# REPORT ON EXAMINATION

# OF

# UNITED HEALTHCARE INSURANCE COMPANY OF NEW YORK, INC.

# AS OF

# DECEMBER 31, 2003

**DATE OF REPORT** **JANUARY 11, 2008**

**EXAMINER** **WAI WONG**

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STATE OF NEW YORK
INSURANCE DEPARTMENT
25 BEAVER STREET
NEW YORK, NEW YORK 10004

Eliot Spitzer
Governor

Eric R. Dinallo
Superintendent

January 11, 2008

Honorable Eric R. Dinallo
Superintendent of Insurance
Albany, New York 12257

Sir:

Pursuant to the provisions of the New York Insurance Law and acting in accordance with the instructions contained in Appointment Number 22140, dated January 30, 2004, attached hereto, I have made an examination into the condition and affairs of United HealthCare Insurance Company of New York, Inc., a company licensed pursuant to the provisions of Article 42 of the New York Insurance Law, as of December 31, 2003 and submit the following report thereon.

The examination was conducted at the Company's offices located at 450 Columbus Blvd., Hartford, CT and Two Penn Plaza, Suite 700, New York, NY. United HealthCare Insurance Company of New York, Inc. is a wholly-owned subsidiary of United HealthCare Insurance Company, which is a wholly-owned subsidiary of UnitedHealth Group Incorporated.

Whenever the terms “UHINY”, or “the Company” appear herein, without qualification, they should be understood to mean United HealthCare Insurance Company of New York, Inc. Whenever the term “the Parent” appears herein, without qualification, it should be understood to mean UnitedHealth Group Incorporated.

A concurrent examination was made of UnitedHealthcare of New York, Inc., an affiliated health maintenance organization (HMO), licensed under the provisions of Article 44 of the Public Health Law. A separate report thereon has been submitted.

## 1. SCOPE OF EXAMINATION

United HealthCare Insurance Company of New York was previously examined as of December 31, 1999. The current examination covered the period from January 1, 2000 through December 31, 2003. Transactions subsequent to this period were reviewed where deemed appropriate.

The examination comprised a verification of assets and liabilities as of December 31, 2003 in accordance with Statutory Accounting Principles (SAP), as adopted by the Department, and a review of income and disbursements deemed necessary to accomplish such verification. The examination also utilized, to the extent considered appropriate, work performed by the Company's independent certified public accountants.

A review or audit was also made of the following items as called for in the Examiners Handbook of the National Association of Insurance Commissioners:

History of the Company
Management and controls
Corporate records
Fidelity bonds and other insurance
Territory and plan of operation
Growth of the Company
Business in force
Reinsurance
Accounts and records
Loss experience
Financial statements
Treatment of policyholders and claimants

This report is confined to financial statements and comments on those matters, which involve departures from laws, rules or regulations, or which are deemed to require explanation or description.

## 2. DESCRIPTION OF COMPANY

The Company is a domestic insurer licensed to write accident and health insurance, as defined in Paragraphs 3(i) and 3(ii) of Subsection (a) of Section 1113 of the New York Insurance Law. The Company was originally incorporated on February 8, 1995, as The MetraHealth Insurance Company of New York and commenced business on December 28, 1995. The Company is a wholly-owned subsidiary of United HealthCare Insurance Company, (formerly known as The MetraHealth Insurance Company and Travelers Insurance Company of Illinois), a Connecticut stock corporation.

The Company's administrative office is located at 2950 Expressway Drive South, Islandia, NY 11749.

### A. Management

Pursuant to the Company's charter and by-laws, management of the Company is to be vested in a board of directors consisting of not less than thirteen, nor more than twenty directors. At December 31, 2003, the thirteen members of the Board of Directors were as follows:

| Name and Residence | Principal Business Affiliation |
|---|---|
| Thomas E. Burton<br>South Windsor, CT | Vice-President and Actuary,<br>United HealthCare Insurance Company |
| Ronald B. Colby<br>Minnetrista, MN | Chairman and President,<br>United HealthCare Insurance Company of New York |
| Loretta D. Eisele<br>East Islip, NY | Healthplan Operations,<br>UnitedHealthcare of New York, Inc. |
| Patrick J. Erlandson<br>North Oaks, MN | Vice-President,<br>UnitedHealthcare of New York, Inc. |
| Matthew L. Friedman<br>West Hartford, CT | Assistant Secretary,<br>United HealthCare Insurance Company of New York |
| Jeffrey W. Kagan<br>Famingville, NY | Vice-President,<br>United HealthCare Insurance Company of New York |
| Amy K. Knapp<br>New York, NY | President,<br>United HealthCare Insurance Company of New York |
| P. Alain McMahon<br>Hebron, CT | Assistant Secretary,<br>United HealthCare Insurance Company of New York |
| William A. Munsell<br>Wayzata, MN | Executive Officer,<br>United HealthCare Insurance Company of New York |
| Nancy J. Sika<br>Ridge, NY | Vice-President,<br>United HealthCare Insurance Company of New York |
| Cecilia A. Walpole Griffin<br>Columbia, CT | Director, Treasury Operations,<br>United HealthCare Insurance Company of New York |
| Laurie Wasserstein<br>Delmar, NY | Vice-President, Underwriting,<br>UnitedHealthcare, Inc. |
| R. Channing Wheeler<br>Westport, CT | Chief Executive Officer,<br>United HealthCare Insurance Company of New York |

The principal officers of the Company as of December 31, 2003 were as follows:

| Name | Title |
|---|---|
| Ronald B. Colby | Chairman and President |
| R. Channing Wheeler | Chief Executive Officer |
| Patrick J. Erlandson | Treasurer |
| Michael J. McDonnell | General Counsel |

The review of the board meetings for calendar years 2000 through 2003 found that the Board did not hold any meetings during this period. All decisions made and actions taken by the Board during the period were through written actions. It is noted; however, that the by-laws of the Company dictate that meetings are to take place at least quarterly and written action shall be limited to those situations where time is of the essence and not in lieu of a regularly scheduled meeting.

According to Section 4.9 of UHINY's by-laws, written actions cannot be taken without unanimous consent of all directors. The review found that written action was taken on three occasions in 2001 without the unanimous written consent of all directors, as some directors failed to sign off on the action.

It is recommended that UHINY comply with its by-laws and hold Board of Directors meetings on at least a quarterly basis.

It is recommended that UHINY establish procedures to ensure that unanimous written consent of all directors is received before adopting any written actions.

It is also recommended that the aforementioned written actions be unanimously ratified by the current board of directors.

B. Territory and Plan of Operation

As of December 31, 2003, the Company was licensed in the State of New York and in the District of Columbia. During the examination period, it only wrote business in the State of New York.

The Company offers Indemnity and Preferred Provider Organization (PPO) products and provides the indemnity portion of a point-of-service (POS) product offered in conjunction with its HMO affiliate, UnitedHealthcare of New York, Inc. POS members of the HMO have the option of going out of their HMO networks; when that occurs, the coverage is provided by UHINY. Coinsurance, deductibles, and limits on coverage apply to the out-of-network benefits provided by UHINY.

The Company insures and administers the medical benefits portion of the "Empire Plan", a health insurance program for New York's public employees and their families. The Empire Plan contract is a fully insured retrospectively rated contract where the State is entitled to a refund if UHINY's expenses fall below an agreed upon level for the year. However, the Company does not receive additional premiums if its costs exceed the agreed upon level, but UHINY does charge an additional fee for accepting the risk of funding medical costs above the agreed upon level.

Refunds that are due the State on the Empire Plan contract are kept as "retro-reserves" by UHINY until a dividend is requested by the State. The amount kept as the retro-reserves by UHINY increased by nearly $110 million in 2003 to a total of approximately $205 million as of December 31, 2003.

United HealthCare Insurance Company of New York, Inc. also has a relationship with the American Association of Retired Persons (AARP). The Company offers Medicare Supplemental coverage to members of AARP.

