REPORT ON EXAMINATION

OF

OXFORD HEALTH INSURANCE, INC.

AS OF

DECEMBER 31, 2016

DATE OF REPORT **JUNE 27, 2018**

EXAMINER **DAVID CRANDALL, CFE**

TABLE OF CONTENTS

Andrew M. Cuomo
Governor

Maria T. Vullo
Superintendent

June 27, 2018

Honorable Maria T. Vullo
Superintendent of Financial Services
Albany, New York 12257

Madam:

Pursuant to the requirements of the New York Insurance Law, and acting in accordance with the instructions contained in Appointment Number 31569, dated February 1, 2017, attached hereto, I have made an examination into the condition and affairs of Oxford Health Insurance, Inc., a for-profit stock company licensed pursuant to Article 42 of the New York Insurance Law, as of December 31, 2016. The following report is respectfully submitted thereon.

The examination was conducted at the administrative office of UnitedHealth Group Incorporated, located at 185 Asylum St. Hartford, CT.

Wherever the designations the "Company" or "OHI" appear herein, without qualification, they should be understood to indicate Oxford Health Insurance, Inc.

Wherever the designation "OHP-NY" appears herein, without qualification, it should be understood to indicate Oxford Health Plans (NY), Inc., a for-profit individual practice association model health maintenance organization, licensed pursuant to the provisions of Article 44 of the New York Public Health Law. OHP-NY is an affiliate of OHI.

Wherever the designation “Oxford” appears herein, without qualification, it should be understood to indicate Oxford Health Plans, LLC, a Delaware corporation, the parent of OHP-NY.

Wherever the designation “UHIC” appears herein, without qualification, it should be understood to indicate UnitedHealthcare Insurance Company, a Connecticut corporation, and the parent of OHI.

Wherever the designation “UHG” appears herein, without qualification, it should be understood to indicate UnitedHealth Group Incorporated, a for-profit holding company and the ultimate parent of OHP-NY and OHI.

Wherever the designation the “Department” appears herein, without qualification, it should be understood to indicate the New York State Department of Financial Services.

1. SCOPE OF THE EXAMINATION

The previous examination was conducted as of December 31, 2012. This examination was a financial examination, as defined in the National Association of Insurance Commissioners ("NAIC") *Financial Condition Examiners Handbook, 2017 Edition* (the "Handbook"), and covered the four-year period January 1, 2013 through December 31, 2016. The examination was conducted observing the guidelines and procedures in the Handbook. Where deemed appropriate by the examiner, transactions occurring subsequent to December 31, 2016 were also reviewed.

The examination was conducted on a risk-focused basis in accordance with the provisions of the Handbook, which provides guidance for the establishment of an examination plan based on the examiner's assessment of risk in the Company's operations and utilizes that evaluation in formulating the nature and extent of the examination. The examiner planned and performed the examination to evaluate the Company's current financial condition, as well as identify prospective risks that may threaten the future solvency of OHI.

The examiner identified key processes, assessed the risks within those processes and assessed the internal control systems and procedures used to mitigate those risks. The examination also included an assessment of the principles used and significant estimates made by management, an evaluation of the overall financial statement presentation, and determined management's compliance with the Department's statutes and guidelines, Statutory Accounting Principles, as adopted by the Department, and NAIC Annual Statement Instructions.

Information concerning the Company's organizational structure, business approach and control environment was utilized to develop the examination approach. The examination

evaluated the Company's risks and management activities in accordance with the NAIC's nine branded risk categories. These categories are as follows:

- Pricing/Underwriting
- Reserving
- Operational
- Strategic
- Credit
- Market
- Liquidity
- Legal
- Reputational

The examination also evaluated the Company's critical risk categories in accordance with the NAIC's ten critical risk categories. These categories are as follows:

- Valuation/Impairment of Complex or Subjectively Valued Invested Assets
- Liquidity Considerations
- Appropriateness of Investment Portfolio and Strategy
- Appropriateness/Adequacy of Reinsurance Program
- Reinsurance Reporting and Collectability
- Underwriting and Pricing Strategy/Quality
- Reserve Data
- Reserve Adequacy
- Related Party/Holding Company Considerations
- Capital Management

The Company was audited annually for the years 2013 through 2016 by the accounting firm of Deloitte & Touche, LLP ("D&T"). The Company received an unmodified opinion in each of those years. Certain audit work papers of D&T were reviewed and relied upon in conjunction with this examination. A review was also made of UHG's Internal Audit function and Enterprise Risk Management program, as they relate to the Company.

This examination was conducted as a coordinated examination, as such term is defined in the Handbook (an examination of one insurer or a group of insurers performed by examiners from more than one state whereby the participating states share resources and allocate work

among the examiners), of the insurance subsidiaries of UnitedHealth Group, Inc. The examination was led by the State of Connecticut with participation from eight additional states. Since the Lead and Participating states, as such terms are defined in the Handbook, are accredited by the NAIC, the states deemed it appropriate to rely on each other's work. The examination team representing the Lead and Participating states identified and assessed the risks for key functional activities across all of UnitedHealth Group, Inc.'s insurance subsidiaries. The examination team also assessed the relevant prospective risks as they relate to the various insurance entities.

