Mary's Hospital and Medical Center
St Mary's Hospital of Superior

St Mary's Hospital Ozaukee
St Mary's Janesville Hospital
St Michaels Hospital
St Nicholas Hospital
St Vincent Hospital
Stoughton Hospital
Theda Clark Medical Center
Tomah Memorial Hospital
Tri County Memorial Hospital
United Hospital System-Kenosha Medical Center
Upland Hills Health
UW Health Partners Watertown Regional
Vernon Memorial Hospital
Waukesha Mem Hospital - Prohealth Care
Waupun Memorial Hospital
Westfields Hospital
Wheaton Franciscan Healthcare Franklin
Wheaton Franciscan Healthcare-All Saints
Wheaton Franciscan Healthcare St Francis
Wheaton Franciscan, Inc
Wild Rose Community Memorial Hospital