The Company contracts with independent practice associations (IPAs), hospitals, and other ancillary providers to render health care services to the insured members of its employer groups. The Company pays negotiated fees for services rendered by these providers.

Upon visiting a UHINY contracted physician for medical services, subscribers are responsible for a varying range of co-payments, depending on the contract that covers the member.

C. Reinsurance

The Company maintains a 70% Quota Share Reinsurance Agreement with London Life Reinsurance Company of Pennsylvania (LLRC), a licensed reinsurer in New York State for its New York State Empire Plan business.

This agreement requires the reinsurer to cover 70% of the Empire Plan claims and allocated loss adjustment expenses. The reinsurer also pays an equal portion of all other costs, including but not limited to commissions, taxes, assessments, licenses and fees. In return, the Company is required to submit 70% of its Empire Plan premium income to LLRC.

London Life Reinsurance Company of Pennsylvania in turn has a stop-loss reinsurance agreement with UHINY's parent, United HealthCare Insurance Company (UHIC), a Connecticut domiciled insurance company, whereby UHIC will cover all losses that exceed a medical loss ratio of 89.4%.

The Company maintains a 50% Quota Share Reinsurance Agreement with its immediate parent, the United HealthCare Insurance Company, Inc. for all remaining business, net of the 70% of the Empire Plan business reinsured with London Life Reinsurance Company of Pennsylvania. This agreement requires the Parent to cover 50% of all of claims and allocated loss adjustment expenses. The reinsurer also pays an equal portion of all other costs, including, but not limited to: commissions, taxes, assessments, licenses and fees. In return, the Company is required to submit 50% of its premium income to the Parent.

The reinsurance agreements contain all of the standard clauses required by the New York Insurance Department and they have been approved by the Superintendent of Insurance.

In accordance with the respective contracts, the accounts are settled on a monthly basis with United HealthCare Insurance Company, Inc., and on a quarterly basis with London Life Reinsurance Company of Pennsylvania.

Under the agreement with its Parent, UHINY withholds funds otherwise due and payable to the reinsurer. Amounts owed between UHINY and its Parent are settled on a net basis as UHINY reports to the reinsurer on a monthly basis the reinsurer's share of net subject written premiums, less the reinsurer's share of losses and loss adjustment

expenses. Any net settlements due are deducted from, and offset against this withheld funds account, unless such settlement will result in a loss of credit for reinsurance under the New York Insurance Law.

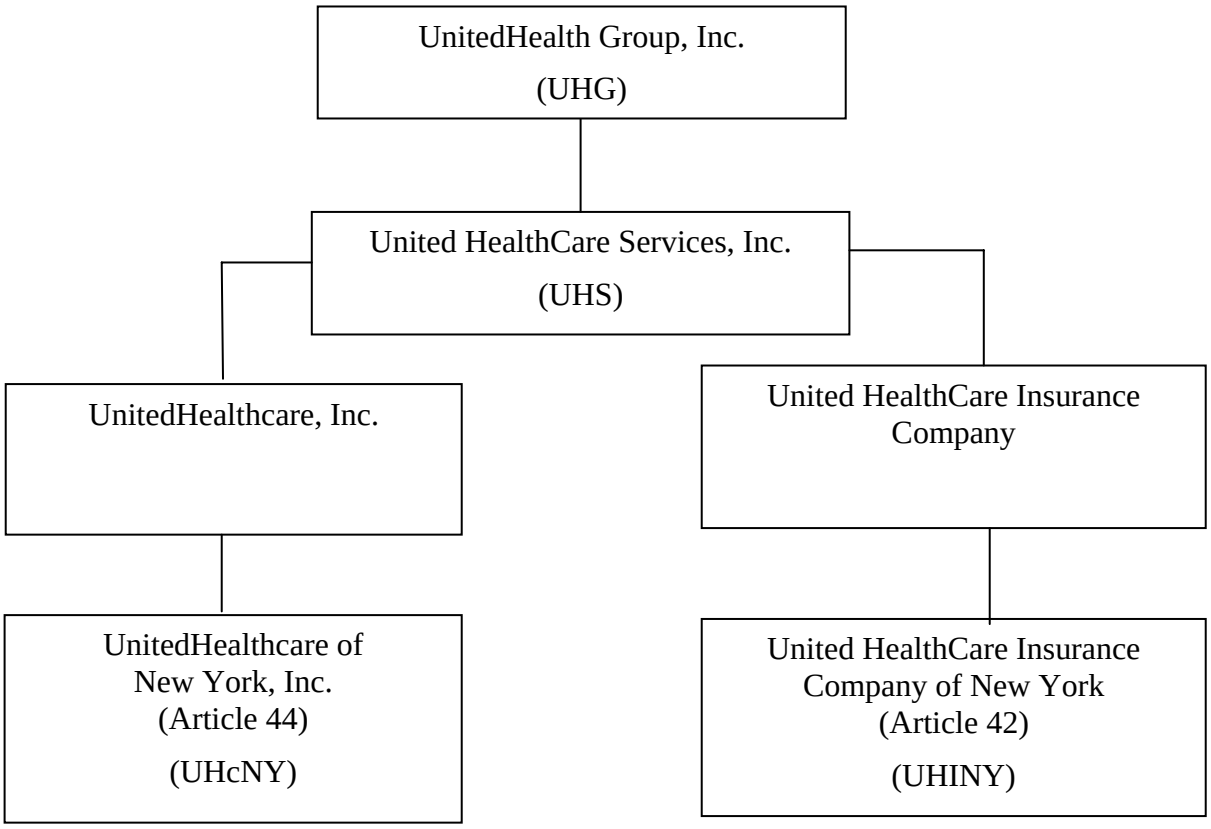
D. Enrollment

During the period January 1, 2000 through December 31, 2003, the Company experienced a net increase in enrollment of 1,550,953 insureds. An analysis of the increase in enrollment is set forth below:

| | 2000 | 2001 | 2002 | 2003 |
|---|---|---|---|---|
| Enrollment, Jan. 1 | 96,499 | 1,361,069 | 1,489,028 | 1,572,768 |
| Net gain | 1,264,570 | 127,959 | 83,740 | 74,684 |
| Enrollment, Dec. 31 | 1,361,069 | 1,489,028 | 1,572,768 | 1,647,452 |

E. Holding Company System

The Company is a wholly-owned subsidiary of United HealthCare Insurance Company. The ultimate parent is UnitedHealth Group, Inc. The following chart depicts the Company's relationship with its parent companies and UnitedHealthcare of New York, Inc., its affiliated New York-licensed HMO at the examination date:




The Parent has an additional 160 subsidiaries not shown within this diagram. Those entities range from HMOs registered and operating in other states to healthcare providers and reinsurers.

The Company has various agreements in effect with its affiliates. The following is an analysis of such agreements:

- United HealthCare Service, LLC (UHSC) provides administrative, financial and managerial services to the Company for a fee based on estimates of actual costs of providing the services. This agreement is explained in more detail below.

- The Specialized Care Services companies are a series of eleven affiliates which provide specialized benefits to the UnitedHealth Group companies. Some of the services provided include: dental, vision, mental health and physical therapy coverage. One of the Specialized Care Services companies UHINY has an agreement with United Behavioral Health, Inc., which provides employee assistance, mental health, and substance abuse services for the Company's enrollees.

- Ingenix provides services related to healthcare information systems including anti-fraud and recovery services for the Company.

- Ovations is a UnitedHealth Group company which provides services and products for insureds age 50 and over for the Company's members who are covered through the Company's contract with the American Association of Retired Persons (AARP).

Where required, these agreements have been approved by the Superintendent pursuant to Section 1505(c) of the New York Insurance Law.