A review was made of the Company's compliance with the provisions of Insurance Regulation 118 (11 NYCRR 89), "Audited Financial Statements." The regulation is based on the Model Audit Rule ("MAR"), as established by the NAIC. The examiner also reviewed the corrective actions taken by the Company with respect to the recommendations concerning financial issues contained in the prior report on examination. The results of the review are contained in Item Six of this report.

A concurrent examination regarding the financial condition of OHP-NY was performed as of December 31, 2016, and a separate financial report on examination was issued thereon.

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

DESCRIPTION OF THE COMPANY

OHI was incorporated in New York State on January 30, 1987 for the purpose of providing accident and health insurance products. It obtained its license from the New York State Department of Insurance (now New York State Department of Financial Services) to engage in the business of accident and health insurance on July 1, 1987, and it commenced operations on that date.

From its date of incorporation until December 31, 1997, OHI was a wholly-owned subsidiary of Oxford Health Plans, Inc., a Delaware corporation. On that date, in accordance with the Department's approval, Oxford Health Plans, Inc. transferred 100% ownership of OHI to OHP-NY, a wholly-owned subsidiary of Oxford, a Delaware corporation. Oxford Health Plans, Inc. was acquired by UHG on July 29, 2004. Oxford Health Plans, Inc. is a subsidiary of UHG. On April 1, 2014, the OHI became a wholly-owned subsidiary of UnitedHealthcare Insurance Company ("UHIC"), a Connecticut corporation, when OHP-NY, who previously was OHI's direct parent, transferred, with approval from the New York State Department of Health, ownership of OHI to OHP-NY's parent Oxford Health Plans, LLC, and ownership of OHI was subsequently transferred to UHIC.

OHI is licensed to transact accident and health insurance as defined in paragraph 3(i) of Section 1113(a) of the New York Insurance Law. As of December 31, 2016, OHI reported total paid-in-capital of $1,000,000, comprised of 500,000 shares authorized, issued, and outstanding $2.00 par value common stock.

The Company's authorized control level Risk-Based Capital ("RBC") was $183,127,375 as of December 31, 2016. Its total adjusted capital was $1,192,593,697, yielding an RBC ratio of 651.2% as of December 31, 2016.

A. Corporate Governance

Pursuant to the Company's charter and by-laws, management of the Company is to be vested in a board of directors (the "Board") consisting of no less than thirteen members. As of the examination date, the Board was comprised of thirteen members. The board met at least four times during each calendar year for the period under examination.

As of December 31, 2016, the members of the board of directors and their principal business affiliations were as follows:

Name and Residence	Principal Business Affiliation
Timothy Callahan Archer Avon, CT	Director, Finance - Northeast Region, United Healthcare Services, Inc.
James Francis Bedard Glastonbury, CT	Chief Financial Officer of Northeast Region, United Healthcare Services, Inc.
William John Golden Northport, NY	Chief Executive Officer of New York Health Plan, United Healthcare Services, Inc.
Rebecca Eden Porter Madsen New York, NY	Regional Vice President, Chief of Staff, United Health Group
Michael McGuire Wycoff, NJ	Chief Executive Officer of Health Plan Northeast, United Health Group
Thomas Joseph McGuire Hartford, CT	Senior Deputy General Counsel, United Healthcare Services, Inc.

Name and Residence	Principal Business Affiliation
Sandra Denise Bruce Nichols, M.D. North Potomac, MD.	Chief Medical Officer, United Healthcare Services, Inc.
Dennis Patrick O'Brien New York, NY	Network Management of the Northeast Region, United Healthcare Services, Inc.
Michael Anthony Santoro Trumbull, CT	Regional Vice President of the Northeast Region, United Healthcare Services, Inc.
Allen Jon Sorbo Trumbull, CT	Chief Actuary, United Healthcare Services, Inc.
Michael James Specht Setauket, NY	National Director, IMO, CDH & Specialty Benefits, United Health Group
Randall Harrison Weinstock Hartford, CT	Chief Operation Officer, United Healthcare Services, Inc.
Vincent Joseph Zuccarello Trumbull, CT	Vice President of Healthcare Economics, United Healthcare Services, Inc.

The review of the minutes of the OHI board of directors' meetings indicated that several directors did not attend at least 50% of the board meetings which they were eligible to attend during the examination period. One director missed all four meetings between September 26, 2014 and June 17, 2015 and three more from March 26, 2016 and September 28, 2017. Four additional directors missed three of four meetings in a one-year period and did not attend several other meetings during the examination.

Members of the board have a fiduciary responsibility and must evidence an ongoing interest in the affairs of the insurer. It is essential that board members attend meetings consistently and set forth their views on relevant matters so that appropriate decisions may be reached by the board. Board members who fail to attend at least one-half of the regular meetings do not fulfill such criteria.

It is recommended that board members who are unable or unwilling to attend meetings consistently resign or be replaced.

The principal officers of the Company as of December 31, 2016 were as follows:

Name	Title
William John Golden	President & Chief Executive Officer
Rebecca Eden Porter Madsen	Chairman
Thomas Joseph McGuire	General Counsel
Robert Worth Oberrender	Treasurer
Nyle Brent Cottington	Vice President
Sanford Paul Cohen, MD	Chief Medical Officer
Timothy Callahan Archer	Chief Financial Officer
Randall Harrison Weinstock	Chief Operating Officer
Heather Anastasia Lang Jacobsen	Assistant Secretary
Michael Anthony Santoro	Assistant Secretary

It should be noted that certain members of the board and senior management of OHI are also members of the Board and senior management of other affiliated companies.