F. Management Agreement

Under the terms of a management agreement between United HealthCare Service, LLC ("UHSC") and the Company, UHSC provides: financial, management, accounting, underwriting, marketing, legal, medical provider, member services, medical management, agency development, employee management and benefit, information systems, and other general and administrative services. United HealthCare Service, LLC also provides claims services, including case management services and review of claim services to the Company, through Uniprise, a UnitedHealth Group Inc., Company. The Company pays UHSC a management fee equal to the actual costs of UHS for providing these services. If the actual cost is not determinable, there will be an allocation of actual costs to the plan on an equitable basis in conformity with customary accounting practices.

Reports are required to be submitted to the Company by UHSC on a monthly basis and are to consist of a written statement of the services performed and the amount estimated to be owed for the services provided pursuant to the agreement. The monthly statements were not provided during the examination period.

It is recommended that United HealthCare Service, LLC submit itemized monthly statements listing the services provided and the amount of estimated charges to the Company for such services in compliance with the requirements of its management agreement.

G. Underwriting Ratios

The underwriting ratios presented below are on an earned/incurred basis and encompass the period January 1, 2000 through December 31, 2003:

| | Amounts | Ratios |
|---|---|---|
| Medical expenses incurred | $1,809,244,039 | 84.30% |
| Administrative expenses incurred | 236,960,957 | 11.04% |
| Claims adjustment expenses incurred | 72,878,655 | 3.40% |
| Underwriting gain | 27,107,713 | 1.26% |
| Premiums earned | $2,146,191,364 | 100.00% |

H. Section 1307 Loan

A "surplus note" of $12.3 million was issued on August 28, 1995 by the Company's parent, United HealthCare Insurance Company, and is included on the balance sheet as a component of capital and surplus. Pursuant to Section 1307 of the New York Insurance Law, no liability appears in UHINY's annual statement for this $12,300,000 loan or the $6,167,100 accrued interest thereon. Section 1307 of the New York Insurance Law requires that these amounts may be repaid only with the permission of the Superintendent of Insurance.

I. Custodial Agreement

The Company maintains a custodial agreement with State Street Bank to protect its securities. A review of that agreement found that it does not contain all of the safeguards recommended by the Department. First, the agreement does not require the bank to maintain in-force Bankers Bond Insurance. Second, the agreement does not

specify that written instructions from the Company to the bank be signed by two authorized officers. Finally, the custodial agreement should allow the insurer the opportunity to obtain the most recent report on the review of the custodian's system of internal controls.

Since the custodial agreement is deficient in regard to certain recommended provisions, it may not provide the Company with sufficient security.

It is recommended that the Company amend its custodial agreement with Street Bank to include the following:

- The bank shall have in-force, for its own protection, Bankers Blanket Bond Insurance of the broadest form available for commercial banks and will continue to maintain such insurance. The bank is to give the insurer 60 days written notice of any material change in the form or amount of such insurance for termination of this coverage.

- Written instructions hereunder shall be signed by any two of the insurer's authorized officers specified in a separate list for this purpose. This list will be furnished to the bank from time to time and signed by the treasurer or an assistant and certified under the corporate seal by the secretary or an assistant secretary.

- The agreement should have a provision that would give the insurer the opportunity to secure the most recent report on the review of the custodian's system of internal control, pertaining to custodian record keeping, as issued by internal or independent auditors.

## J. Accounts and Records

During the course of the examination, it was noted that the Company's treatment of certain items was not in accordance with Statutory Accounting Principles or Annual Statement Instructions. A description of such items is as follows:

1. The Company has repurchase agreements for certain investments on a continuous basis; however, UHINY failed to make the required disclosures detailed below on its annual statement filing. For companies engaged in repurchase agreements, Paragraph 18 of SSAP No. 45 requires that the reporting entity make the following disclosures on its financial statements:

> "...its policy for requiring collateral or other security;
>
> (b) A description of the securities underlying the agreements, including book values and fair values, maturities, and weighted average interest rates for the following categories: (i) securities subject to reverse repurchase agreements; (ii) securities subject to repurchase agreements; (iii) securities subject to dollar repurchase agreements; and (iv) securities subject to dollar reverse repurchase agreements; and
>
> (c) A description of the terms of reverse repurchase agreements whose amounts are included in borrowed money."

It is recommended that UHINY make the appropriate disclosures in its annual statement filings in accordance with Paragraph 18 of SSAP No. 45.

2. The Company uses the accrued interest on its money market fund to reduce its "payable for securities" balance. The accrued interest receivable should be reported on a separate basis, rather than netted against its payable for securities. Net investment income earned was also misstated on the Income Statement and the Investment Income Exhibit.

It is recommended that UHINY report its interest due and accrued on page 2, line 11, of its annual statement filing.

It is recommended that UHINY adjust its net investment income earned amounts on both its income statement and investment income exhibit, to reflect the accrued interest receivable amount. No change was made to the financial statements herein, in regard to this item.

## 3. FINANCIAL STATEMENTS

A. Balance Sheet

The following shows the assets, liabilities and surplus as regards policyholders as determined by this examination as of December 31, 2003. This is the same as the balance sheet filed by the Company in its December 31, 2003 annual statement:

| | Examination | Company |
|---|---|---|
| Assets | Admitted Assets | Admitted Assets |
| Bonds | $ 548,298,603 | $ 548,298,603 |
| Cash, cash equivalents and short-term investments | 107,126,437 | 107,126,437 |
| Investment income due and accrued | 6,660,756 | 6,660,756 |
| Uncollected premiums and agents' balances in course of collection | 54,022,256 | 54,022,256 |
| Amounts recoverable from reinsurers | 235,616,625 | 235,616,625 |
| Current federal and foreign income tax recoverable and interest thereon | 15,322 | 15,322 |
| Net deferred tax asset | 5,093,712 | 5,093,712 |
| Amounts recoverable from reinsurers for commissions and expenses due | 31,808,251 | 31,808,251 |
| Total assets | $ 988,641,962 | $ 988,641,962 |

| Liabilities, Capital and Surplus | Examination | Company |
|---|---|---|
| Claims unpaid | $ 86,981,528 | $ 86,981,528 |
| Unpaid claims adjustment expenses | 2,741,684 | 2,741,684 |
| Aggregate health policy reserves | 5,375,376 | 5,375,376 |
| Aggregate health claim reserves | 15,838,538 | 15,838,538 |
| Premiums received in advance | 9,113,406 | 9,113,406 |
| General expenses due or accrued | 17,658,657 | 17,658,657 |
| Amounts withheld or retained for the account of others | 2,365,062 | 2,365,062 |
| Amounts due to parent, subsidiaries and affiliates | 1,487,725 | 1,487,725 |
| Payable for securities | 5,196,850 | 5,196,850 |
| Funds held under reinsurance treaties | 201,606,087 | 201,606,087 |
| Payable to reinsurers in respect of ceded premiums | 338,406,624 | 338,406,624 |
| Provision for experience rated refunds | 112,676,497 | 112,676,497 |
| Miscellaneous payable | 882,781 | 882,781 |
| Total liabilities | $ 800,330,815 | $ 800,330,815 |
| Common capital stock | $ 300,000 | $ 300,000 |
| Gross paid in and contributed surplus | 54,300,000 | 54,300,000 |
| Surplus notes | 12,300,000 | 12,300,000 |
| Unassigned funds (surplus) | 121,411,147 | 121,411,147 |
| Total capital and surplus | $ 188,311,147 | $ 188,311,147 |
| Total liabilities, capital and surplus | $ 988,641,962 | $ 988,641,962 |

Note 1: The Internal Revenue Service has not conducted any audits of the income tax returns filed on behalf of the Company through tax year 2003. The examiner is unaware of any potential exposure of the Company to any tax assessments and no liability has been established herein relative to such contingency.

Note 2: Pursuant to Section 1307 of the New York Insurance Law, no liability appears in the statement for loans in the amount of $12,300,000 of principal and $6,167,000 of interest accrued thereon. The principal and interest may be repaid only with the permission of the Superintendent of Insurance.

B. Underwriting and Investment Exhibit

Surplus as regards policyholders increased $116,670,506 during the examination period, January 1, 2000 through December 31, 2003, detailed as follows:

| | | |
|---|---|---|
| **Income** | | |
| Net premium income | $ 2,126,008,891 | |
| Change in unearned premium reserves and reserve for rate credits | (257,510) | |
| Aggregate write-ins for other health care related revenues | 20,439,983 | |
| Net reinsurance recoveries | 4,735,415,657 | |
| Net investment income earned | 101,189,673 | |
| Net realized capital gain or loss | 7,801,067 | |
| Aggregate write-ins for other income or expenses | (1,019,616) | |
| Total revenue | | $ 6,989,578,145 |
| **Expenses** | | |
| Hospital/medical benefits | $ 6,373,877,378 | |
| Other professional services | 45,732,528 | |
| Prescription drugs | 60,527,288 | |
| Aggregate write-ins for other hospital and medical | 60,944,502 | |
| Claims adjustment expenses | 72,878,655 | |
| General administrative expenses | 236,960,957 | |
| Increase in reserves for life and accident and health contracts | 3,578,000 | |
| Total expenses | | 6,854,499,308 |
| Net income before federal income taxes | | $ 135,078,837 |
| Federal and foreign income taxes incurred | | 36,409,765 |
| Net income | | $ 98,669,072 |

Capital and Surplus Account

| | | | |
|---|---|---|---|
| Surplus as regards policyholders, per report on examination as of December 31, 1999 | | | $ 71,640,641 |
| | Gains | Losses | |
| Net income | $ 98,669,072 | $ | |
| Net unrealized capital gain or loss | | (4,109) | |
| Change in net deferred income tax | | (738,840) | |
| Change in non-admitted assets | 1,192,165 | | |
| Change in unauthorized reinsurance | | (1) | |
| Cumulative effect of changes in accounting principles | 1,679,362 | | |
| Aggregate write-ins for (losses) in surplus | | (227,143) | |
| Capital changes - paid in | 16,100,000 | | |
| | $ 117,640,599 | $ (970,093) | |
| Net increase in net worth | | | $ 116,670,506 |
| Surplus as regards policyholders, per report on examination as of December 31, 2003 | | | $ 188,311,147 |

## 4. CLAIM RESERVES

The examination liability of $86,981,528 is the same as the amount reported by the Company in its 2003 filed annual statement.

The examination analysis of the unpaid claims reserves was conducted in accordance with generally accepted actuarial principles and practices and was based on statistical information contained in the Company’s internal records and in its filed annual

statements as verified during the examination. The examination reserve was based upon actual payments made plus an estimate for claims remaining unpaid at that date. Such estimate utilized the Company's past experience in projecting the ultimate cost of claims incurred on or prior to December 31, 2003.

## 5. MARKET CONDUCT

In the course of this examination, a review was made of the manner in which the Company conducts its business and fulfills its contractual obligations to policyholders and claimants. The review was general in nature and is not to be construed to encompass the more precise scope of a market conduct examination. The review was directed at the practices of the Company in the following major areas:

A. Claims processing
B. Prompt Pay Law
C. Denied claims
D. Explanation of benefits statements
E. Schedule M
F. Grievances
G. Utilization review
H. Appointment of agents
I. Fraud prevention and detection

### A. Claims Processing

A review of claims adjudicated by the Company was performed by using a statistical sampling methodology covering claims processed during the period January 1, 2003 through December 31, 2003, in order to evaluate the overall accuracy and compliance of UHINY's claims processing environment.

The claims population for the Company was divided into medical and hospital claim segments. A random statistical sample was drawn from each segment. It should be noted for the purposes of this analysis, those medical costs characterized as Pharmacy, Medicare/Medicaid, Dental, Capitated Payments, Federal Employees Program subscribers and HCRA bulk payments were excluded.

The sample size for each population (one for medical claims and one for hospital claims) was comprised of 167 randomly selected claim transactions. Additional random samples were generated for each group as "replacement items" in the event it was determined a particular claim transaction selected in the sample should be excluded. Accordingly, various replacement items were appropriately utilized. In total, 334 claims were selected for this review.

The examination review of the Company found a calculated financial error rate of 8.98% for medical claims and 15.57% for hospital claims and overall claims processing financial accuracy levels were 91.02% for medical claims and 84.43% for hospital claims. Procedural error rates were 11.38% for medical claims and 16.17% for hospital claims and overall claims processing procedural accuracy levels were 88.62% for medical claims and 83.83% for hospital claims.

Financial accuracy is defined as the percentage of times the dollar value of the claim payment was correct. Procedural accuracy is defined as the percentage of times claim transactions were processed in accordance with the Company's guidelines and/or Department regulations. An error in processing accuracy may or may not affect the

financial accuracy. However, a financial error is caused by a procedural error and as such, it is counted both as a financial error and a procedural error.

The following charts illustrate the financial and procedural claims accuracy findings summarized above:

## Summary of Financial Claims Accuracy

| | Medical Claims | Hospital Claims |
|---|---|---|
| Population | 13,777,571 | 1,378,735 |
| Sample size | 167 | 167 |
| Number of claims with errors | 12 | 25 |
| **Calculated error rate** | **8.98%** | **15.57%** |
| Upper error limit | 13.32% | 21.07% |
| Lower error limit | 4.65% | 10.07% |
| **Calculated claims in error** | **1,237,226** | **214,669** |
| Upper limit claims in error | 1,835,172 | 290,499 |
| Lower limit claims in error | 640,657 | 138,839 |

Note: The upper and lower error limits represent the range of potential error (e.g., if 100 samples were selected the rate of error would fall between these limits 95 times).

## Summary of Procedural Claims Accuracy

| | Medical Claims | Hospital Claims |
|---|---|---|
| Population | 13,777,571 | 1,378,735 |
| Sample size | 167 | 167 |
| Number of claims with errors | 16 | 26 |
| **Calculated error rate** | **11.38%** | **16.17%** |
| Upper error limit | 16.19% | 21.75% |
| Lower error limit | 6.56% | 10.58% |
| **Calculated claims in error** | **1,567,888** | **222,941** |
| Upper limit claims in error | 2,230,589 | 299,875 |
| Lower limit claims in error | 903,809 | 145,870 |

Note: The upper and lower error limits represent the range of potential error (e.g., if 100 samples were selected the rate of error would fall between these limits 95 times).

During the process of reviewing the claim transactions within the various claim adjudication samples, the following was noted:

- There were several instances where a hospital (HCRA) surcharge amount was either paid incorrectly or not at all on laboratory claims.

It is recommended that UHINY take steps to ensure that all hospital surcharge amounts are paid and that the amount paid is correct.

It is recommended that UHINY review all claims where a HCRA surcharge was applicable for the period January 1, 2003 to December 31, 2003 and determine whether the HCRA surcharge was determined and paid correctly.

It is recommended that UHINY properly account for the hospital surcharges as liabilities on its financial statements.

- United HealthCare Insurance Company has the following procedures in place to pay claims for services rendered outside the United States. Any travel related claims over $2,500 and expatriate claims over $10,000 are referred to the Special Investigations Unit. Other items that are reviewed on claims submissions for evidence of fraud include dates of service and other medical information not matching within the records and claims that are from countries known to be a high risk for fraud or abuse activities. The first criteria for determining whether a claim is referred to the Special Investigation Unit is the dollar threshold, however claims are reviewed regardless of the dollar threshold.

Typically, service outside of the United States is difficult to confirm, so insurance fraud is easier to commit; providers are often unknown and their credentials cannot be confirmed. Further, the possibility for collusion is high. For these reasons, the dollar threshold for claims may not provide adequate protection against fraud.

It is recommended that UHINY re-evaluate the level at which foreign claims will be referred to its special investigation unit oversight group for investigation prior to payment.

B. Prompt Pay Law

Section 3224-a of the New York Insurance Law "Standards for prompt, fair and equitable settlement of claims for health care and payments for health care services" (Prompt Pay Law) requires all insurers to pay undisputed claims within forty-five days of receipt. If such undisputed claims are not paid within forty-five days of receipt, interest may be payable.