UnitedHealthcare Insurance Company ("UHIC") became the parent company of OHI effective April 1, 2014. UHIC has established an Audit Committee ("UHIC AC"), which has been designated as the audit committee of various affiliates, including OHI. To facilitate effective corporate governance, the UHIC AC coordinates certain activities with the Company's ultimate parent, UHG and UHG's own Audit Committee. It is the responsibility of the UHIC AC to communicate significant un-remediated deficiencies or material weaknesses in financial reporting internal controls to the UHG AC.

B. Enterprise Risk Management

UHG is a publicly traded, diversified health company subject to the Sarbanes-Oxley Act of 2002, and is required to be compliant with Insurance Regulation No. 203 (11 NYCRR 82)-Enterprise Risk Management and Own Risk and Solvency Assessment. Enterprise Risk Management ("ERM") and Internal Audit are enterprise-wide functions; thus, unless otherwise noted, references to UHG are applicable to the Company.

UHG has adopted an ERM framework for addressing and mitigating risks, including prospective business risks. Exhibit M of the Handbook (*Understanding the Corporate Governance Structure*) was utilized by the examiner as guidance for assessing corporate governance. Overall, it was determined that the Company's corporate governance structure is adequate, sets an appropriate "tone at the top," supports a proactive approach to operational risk management, and contributes to an effective system of internal controls. It was found that senior management promotes a corporate culture that acknowledges, understands and maintains an effective control environment.

The Company's management has an adequate approach to identifying and mitigating risks across the organization, including prospective business risks. The Company deals proactively with its areas of risk, and its management is knowledgeable about mitigation strategies. Through risk discussions and other measures, the Company's management discusses significant issues and reacts to changes in the environment with a clear commitment to address risk factors and manages the business accordingly. The Company's overall risk management process takes a proactive approach to identifying, tracking, and dealing with significant current and emerging risk factors.

C. Internal Audit Department

UHG has an established Internal Audit Department ("IAD"), which is independent of management, to serve the UHG Audit Committee ("UHG AC") of the Board. The UHG AC is comprised entirely of external directors. During the examination period, a portion of UHG's internal audit work was outsourced to, and therefore executed by, Ernst & Young ("EY"), an independent accounting firm. EY has experience consistent with industry norms, and all EY manager-level and above resources maintain applicable industry certifications. The IAD directs and supervises all internal audit work performed by EY. The IAD reviews and tests financial and operational controls and processes established by management to ensure compliance with laws, regulations and UHG policies. The scope of the IAD's program is coordinated with UHG's independent certified public accountants to ensure adequate coverage and maximum efficiency.

During the course of this examination, consideration was given to the significance and potential impact of certain IAD findings. To the extent possible, the examiner relied upon the work performed by the IAD, as required by the Handbook.

D. Territory and Plan of Operation

As of December 31, 2016, the Company was authorized to transact business in the states of Connecticut, New Jersey, New York, and the Commonwealth of Pennsylvania. The Company is licensed to transact accident and health insurance as defined in paragraph 3(i) of Section 1113(a) of the New York Insurance Law.

OHI, in conjunction with OHP-NY, provides a point-of-service ("POS") product called the "Freedom Plan." The Freedom Plan combines the health maintenance organization ("HMO") benefits and coverage of OHP-NY with conventional indemnity health insurance

provided by OHI. The Freedom Plan enrollees pay a composite rate for their health coverage, which is developed from the community rate for the HMO coverage and a separate rate for the indemnity ("out-of-plan") coverage. Larger groups have a manual rate for the HMO coverage combined and blended with the group's experience ("experience rated"). OHP-NY's Commercial HMO Certificate of Authority ("COA") was withdrawn on January 1, 2017.

The Liberty Plan is another POS health care plan offered jointly by OHI and OHP-NY. This Plan offers lower premiums than the Freedom Plan since members choose from a smaller number of in-network providers.

In addition, OHI offers a Preferred Provider Organization ("PPO") plan which allows members to obtain coverage for services from participating or non-participating providers.

OHI participated in the Small Business Health Options Program "SHOP" exchange effective January 1, 2014 for small group, and exited upon renewal starting January 1, 2015.

The following schedule shows direct premiums written in the State of New York compared to the total of direct premiums written in all states during the period under examination:

Year	New York	Total Direct Written Premiums	Percentage
2016	$5,170,526,416	$6,431,145,741	80.39%
2015	$4,607,203,938	$5,818,972,138	79.18%
2014	$4,060,486,873	$4,922,925,912	82.48%
2013	$2,432,614,696	$2,860,270,781	85.04%

As of December 31, 2016, the Company had 909,492 members. The following schedule shows the membership increase/decrease by number and percentage during the examination period:

	2016	2015	2014	2013
Members	909,492	862,315	826,168	983,506
Growth	5.5%	4.4%	(16.0%)	(5.3%)

The decrease in membership and concurrent increase in premium in 2014 was the result of competitor pricing that lowered membership while the increase in net premiums was attributable to the termination of a 50% quota share reinsurance agreement with the Company's parent UHIC on April 1, 2014.

The following schedule, obtained from information contained in annual statements for the period currently under review, reflects the Company's results:

Year	Net Premiums Written	Net Paid Health Claims	Net Income	Surplus	Ratio of Net Premiums Written to Surplus
2016	$6,431,145,741	$5,025,433,937	$363,581,429	$1,192,593,697	5.39
2015	5,818,972,138	4,337,731,202	418,489,091	1,257,196,982	4.62
2014	4,922,279,781	3,897,407,207	236,979,320	917,347,956	5.37
2013	2,862,871,502	2,667,266,255	141,381,201	855,211,085	3.34

New York Department of Health Law Section 2807-d(1)(a) states the following in part:

> "Hospitals, as defined in this article… are charged assessments on their gross receipts received from all patient care services and other operating income, less personal needs allowances and refunds, on a cash basis in the percentage amounts and for the periods specified in subdivision two of this section. Such assessments shall be submitted to the commissioner or his designee."

During the Department's walkthrough of controls over the application of the New York Health Care Reform Act ("NYHCRA") surcharge (the "Surcharge"), it was noted that there were insufficient controls to ensure the system properly identified all of the facilities that were surcharge-eligible. At the request of the examiner, the Company performed an analysis and noted that, between 2014 through 2016, there were a total of two hundred thirty-eight facilities within the Claim Adjudication System where a surcharge was due but not paid.

It is recommended that the Company comply with New York Department of Health Law Section 2807-d (1) (a) by instituting controls to ensure that all facilities for which the Surcharge is due are properly identified within the system.

It is further recommended that Oxford determine the total amount of additional liability to NYHCRA and pay such fees.

E. Reinsurance

The Company was subject to Section 1341 of the Affordable Care Act which established a transitional Reinsurance Program to help stabilize premiums for coverage in the individual market during the years 2014 through 2016. The statute required all health insurance issuers and third-party administrators on behalf of self-insured group health plans to make contributions under the program to support payments to individual market issuers that cover high-cost individuals (payment-eligible issuers). Reinsurance premiums paid, and reinsurance premiums incurred but not paid, are deducted from amounts related to the reinsurance program and are reflected in the accompanying statutory basis statements of operations and in the accompanying statutory basis Statements of Admitted Assets, Liabilities, and Capital and Surplus. The Reinsurance Program was terminated after the plan year ended in 2016.

The Company also has a reinsurance agreement with an unaffiliated company, Consulting Engineers Reinsurance Company ("CERC"), that was established as a captive reinsurer for the American Council of Engineering Companies. These amounts are reflected as a reduction to net premium income, total hospital and medical, claims adjustment expenses, and general administrative expenses in the accompanying statutory basis financial statements. Pursuant to the quota-share agreements, the Company records amounts recoverable from CERC for claims paid, general administrative expenses and claims adjustment expenses as reinsurance in the statutory basis Statements of Admitted Assets, Liabilities, and Capital and Surplus and as a reduction to total hospital and medical, general administrative expenses, and claims adjustment expenses in the statutory basis statements of operations. In addition, the Company participates in the Connecticut Small Employer Health Insurance Pool. Reinsurance premiums paid and incurred are deducted from net premium income in the accompanying statutory basis statements of operations.

Effective February 1, 2014, the Company entered into a reinsurance agreement with Unimerica Insurance Company ("Unimerica"), an affiliate, through which a contractual per member per month ("PMPM") rate of earned member premiums and 100% of obligations relating to transplants, infertility treatments, chiropractic and physical therapy for Connecticut and New Jersey policies and mental health and substance abuse treatments and services for New Jersey policies is ceded to the reinsurer. The Company remains primarily liable as the direct insurer on the risks reinsured. Reinsurance premiums paid, and reinsurance premium incurred but not paid are deducted from net premium income in the statutory basis financial statements. Pursuant to the reinsurance agreement, any amounts recoverable from the reinsurer for claims

paid or estimates of claims incurred but not yet paid are recorded as amounts recoverable from reinsurers and as a reduction to claims unpaid, respectively, in the statutory basis Statements of Admitted Assets, Liabilities, and Capital and Surplus and as net reinsurance recoveries in the statutory basis statements of operations.

The Company also has a reinsurance agreement with an affiliate, Oxford Health Plans (NJ), Inc. (OHP-NJ) to assume OHP-NJ's out-of-network (Point-of-service business) through a contractual PMPM rate.

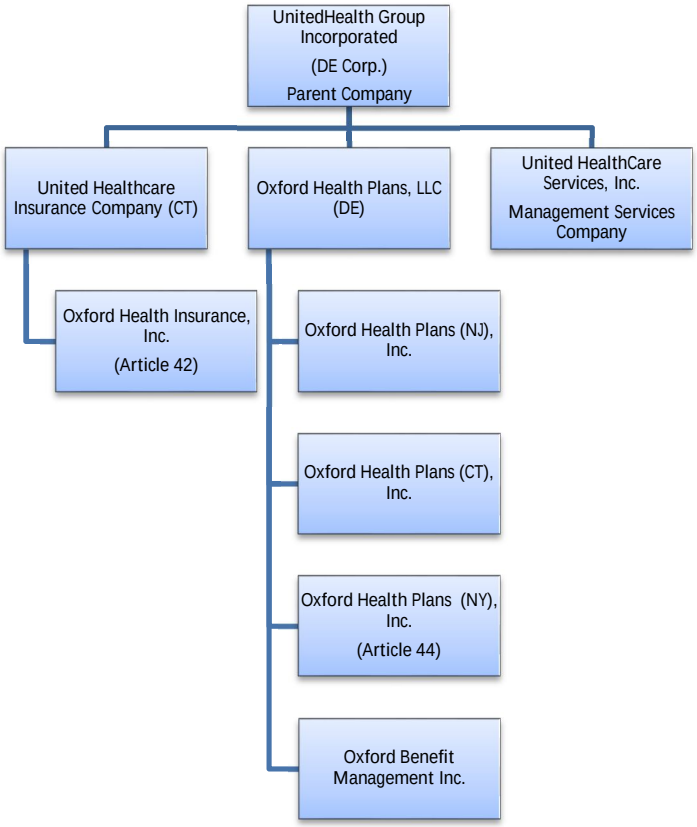
The affiliated reinsurance agreements with Unimerica and OHP-NJ were both approved by the Department prior to execution.