Section 3224-a(a) of the New York Insurance Law states:

> "(a) Except in a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three of this chapter or article forty-four of the public health law to pay a claim submitted by a policyholder or person covered under such policy or make a payment to a health care provider is not reasonably clear, or when there is a reasonable basis supported by specific information available for review by the superintendent that such claim or bill for health care services rendered was submitted fraudulently, such insurer or organization or corporation shall pay the claim to a policyholder or covered person or make a payment to a health care provider within forty-five days of receipt of a claim or bill for services rendered."

Section 3224-a(c) of the New York Insurance Law states:

> "(c) Each claim or bill for health care services processed in violation of this section shall constitute a separate violation. In addition to the penalties provided in this chapter, any insurer or organization or corporation that fails to adhere to the standards contained in this section shall be obligated to pay to the health care provider or person submitting the claim, in full settlement of the claim or bill for health care services, the amount of the claim or health care payment plus interest on the amount of such claim or health care payment of the greater of the rate equal to the rate set by the commissioner of taxation and finance for corporate taxes pursuant to paragraph one of subsection (e) of section one thousand ninety-six of the tax law or twelve percent per annum, to be computed from the date the claim or health care payment was required to be made. When the amount of interest due on such a claim is less then two dollars, an insurer or organization or corporation shall not be required to pay interest on such claim."

Two statistical samples (one for hospital claims and one for medical claims) of claims not adjudicated within 45 days of submission to the Company was reviewed to determine whether the payment was in violation of the timeframe requirements of Section 3224-a(a) of the New York Insurance Law and if interest was appropriately paid pursuant to Section 3224-a(c) of the New York Insurance Law. Accordingly, all claims that were not adjudicated within 45 days of receipt, during the period January 1, 2003 through December 31, 2003 were segregated. A statistical sample of each population was then selected to determine whether the claims were subject to interest, and whether such interest was properly calculated, as required by statute.

The following charts illustrate Prompt Pay compliance as determined by this examination:

## Summary of Violations of Section 3224-a(a) of the NYIL

| | Medical Claims | Hospital Claims |
|---|---|---|
| Total population | 13,777,571 | 1,378,735 |
| Population of claims adjudicated past 45 days of receipt | 131,668 | 9,115 |
| Sample size | 167 | 167 |
| Number of claims with errors | 135 | 143 |
| **Calculated error rate** | **80.84%** | **85.63%** |
| Upper error limit | 86.81% | 90.95% |
| Lower error limit | 74.87% | 80.31% |
| **Calculated claims in error** | **106,440** | **7,805** |
| Upper limit claims in error | 114,301 | 8,290 |
| Lower limit claims in error | 98,580 | 7,320 |

Note: The upper and lower error limits represent the range of potential error (e.g., if 100 samples were selected the rate of error would fall between these limits 95 times).

## Summary of Violations of Section 3224-a(c) of the NYIL

| | Medical Claims | Hospital Claims |
|---|---|---|
| Total population | 13,777,571 | 1,378,735 |
| Population of claims paid after 45 days of receipt (that are eligible for interest) | 43,658 | 4,474 |
| Sample size | 167 | 167 |
| Number of claims with errors | 19 | 31 |
| **Calculated error rate** | **11.38%** | **18.56%** |
| Upper error limit | 16.19% | 24.46% |
| Lower error limit | 6.56% | 12.67% |
| **Calculated claims in error** | **4,968** | **830** |
| Upper limit claims in error | 7,068 | 1,094 |
| Lower limit claims in error | 2,864 | 567 |

Note: The upper and lower error limits represent the range of potential error (e.g., if 100 samples were selected the rate of error would fall between these limits 95 times).

It is noted that the extrapolated number of violations relates to the population of claims used for the sample, which consisted of only those claims adjudicated over forty-five days from receipt (for Section 3224-a(a)), and those claims which incurred interest of two dollars or more (for Section 3224-a(c)), based upon the examinations calculations for claims adjudicated by the Company during the period January 1, 2003 through December 31, 2003.

The population of claims adjudicated after forty-five days from date of receipt for the Company consisted of 131,668 medical and 9,115 hospital claims out of 13,777,571 medical and 1,378,735 hospital claims processed during the period January 1, 2003 through December 31, 2003. The population of claims which incurred interest of two dollars or more consisted of 43,658 medical and 4,474 hospital claims out of 13,777,571 medical and 1,378,735 hospital claims processed during the period January 1, 2003 through December 31, 2003.

The Company's claim processing system calculates interest due on a claim from the date a claim is overdue, through the adjudication date, plus two additional days, to allow time to mail the payment. During the examiner's review it was found that claims were often mailed later or earlier than the two days allowed for. This resulted in incorrect interest charges being applied.

Five of the twenty-six Prompt Pay interest errors uncovered during the examiner's review of hospital claims, were the result of incorrect interest payment amounts.

During the review of Prompt Pay, for claims where interest was due, the Company reprocessed and paid interest on many of the sampled claims if they found that the claim was initially processed incorrectly.

It is recommended that the Company review its Prompt Pay procedures to improve its compliance with Section 3224-a(a) of the New York Insurance Law.

It is also recommended that the Company implement the necessary procedures and training in order to ensure compliance with Section 3224-a(a) of the New York Insurance Law.

It is further recommended that the Company comply with Section 3224-a(c) of the New York Insurance Law and calculate interest due on all applicable claims paid after 45 days of receipt.

As a result of the findings during Prompt Pay reviews by this Department's Consumer Services Bureau (CSB), the Company entered into several stipulations with the Department. As a condition of the stipulations, the CSB required the Company to reprocess and pay all late claims received as complaints by the Bureau over the six month period of its review, and reprocess all late claims for an additional (subsequent) three month period. The stipulations dated November 6, 2003 and April 14, 2004, required the Company to conduct a review of overdue claims for the periods January 1, 2003 to June 30, 2003 and October 1, 2003 to December 31, 2003.

It is recommended that the Company reprocess all claims adjudicated during the period January 1, 2003 to December 31, 2003 that were not covered by the stipulations noted above, for compliance with Section 3224-a(a) of the New York Insurance Law and pay any interest owed pursuant to Section 3224-a(c) of the New York Insurance Law.

C. Denied Claims

Section 3224-a(b) of the New York Insurance Law states in part:

> "In a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three of this chapter or article forty-four of the public health law to pay a claim or make a payment for health care services rendered is not reasonably clear due to a good faith dispute regarding the eligibility of a person for coverage, the liability of another insurer or corporation or organization for all or part of the claim, the amount of the claim, the benefits covered under a contract or agreement, or the manner in which services were accessed or provided, an insurer or organization or corporation shall pay any undisputed portion of the claim in accordance with this subsection and notify the policyholder, covered person or health care provider in writing within thirty calendar days of the receipt of the claim:…"

During the examination of UnitedHealthcare of New York, Inc., a sample of fifty medical claims with a "zero payment" was reviewed from a data file provided from UnitedHealthcare of New York, Inc. to determine the HMO's compliance with the above statue.

The review found that most of the claims in the sample were not actually denied claims, but were adjustments to previously processed claims. Thirty-five out of the fifty medical claims and thirty-six out of the fifty hospital claims were adjustments of previously processed claims.

When claims are reprocessed in the HMO's claim system, they are reprocessed with the total adjudicated amount rather than the adjusted amount. The previous claim process is then reversed resulting in a claim with a zero payment. These claim adjustments were included in the data and were picked up as zero payments for claims processed in 2003.

Numerous attempts were made to review and stratify the data, but the reprocessed claims which showed zero payments could not be isolated from claims which were actually denied. It was determined that an accurate review of UnitedHealthcare of New York, Inc's denied claims could not be done. Since the same issue with the data was also present in United HealthCare Insurance Company of New York's claim population, a review of denials was not done for the Company.

It is recommended that UHINY put in place procedures that allow the claim system to differentiate between claim adjustments that create zero payments and actual denied claims.