F. Holding Company System

From its date of incorporation until December 31, 1997, OHI was a wholly-owned subsidiary of Oxford Health Plans, Inc. On that date, Oxford transferred 100% ownership of OHI to OHP-NY, which is a wholly-owned subsidiary of Oxford, a Delaware corporation. Oxford was acquired by UHG on July 29, 2004, and is a direct subsidiary of UHG. On April 1, 2014, OHI became a wholly-owned subsidiary of UnitedHealthcare Insurance Company ("UHIC"), a Connecticut corporation, following the redemption and retirement of all issued and outstanding shares to UHG and subsequent distribution to UHIC.

As a member of a holding company system, OHI is required to file registration statements pursuant to the requirements of Section 1503 of the New York Insurance Law and Insurance Regulation 52 (11 NYCRR 80). All such filings made during the examination period were reviewed, and no exceptions were noted.

The following is an excerpt of the organizational chart of the Company's holding company system as of December 31, 2016:



The following is a summary of OHI's relationship with several of the affiliates shown above:

- UnitedHealth Group Incorporated ("UHG") is a Delaware corporation that is publicly traded and the ultimate parent of Oxford Health Insurance, Inc., Oxford Health Plans (NY), Inc., Oxford Health Plans, LLC, UnitedHealthcare Services, Inc., and over one hundred and fifty (150) other affiliated companies.

- United HealthCare Services, Inc. ("UHS"), a management services company within UHG, provides administrative, 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 to affiliated companies within UHG's holding company system. Most of the directors and officers of Oxford and various UHG companies are considered employees of UHS rather than the individual insurers under UHG's holding company system.

- Oxford Health Plans, LLC is a Delaware corporation and the parent corporation of Oxford Health Plans (NY), Inc. and various other Oxford companies.
- UnitedHealthcare Insurance Company (CT), Inc. is a Connecticut corporation and the parent corporation of OHI.

The Company maintains significant intercompany agreements with several affiliated organizations, as follows:

Management Services Agreement

Pursuant to the terms of a management service agreement, which was approved by the Department on January 31, 2011, UHS provides management services to the Company for a fee based on cost reimbursement. The agreement may be terminated upon the written agreement of either parties.

Management fees under this arrangement are included in general administrative expenses and claims adjustment expenses in the accompanying statement of revenue and expenses. Direct expenses not included in the management service agreement, such as broker commissions, examination fees, and premium taxes are paid by UHS on the behalf of the Company. UHS is reimbursed by the Company for these direct expenses.

Network Services Agreement

Effective December 1, 2011, OHI entered into a Network Services Agreement (the "Network Services Agreement") with OptumHealth. Pursuant to the Network Services Agreement, OptumHealth provides network access for physical, occupational and speech therapy services and chiropractic services to OHI's commercial members. The Network

Services Agreement was submitted for review and approval to the Department on October 17, 2011 and was approved on November 11, 2011.

Tax Sharing Agreement

The Department Circular Letter No. 33 (1979), Paragraph 2, requires the following:

> "The ultimate holding corporation, any intermediate corporation which owns a controlling interest in the stock of the domestic insurer and the domestic insurer itself must be parties to, but need not necessarily participate in, the consolidated federal income tax agreement. In the case of an alien owned domestic insurer, the ultimate United States Corporation, in whose behalf the consolidated corporate federal income tax return is filed with the Internal Revenue Service, may be substituted for the ultimate holding corporation."

On July 29, 2004, OHI entered into a Tax Allocation Agreement (the "Tax Agreement") with UHG, the ultimate controlling parent and Oxford. The Tax Agreement established 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. The Tax Agreement was submitted for review and approval to the Department on August 17, 2004, and was retroactively approved to July 29, 2004 on September 8, 2004.

UnitedHealth Group altered the corporate structure of Oxford Health Insurance on April 1, 2014 whereby its shares were transferred from Oxford Health Plans, LLC (DE) to UnitedHealthcare Insurance Company (CT). The Company did not amend the existing tax allocation agreement to reflect this change in control, in violation of Circular Letter No. 33, until the deficiency was pointed out during the examination.

It is recommended that the Company comply with Department Circular Letter No. 33 (1979) by ensuring amendments to tax allocation agreements are completed and approved prior to any future changes in the corporate structure of its parent.

In addition to the agreements described above, the Company maintains several immaterial agreements with other affiliated organizations.