It is recommended that the Company create procedures to ensure that outstanding claims in its claims system be paid in a timely manner when originally submitted, or properly denied within the applicable period as required by Section 3224-a(b) of the New York Insurance Law.

D. Explanation of Benefits Statements

As part of the review of the Company's claims practices and procedures, an analysis of the Explanation of Benefits Statements ("EOB") sent to subscribers and/or providers by the Company was performed. An EOB is an important link between the subscriber, the provider, and the Company. It should clearly communicate to the subscriber and/or provider that the Company has processed a claim and how that claim was processed. It should clearly describe the charges submitted, the date the claim was received, the amount allowed for the services rendered, and show any balance owed to the provider. It should also serve as the documentation to recover any money from coordination of benefits with other carriers. The samples selected for analyzing EOBs were the same hospital claims sample and medical claims sample used for the claims processing review noted above.

Section 3234 (b) of the New York Insurance Law states:

> "(b) The explanation of benefits form must include at least the following:
> (1) the name of the provider of service the admission or financial control number, if applicable;
> (2) the date of service;
> (3) an identification of the service for which the claim is made;
> (4) the provider's charge or rate;
> (5) the amount or percentage payable under the policy or certificate after deductibles, co-payments, and any other reduction of the amount claimed;
> (6) a specific explanation of any denial, reduction, or other reason, including any other third-party payor coverage, for not providing full reimbursement for the amount claimed; and
> (7) a telephone number or address where an insured or subscriber may obtain clarification of the explanation of benefits, as well as a description of the time limit, place and manner in which an appeal of a denial of benefits must be brought under the policy or certificate and a notification that failure to comply with such requirements may lead to forfeiture of a consumer's right to challenge a denial or rejection, even when a request for clarification has been made."

The EOB issued do not provide a sufficient description of the submitted charges. In many cases, non-specific terms such as “medical services”, “laboratory services” or “radiology services”, are routinely used to describe the submitted charges. If UHINY would display the five digit Current Procedural Technology (CPT) codes, the codes identifying the service for which the claim is made, on its EOB along with a brief description, a satisfactory explanation of the submitted charges could be provided to the subscriber.

It is recommended that UHINY display the five-digit CPT codes for procedures and services that it used to determine payment on all Explanation of Benefits along with a brief description of the codes.

E. Schedule M

The Company’s filed 2003 annual statement reported 1,084 utilization review appeals and five external appeals filed and closed in 2003. The Company provided two utilization review appeal registers. One register was for the Empire Plan, which contained 919 cases filed and closed in 2003. The other register was for all other UHINY business and it contained 63 cases filed and closed in 2003, for a combined total of 982 utilization review appeals. The Company did not provide an external appeals register. Thus, the examiner determined that utilization review appeals were understated by 102 cases and external appeals were understated by five cases when compared to the numbers in the filed annual statement.

It is recommended that UHINY accurately report its utilization review cases in its filings with this Department.

It is further recommended that UHINY keep an accurate external appeals register.

F. Grievances

For the period January 1, 2003 through December 31, 2003, UHINY provided a grievance log which contained 27 files. A sample of five files was selected for review. The files were reviewed to determine compliance with UHINY's policy and procedures and Department statutes on grievance cases. The following was determined:

- One out of five cases reviewed found that the appeals coordinator provided an incorrect time frame in which a New York member is able to file an appeal.
- One out of five cases reviewed found that the acknowledgement letter was not sent within 15 business days of the receipt of the request for review.

It is recommended that UHINY provide the correct time frames in which to file an appeal of an adverse grievance determination.

It is recommended that UHINY ensure that all acknowledgement letters are sent within 15 business days of the receipt of the request for review.

Section 243.2(b)(8) of Department Regulation No. 152 (11 NYCRR 243) sets forth standards of retention of records by an insurer.

Section 243.2(b)(8) states that an insurer shall maintain:

> "(b) Except as otherwise required by law or regulation, an insurer shall maintain:
>
> (8) Any other record for six calendar years from its creation or until after the filing of a report on examination or the conclusion of an investigation in which the record was subject to review."

The Company failed to maintain the necessary documentation for one of the five grievance case files reviewed as required by Section 243.2(b)(8) of Department Regulation 152.

It is recommended that UHINY comply with the requirements of Section 243.2(b)(8) of Department Regulation 152 and retain all necessary documentation on its grievance cases for at least 6 calendar years.

## G. Utilization Review

Sections 4902, 4903 and 4904 of the New York Insurance Law set forth the minimum utilization review program standards, requirements of utilization review determinations for prospective, concurrent and retrospective reviews, and appeals of adverse determinations by utilization review agents respectively, for companies licensed under Article 42 of the New York Insurance Law.

For the period January 1, 2003 through December 31, 2003, UHINY provided the examiners with utilization review appeal logs for Empire Plan cases and other UHINY cases.

As noted above, the Empire Plan log contained 919 utilization review appeals. Ten files were randomly selected from this list for review. The files were reviewed to determine compliance with Article 49 of the New York Insurance Law.

Section 4904(c) of the New York Insurance Law states:

> "A utilization review agent shall establish a standard appeal process which includes procedures for appeals to be filed in writing or by telephone. A utilization review agent must establish a period of no less than forty-five days after receipt of notification by the insured of the initial utilization review determination and receipt of all necessary information to file the appeal from said determination. The utilization review agent must provide written acknowledgment of the filing of the appeal to the appealing party within fifteen days of such filing and shall make a determination with regard to the appeal within sixty days of the receipt of necessary information to conduct the appeal. The utilization review agent shall notify the insured, the insured's designee and, where appropriate, the insured's health care provider, in writing of the appeal determination within two business days of the rendering of such determination. The notice of the appeal determination shall include:
>
> (1) the reasons for the determination; provided, however, that where the adverse determination is upheld on appeal, the notice shall include the clinical rationale for such determination; and
>
> (2) a notice of the insured's right to an external appeal together with a description, jointly promulgated by the superintendent and the commissioner of health as required pursuant to subsection (e) of section four thousand nine hundred fourteen of this article, of the external appeal process established pursuant to title two of this article and the time frames for such external appeals."

Three out of the ten (30%) Empire Plan utilization review appeal files failed to provide written acknowledgement of the filing of the appeal within 15 days as required by Section 4904(c) of the New York Insurance Law.

Three out of ten (30%) Empire Plan utilization review appeal files failed to provide the enrollee with notice of the appeal determination within 2 business days of the rendering of such determination as required by Section 4904(c) of the New York Insurance Law.

Three out of ten (30%) Empire Plan utilization review appeal files reviewed were found to be misclassified as utilization review files and its correspondence were mislabeled as "Notice of Adverse determination."

The UHINY log for members that were not part of the Empire Plan contained 63 utilization review cases. Fifteen files were randomly selected for review. The files were reviewed to determine compliance with Article 49 of the New York Insurance Law.

Two out of fifteen (13.33%) of the non-Empire Plan utilization review appeal files failed to provide the enrollee with notice of the appeal determination within 2 business days of the rendering of such determination as required by Section 4904(c) of the New York Insurance Law.

It is recommended that UHINY comply with the requirements of Section 4904(c) of the New York Insurance Law and provide written acknowledgement within 15 days of receipt of an appeal of a utilization review determination.

It is also recommended that UHINY comply with the requirements of Section 4904(c) of the New York Insurance Law and provide the enrollee with notice of the appeal determination within 2 business days of the rendering of such determination.

It is further recommended that UHINY properly classify its utilization review appeal files and label its correspondence properly.

The Company failed to maintain the necessary documentation for two of the fifteen non-Empire Plan utilization review files, as required by Section 243.2(b)(8) of Regulation 152 as quoted above.

It is recommended that UHINY comply with the requirements of Section 243.2(b)(8) of Regulation 152 and retain all required documentation for its utilization review files for at least 6 calendar years.