G. Significant Operating Ratios

The following ratios have been computed as of December 31, 2016, based upon the results of this examination:

Ratio	2016
Net Change in Capital and Surplus	(5.1%)
Liquid Assets & Receivables to Current Liabilities	209.6%
Enrollment ratio	5.5%
Premium and Risk Revenue to Capital and Surplus	5.4 to 1
Medical Loss Ratio	77.1%
Combined Loss Ratio	91.1%
Administrative Expense Ratio	14.0%

The above ratios fall within the benchmark ranges set forth in the Financial Analysis Solvency Tools ("FAST") scoring ratios of the NAIC.

The underwriting ratios presented below are on an earned-incurred basis and encompass the four-year period covered by this examination:

	Amounts	Ratios
Total hospital and medical	$ 15,528,024,578	77.5%
Other claim adjustment expenses	218,909,367	1.1%
Cost containment expenses	255,437,580	1.3%
General administrative expenses	2,228,776,018	11.1%
Net underwriting gain	1,804,121,619	9.0%
Net premium income	$ 20,035,269,162	100.0%

3. MEDICAL LOSS RATIO REPORTING

The Company's 2016 Medical Loss Ratio ("MLR") Annual Reporting Form for the states of New York, Connecticut and New Jersey were examined to assess compliance with the requirements of Title 45 of the Code of Federal Regulations ("CFR"), Part 158, which implements section 2718 of the Public Health Service Act ("PHS Act"). Section 2718 of the PHS Act, as added by the Affordable Care Act, generally requires health insurance companies to submit to the Secretary of the U.S. Department of Health and Human Services ("HHS") an annual report on their MLRs. The MLR is the proportion of premium revenue expended by a company on clinical services and activities that improve health care quality in a given market. Section 2718 of the PHS Act also requires a company to provide rebates to consumers if it does not meet the MLR standard (82% in the individual and small group markets and 85% in the large group market for the state of New York and 80% in the individual and small group markets and 85% in the large group market for the states of Connecticut and New Jersey).

This is the first examination of the Company's MLR Annual Reporting Form performed by the Department. This examination of the Company's 2016 MLR Annual Reporting Form

covered the reporting period of January 1, 2014 through December 31, 2016, including 2014 and 2015 experience and claims run-out through March 31, 2017.

The examination was conducted in accordance with the NAIC's 24 MLR Agreed Upon Procedures ("MLR AUPs"). The MLR AUPs set forth the procedures for performing an examination to evaluate the validity and accuracy of the data elements and calculated amounts reported on the MLR Annual Reporting Form, and the accuracy and timeliness of any rebate payments. The examination included assessing the principles used and significant estimates made by the Company, evaluating the reasonableness of expense allocations, and determining compliance with relevant statutory accounting standards, MLR regulations and guidance, and the MLR Annual Reporting Form Filing Instructions.

Title 45 CFR §158.110(b) requires that a report for each MLR reporting year is to be submitted to the Secretary of HHS by July 31st of the year following the end of an MLR reporting year, on a form and in the manner prescribed by the Secretary of HHS. Based on the examiner's review, the 2016 MLR Annual Reporting Form filed by the Company contains some elements that are not fully compliant with the requirements of Title 45 CFR §158, as more fully described in the sections below.

Title 45 CFR §158.210 (a), (b) and (c) requires that an issuer must provide a rebate to enrollees if the issuer has an MLR below the required amount (less than 82% in the individual and small group markets and 85% in the large group market for the state of New York and 80% in the individual and small group markets and 85% in the large group market for the states of Connecticut and New Jersey). The Company's New York, Connecticut and New Jersey MLR and rebate calculations, as reported on the 2016 MLR Annual Reporting Form were as follows:

New York

MLR Components	Individual	Small Group	Large Group
Adjusted Incurred Claims	$361,403,724	$7,501,096,981	$3,042,780,320
Plus: Quality Improvement Expenses	$2,375,376	$67,150,501	$28,234,388
Less: Cost-sharing reductions	$0		
Less: Federal Transitional Reinsurance Program payments expected from HHS	$0		
Less: Federal Risk Adjustment Program net payments expected from (payable to) HHS	$4,731,809	$610,277,966	
Less: Federal Risk Corridors Program net payments (charges)	$0	$0	
MLR Numerator	**$359,047,291**	**$6,958,958,576**	**$3,071,014,707**
Premium Earned	$346,724,189	$9,506,472,788	$4,105,522,293
Less: Federal & State Taxes and Licensing/Regulatory Fees	$5,229,068	$1,058,558,810	$458,897,171
MLR Denominator	**$341,495,121**	**$8,447,913,977**	**$3,646,625,122**
Preliminary MLR	105.1%	82.4%	84.2%
Credibility Adjustment	1.2%	0.0%	0.0%
Credibility–Adjusted MLR	**106.3%**	**82.4%**	**84.2%**
MLR Standard	82%	82%	85%
Rebate Amount	**$0**	**$0**	**$10,922,531**

Connecticut

MLR Components	Individual	Small Group	Large Group
Adjusted Incurred Claims	$13,733,709	$283,143,401	$342,608,037
Plus: Quality Improvement Expenses	$97,150	$2,703,923	$3,720,508
Less: Cost-sharing reductions	$0		
Less: Federal Transitional Reinsurance Program payments expected from HHS	$0		
Less: Federal Risk Adjustment Program net payments expected from (payable to) HHS	$0	$15,606,122	
Less: Federal Risk Corridors Program net payments (charges)	$0	$0	
MLR Numerator	**$13,830,859**	**$270,241,202**	**$346,328,545**
Premium Earned	$15,973,058	$360,125,469	$426,992,766
Less: Federal & State Taxes and Licensing/Regulatory Fees	$1,129,711	$36,673,646	$30,909,929

MLR Denominator	**$14,843,348**	**$323,451,823**	**$396,082,837**
Preliminary MLR	93.2%	83.5%	87.4%
Credibility Adjustment	6.2%	1.0%	0.3%
Credibility–Adjusted MLR	**99.3%**	**84.5%**	**87.7%**
MLR Standard	80%	80%	85%
Rebate Amount	**$0**	**$0**	**$0**

New Jersey

MLR Components	Individual	Small Group	Large Group
Adjusted Incurred Claims	$277,318,865	$829,159,053	$1,113,688,008
Plus: Quality Improvement Expenses	$1,336,967	$8,434,433	$12,215,622
Less: Cost-sharing reductions	$0		
Less: Federal Transitional Reinsurance Program payments expected from HHS	$40,039,752		
Less: Federal Risk Adjustment Program net payments expected from (payable to) HHS	$127,584,587	$21,815,239	
Less: Federal Risk Corridors Program net payments (charges)	$0	$0	
MLR Numerator	**$111,031,494**	**$815,798,638**	**$1,125,903,630**
Premium Earned	$176,966,843	$1,052,642,095	$1,460,201,874
Less: Federal & State Taxes and Licensing/Regulatory Fees	$23,038,098	$58,592,267	$116,864,861
MLR Denominator	**$153,928,744**	**$994,049,829**	**$1,343,337,013**
Preliminary MLR	72.1%	82.1%	83.8%
Credibility Adjustment	0.0%	0.0%	0.0%
Credibility–Adjusted MLR	**72.1%**	**82.1%**	**83.8%**
MLR Standard	80%	80%	85%
Rebate Amount	**$3,817,859**	**$0**	**$6,205,582**

A. MLR Numerator

According to Title 45 CFR §158.221(b), the numerator of the MLR calculation is comprised of incurred claims, as defined in Title 45 CFR §158.140, expenditures for activities that improve health care quality as defined in Title 45 CFR §158.150, and Title 45 CFR

§158.151, Cost Sharing Reductions Program as defined in Title 45 CFR §158.140(b)(1)(iii) and Federal Transitional Reinsurance, Federal Risk Adjustment and Federal Risk Corridor Programs as defined by Title 45 CFR §158.140(b)(4)(ii).

Incurred Claims

The examiner reviewed the accuracy and appropriateness of the amounts reported within incurred claims as defined by Title 45 §CFR 158.140, including the verification of the data used by the Company to calculate adjusted incurred claims and the validation of a sample of incurred claims reported by the Company.

The 2016 MLR Annual Reporting Form that was filed by the Company for the state of New York did not fully comply with the MLR Annual Reporting Form Filing Instructions, in violation of Title 45 CFR §158.110. The Company does not have Qualified Health Plan (QHP) eligible business and incorrectly reported claims, premiums, Quality Improvement Activities ("QIA"), taxes and other amounts in the Risk Corridor (RC) column for the small group market on Parts 1, 2 and 3. There is no impact on rebates since "zero" was correctly reported for the total column on Part 3, Line 1.7, Federal Risk Corridors Program.

It is recommended that the Company implement procedures to ensure it completes the MLR Annual Reporting Form in accordance with the applicable MLR Annual Reporting Form Filing Instructions and Title 45 CFR §158.110.

Based on the procedures performed, other than the exception noted above, the Company's incurred claims were accurately reported on the New York, Connecticut and New Jersey 2016 MLR Annual Reporting Forms.

Quality Improvement Activities ("QIA")

The Company's QIA process consists of three separate components: affiliated vendors, external vendors and management fees. These components are aggregated to determine the total QIA reported on the MLR Annual Reporting Form.

The examiner reviewed the accuracy and reasonableness of health care quality improvement expenses, including the validation of a sample of the QIA amounts reported, to ensure they are in conformity with the definition of Healthcare Quality Improvement Expenses as defined by Title 45 CFR §158.150 and Title 45 CFR §158.151, and confirmation that the allocation methodology is reasonable and complies with the requirements set forth by Title 45 CFR §158.170.

Management Fee QIA

Part 243.2 (b)(8) of New York Insurance Regulation No. 152 (11 NYCRR 243.8) states in part:

> "(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."

Title 45 CFR Part 158 requires issuers to maintain all documents and other evidence necessary to verify that the data submitted is in compliance with the definitions and criteria set forth in Title 45 CFR Part 158 and that the MLR and any rebates owed are calculated and provided in accordance with the regulation. In addition, such records are required to be maintained under Part 243.2 (b)(8) of Insurance Regulation No. 152 (11 NYCRR 243.8), cited above. In testing for compliance with these requirements, it was noted that, in violation of the

cited regulations, the Company did not maintain adequate documentation to support the percentages reported in the internal cost center/department survey.

It is recommended that the Company comply with Title 45 CFR §158.502 and Part 243.2 (b)(8) of Insurance Regulation No. 152 (11 NYCRR 243.8) by maintaining sufficient quantitative analyses to adequately support the QIA allocation percentages reported in the internal cost center/department survey for management fee expenses.