H. Appointment of Agents

The Company provided a listing of 5,937 active agents as of December 31, 2003 and 1,822 terminated agents for the period January 1, 2003 to December 31, 2003. Separate samples of 167 active agents and 167 terminated agents were selected and reviewed against the active and terminated listings provided by the Department's Licensing Bureau.

Section 2112(a) of the New York Insurance Law states:

> "Every insurer, fraternal benefit society or health maintenance organization doing business in this state shall file a certificate of appointment in such form as the superintendent may prescribe in order to appoint insurance agents to represent such insurer, fraternal benefit society or health maintenance organization."

The Department had no record of certificates of appointment for 42 out of the 167 (25%) sampled agents listed as being active by UHINY. The Company was able to provide documentation that 23 of the 42 (55%) were appointed. The Company could not provide documentation that the other 19 agents (11.38%) were appointed.

It is recommended that UHINY comply with Section 2112(a) of the New York Insurance Law and file certificates of appointments for all agents.

Section 2112(d) of the New York Insurance Law states:

> "Every insurer, fraternal benefit society or health maintenance organization or insurance producer or the authorized representative of the insurer, fraternal benefit society, health maintenance organization or insurance producer doing business in this state shall, upon termination of the certificate of appointment as set forth in subsection (a) of this section of any insurance agent licensed in this state, or upon termination for cause for activities as set forth in subsection (a) of section two thousand one hundred ten of this article, of the certificate of appointment, of employment, of a contract or other insurance business relationship with any insurance producer, file with the superintendent within thirty days a statement, in such form as the superintendent may prescribe, of the facts relative to such termination for cause. The insurer, fraternal benefit society, health maintenance organization, insurance producer or the authorized representative of the insurer, fraternal benefit society, health maintenance organization or insurance producer shall provide, within fifteen days after notification has been sent to the superintendent, a copy of the statement filed with the superintendent to the insurance producer at his, or her or its last known address by certified mail, return receipt requested, postage prepaid or by overnight delivery using a nationally recognized carrier. Every statement made pursuant to this subsection shall be deemed a privileged communication."

The Department had no record of 131 of the 167 (78.44%) sampled agents whose appointments UHINY had listed as terminated for the period January 1, 2003 to December 31, 2003. Of these 131 agents, 93 (71%) were sixty day letter terminations, 28 (22%) were mailing address terminations and 9 (7%) were terminations that were not

reported to the Department because of miscellaneous errors. These are detailed as follows:

The sixty-day letter termination errors were caused through the implementation by UHINY (on November 30, 2002) of a new process, called the "sixty-day letter process" which monitored the expiration of non-perpetual licenses based on the most current license end date entered in UHINY's Producer Credentialing Information System (PCIS). The system automatically sent a letter to a producer requesting a copy of their current renewal license sixty days prior to the expiration date on file in PCIS. If the license was not updated in PCIS with the new expiration date based on the renewal copy, the system automatically terminated the appointment.

The Company failed to include its appointment vendor SIRCON in the initial electronic processing of terminations. For this reason, the producer appointments within the scope of the sixty-day letter process appeared as terminated in UHINY's records only. As of December 14, 2003, UHINY modified the sixty-day letter process to transmit the terminations to the Department using its vendor SIRCON.

The mailing address terminations were the result of UHINY "data clean" up initiative implemented by UHINY several times from June 2003 to February 2004 to terminate producers which UHINY inherited through its mergers and business transformation from Travelers and MetraHealth. Many of these producers whose records were converted from the Travelers and MetraHealth companies contained various data integrity issues, such as missing tax identification numbers, invalid license and appointment information, or missing mailing addresses. United HealthCare Insurance

Company of New York, Inc. terminated the appointments of producers with effective dates prior to January 1, 2001, if the data was missing from the producer's record.

The Company did not report the terminations to the Department, because it did not believe the terminations could have been processed since original appointments were not submitted to the Department, or converted producer records were missing the data necessary for the Department to process the transactions correctly.

It is recommended that UHINY report all appointment terminations to the New York State Insurance Department in order to comply with the requirements of Section 2112(d) of the New York Insurance Law.

It is recommended that UHINY improve its record keeping as regards to agents and brokers certificates of appointments and licensing.

The Company uses two types of external agents. The first type of external agent it uses is "individual independent agents". The second type it utilizes is "general agents" or agencies that consist of multiple salespersons. General agents represent UHINY in the sale of small group medical insurance. Currently, UHINY utilizes a written agreement between itself and its general agents to clearly spell out the rights and responsibilities of the agency. This practice serves to protect UHINY in its relationship with the general agents. It is noted, however, that there are no such written agreements between the UHINY and the individual agents.

It is recommended that UHINY initiate a formal written agreement with its individual independent agents.

## I. Fraud Prevention and Detection

To prevent, detect and investigate Medicare fraud, United HealthCare Insurance Company of New York employs Ovations Insurance Solutions SIU a Special Investigations Unit ("SIU"), dedicated to its Medicare Supplement product, which is located in Fort Washington, Pennsylvania.

A full-time SIU located in Kingston, New York investigates Empire Plan claim referrals. The Empire Plan is a health insurance program for New York's public employees and their families. United HealthCare Insurance Company of New York insures and administers the medical benefits part of this program. In addition to the Empire Plan SIU, Empire also utilizes Ingenix Recovery Services, as a concurrent resource, for investigating potential provider fraud cases.

Ingenix Recovery Services investigates medical claims for UnitedHealthcare of New York, Inc., and United HealthCare Insurance Company of New York, and functions as the internal vendor of these services.

Ingenix Recovery Services, a division within Ingenix, offers products and services internally, to other companies within UnitedHealth Group, and to external clients, which include compliance research and monitoring, detection technology, investigation and recovery services (collection of financial loss caused by insurance fraud), training, consulting and subrogation.

Ingenix Recovery Services is located in two primary sites: Hartford, Connecticut and Minneapolis, Minnesota and focuses most of its fraud detection efforts at the

physician and other health care provider level; that is, identifying the suspected physicians/providers and reviewing their claims prospectively, prior to payment, and as potential recovery cases, post-payment.

Ingenix Recovery Services is comprised of several units, totaling over 100 personnel (not including management), who conduct or support the investigative process. The personnel are comprised of: prospective and recovery investigators, case development analysts, data mining analysts, associate investigators (or investigative assistants), and clinical personnel, who focus on detecting and investigating fraudulent and abusive claim payments. Not all of these personnel investigate, or support the claims investigation process involving New York providers.

Ingenix Recovery Services' investigators, review New York fraud claim referrals. New York fraud claim referrals are investigated by the Northeast Regional Team, which is comprised of seven personnel who dedicate approximately 95% of their time and resources to New York providers.

Section 86.6(c) of Department Regulation No. 95 (11 NYCRR 86.1) states:

> "Persons employed by Special Investigations Units as investigators or by an independent provider of investigative services under contract with an insurer shall be qualified by education and/or experience which shall include:
>
> (1) an associate's or bachelor's degree in criminal justice or a related field; or
>
> (2) five years of insurance claims investigation experience or professional investigation experience with law enforcement agencies; or
>
> (3) seven years of professional investigation experience involving economic or insurance related matters; or
>
> (4) an authorized medical professional to evaluate medical related claims."

Though an additional number of over ninety (90) personnel are potentially available for investigating or supporting the investigative process involving New York physicians/providers, only those investigators from other teams or units from within Ingenix Recovery Services, who are qualified under Department Regulation 95, Section 86.6(c), are permitted to work on such cases.

Section 405(a) of the New York Insurance Law states:

> "(a) Any person licensed pursuant to the provisions of this chapter, and any person engaged in the business of insurance in this state who is exempted from compliance with the licensing requirements of this chapter, including the state insurance fund of this state, who has reason to believe that an insurance transaction may be fraudulent, or has knowledge that a fraudulent insurance transaction is about to take place, or has taken place shall, within thirty days after determination by such person that the transaction appears to be fraudulent, send to the insurance frauds bureau on a form prescribed by the superintendent, the information requested by the form and such additional information relative to the factual circumstances of the transaction and the parties involved as the superintendent may require. The insurance frauds bureau shall accept reports of suspected fraudulent insurance transactions from any self insurer, including but not limited to self insurers providing health insurance coverage or those defined in section fifty of the workers' compensation law, and shall treat such reports as any other received pursuant to this section."

United HealthCare Insurance Company of New York, Inc. and UnitedHealthcare of New York, Inc. (including Ovations Insurance Solutions), and the Empire Plan insure 1,440,381 members, and they receive/process 31,113,083 claims annually, as indicated in the 2003 Section 409(g) Annual Anti-Fraud Report filed with the Department.

The 2003 Anti-Fraud Report filing contained the combined data for both United HealthCare Insurance Company of New York and UnitedHealthcare of New York. The report indicated that the companies reviewed 1,091 cases in 2003, a decrease of 805 cases

from its 2002 fling. The companies reported 1,298 cases closed in 2003 from cases filed in 2003 and prior. Out of the 1,091 cases reviewed, only 139 IFB-1 Forms, forms used for reporting suspected fraudulent activities, were filed with the Insurance Department's Frauds Bureau reporting fraudulent transactions.

Section 86.6(b)(3) of Department Regulation No. 95 (11 NYCRR 86.1) states:

> "(b) The plan shall include the following provisions:
>
> (3) The rationale for the level of staffing and resources being provided for the Special Investigations Unit which may include, but is not limited to, the following objective criteria such as number of policies written and individuals insured in New York, number of claims received with respect to New York insureds on an annual basis, volume of suspected fraudulent New York claims currently being detected, other factors relating to the vulnerability of the insurer to fraud, and an assessment of optimal caseload which can be handled by an investigator on an annual basis."

Section 86.6(b)(3) of Department Regulation 95 states that one of the criteria used to determine the adequacy of staffing in an SIU unit is to compare claims to investigators. The companies generated over 31 million claims in 2003 and only had seven full time investigators.

It is the contention of the Department that the companies staffing level of seven full time examiners is inadequate with a base of 1.4 million members. In addition, the number of fraud cases detected decreased by 42% from 1,896 in 2002 to 1,091 in 2003. Clearly, an increase in the number of investigators would increase fraud detection and prevention.

It is recommended that UHINY adequately staff its Special Investigations Unit (SIU), so that it can effectively detect, investigate and prevent fraud.

United HealthCare Insurance Company of New York, Inc. provided a listing of 616 cases, opened and closed in 2003, to the examiners. A review was performed on 30 randomly selected cases from this listing. The following are the findings of the review:

- There was no indication whether IFB-1 Forms were filed on any of the cases.
- There was no indication on the closed cases that a supervisor reviewed the case before it was closed.

It is recommended that UHINY comply with its procedures to ensure that IFB-1 forms are filed when required and that the files document when and if these filings occur.

It is recommended that UHINY put in place procedures to ensure that all cases are reviewed by a supervisor before the case is closed.

## 6. COMPLIANCE WITH PRIOR REPORTS ON EXAMINATION

There were two comments and recommendations from prior report on examination as of December 31, 1999 that the Company has not complied with. They are repeated herein as follows (page numbers refer to the prior report):

| ITEM NO. | | PAGE NO. |
|---|---|---|
| 1. | It is recommended that the board comply with the by-laws and hold quarterly meetings.<br><br>The Company has not complied with this recommendation and a similar recommendation is repeated herein.<br><br>Subsequent to the examination date, effective October 2004, the Company provided evidence to show that its board meetings were being held on a quarterly basis. | 6 |
| 2. | It is recommended that the Company amend its custodial agreement to include the following:<br><br>• A provision requiring the bank to have and maintain Bankers Blanket Bond Insurance of the broadest form available for commercial banks. Further, the bank should be required to give 60 days written notice to the Company of any material change in the form or amount of such coverage.<br>• A provision indicating to the bank that written instructions given to the bank by the Company are to be signed by at least two of its Authorized Officers. Said officers will be authorized in a list that will be furnished to the bank as necessary and signed by the treasurer or an assistant treasurer and certified under the corporate seal by the secretary or an assistant secretary.<br>• A provision that would give the insurer the opportunity to secure the most recent report on the review of the custodian's system of internal controls, pertaining to custodian record keeping, issued by internal or independent auditors. | 12 |

**ITEM NO.** **PAGE NO.**

The Company has not complied with the recommendation and a similar recommendation is repeated herein.

Subsequent to the date of the examination, in March 2007, the Company provided documentation to show that the aforementioned agreement has been amended to contain the suggested wording.

There were four comments and recommendations from the prior market conduct report as of December 31, 1999 that the Company has not complied with. They are repeated herein as follows (page numbers refer to the prior report):

| ITEM NO. | | PAGE NO. |
|---|---|---|
| | **Sales/Underwriting** | |
| 1. | It is recommended that the Company initiate a written agreement with its individual producers. Additionally, it is recommended that the Upstate HMO formalize an agreement with its general agents.<br><br>The Company has not complied with this recommendation and it is repeated herein.<br><br>Subsequent to the date of the examination, effective April 2005, the Company provided documentation to demonstrate that it has instituted policies and procedures to ensure written agreements with producers. | 13 |
| 2. | It is recommended that the United HealthCare Companies improve their record keeping as regards agents and brokers.<br><br>The Company has not fully complied with this recommendation and it is repeated herein.<br><br>Subsequent to the date of the examination, effective April 2005, the Company provided documentation to demonstrate that it has developed a process of imaging all appropriate agent and broker documentation. | 15 |
| | **Claims Processing** | |
| 3. | It is recommended that the Company reevaluate the level at which foreign claims will be referred to its fraud oversight group for investigation prior to payment.<br><br>The Company has not complied with this recommendation and a similar recommendation is repeated herein. | 20 |
| 4. | It is recommended that the Company display the five-digit CPT codes for procedures and services that it used to determine payment on all Explanation of Benefit statements along with a brief description of the codes.<br><br>The Company has not complied with this recommendation and it is repeated herein. | 23 |

## 7. SUMMARY OF COMMENTS AND RECOMMENDATIONS

**ITEM** **PAGE NO.**

C. **Custodial Agreement**

It is recommended that the Company amend its custodial agreement with Street Bank to include the following: 15

- The bank shall have in force, for its own protection, Bankers Blanket Bond Insurance of the broadest form available for commercial banks and will continue to maintain such insurance. The bank will give the insurer 60 days written notice of any material change in the form or amount of such insurance of termination of this coverage.
- Written instructions hereunder shall be signed by any two of the insurer's authorized officers specified in a separate list for this purpose. This list will be furnished to the bank from time to time and signed by the treasurer or an assistant and certified under the corporate seal by the secretary or an assistant secretary.
- The agreement should have a provision that would give the insurer the opportunity to secure the most recent report on the review of the custodian's system of internal control, pertaining to custodian record keeping, as issued by internal or independent auditors.

D. **Accounts and Records**

i. It is recommended that UHINY make the appropriate disclosures in its annual statement filings in accordance with Paragraph 18 of SSAP No. 45. 16

ii. It is recommended that UHINY report its interest due and accrued on page 2, line 11, of its annual statement filing. 16

iii. It is recommended that UHINY adjust its net investment income earned amounts on the Income Statement and Investment Income Exhibit to reflect the accrued interest receivable amount. 17

Appointment No. ***22140***

# STATE OF NEW YORK
# INSURANCE DEPARTMENT

I, ***GREGORY V. SERIO***, Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:

**Wai Wong**

*as a proper person to examine into the affairs of the*

**UNITED HEALTHCARE INSURANCE COMPANY OF NY, INC.**

*and to make a report to me in writing of the said*

**Company**

with such information as he shall deem requisite.

In Witness Whereof, I have hereunto subscribed by the name and affixed the official Seal of this Department, at the City of New York.

this *30th* day of *January 2004*

Gregory V. Serio
Superintendent of Insurance