Additionally, it was noted that the Company classified certain overhead expense amounts as QIA expenses that did not qualify for such classification under Title 45 CFR §158.150 or the 2016 NAIC Annual Statement Instructions - Health. For some UHG overhead expense categories, such as Occupancy/Real Estate, there were expenses included that did not qualify as QIA, while, in others, such as Employee Recruitment, none of the expenses qualified as QIA. In a third category, the allocated percentages for items such as Capital Development and Depreciation, were inaccurate.

It is recommended that the Company only classify overhead expenses as QIA when such items are allowed pursuant to Federal Regulation 45 CFR §158.150 and the NAIC Annual Statement Instructions – Health.

In testing the management fee QIA expenses for OHI's commercial line of business MLR calculation, it was noted that the Company utilized expenses that did not relate to commercial product enrollees.

It is recommended that the Company exclude any non-commercial dedicated departments from the determination of the commercial management fee QIA blended rates.

External Vendors QIA

In establishing the expenses to apply to QIA for costs attributable to the use of external vendors, the Company relied on surveys provided by those vendors, which are loaded into a matrix. However, it was noted during the examiner's review that the Company did not have a key control in place to adequately mitigate the risk that inaccurate external vendors survey results could be loaded into the survey matrix.

It is recommended that the Company develop and add a key control to adequately mitigate the risk that inaccurate external vendor survey results are loaded into the survey matrix.

It was also noted that the operating effectiveness of one external vendor's key control was deemed to have failed because there was no formal documented review and signoff or verification that variances were resolved timely.

It is recommended that the Company maintain adequate documentation that supports the operating effectiveness of key internal controls.

For one external vendor, the Company incorrectly calculated the retro adjustment for newly established contract rates. As a result, the Company's external vendor QIA expense for all market segments was overstated, albeit by an immaterial amount that did not impact any market's credibility-adjusted MLR.

It is recommended that the Company implement internal controls to ensure the use of proper contracted rates in the calculation and recording of the related external vendor expenses. Before a process is used other than the one noted in the contract, the Company should obtain written documentation from the vendor with regards to the agreed upon process to be used.

In some cases, the expenses related to the Company's external vendors were allocated based on the Company's departments' QIA allocation percentage, without consideration of the external vendor's own survey results.

It is recommended that the Company treat direct and indirect external vendors consistently and obtain surveys for external vendors regardless of whether the expense is indirectly allocated as part of the management fee QIA process. Further, the external vendor survey results should be provided to the applicable departments for consideration in the determination of the department level management fee QIA percentage.

The Company's external vendor QIA expense allocation method disclosed on Part 6 of the MLR Annual Reporting Form was inconsistent with the actual external vendor QIA allocation method used by the Company in that it did not include the allocation method for indirect external vendor expenses that was part of the management fee QIA allocation process.

It is recommended that the Company implement procedures to ensure it completes Part 6 of the MLR Annual Reporting Form in accordance with the MLR Annual Reporting Form Filing Instructions.

Affiliated Vendors QIA

Title 45 CFR Section 158.502 requires an issuer to maintain all documents and other evidence necessary to verify that the data submitted was in compliance with the definitions and criteria set forth in the Regulation. In testing for compliance with this requirement and Part 243.2 (b)(8) of Insurance Regulation No. 152 (11 NYCRR 243.8) cited elsewhere in this report, it was noted that the Company had insufficient documentation to support the QIA allocation

percentages contained in the service matrix surveys for affiliate vendors that were applied as QIA.

It is recommended that the Company comply with Title 45 CFR §158.502 and Part 243.2 (b)(8) of Insurance Regulation No. 152 (11 NYCRR 243.8) by implementing additional quantitative analyses to adequately support the QIA allocation percentage determination reported in the service matrix survey for its affiliate vendors.

It was also noted that the operating effectiveness of one affiliated vendor's key control was deemed to have failed because there was no formal documented review and signoff or verification that variances were resolved timely.

It is recommended that the Company maintain adequate documentation that supports the operating effectiveness of key internal controls.

In consideration of the recommendations that have been made as regards QIA, it is recommended that the Company update its process documentation to accurately reflect the QIA process currently in place and include a detailed end to end walkthrough of the entire QIA process covering affiliated vendors, external vendors and management fees, including, but not limited to, screenshots, examples and referencing amongst worksheets.

Cost Sharing Reductions ("CSR")

The Company did not report any advanced payments of CSR received from HHS as a deduction from incurred claims on the New York, Connecticut or New Jersey MLR Annual Reporting Forms.

Federal Premium Stabilization Programs

The examiner reviewed the accuracy of the amounts reported in connection with the Federal Transitional Reinsurance and Federal Risk Adjustment and Federal Risk Corridor Programs as defined by Title 45 CFR §158.140(b)(4)(ii), including the verification of amounts to HHS program summary reports and the Company's transactional records. The Company did not report any Federal Risk Corridor Program amounts as a deduction from incurred claims on the New York, Connecticut or New Jersey MLR Annual Reporting Forms.

Based on the procedures performed, the Company's Federal premium stabilization programs amounts were accurately reported on the New York, Connecticut and New Jersey MLR Annual Reporting Forms.

B. MLR Denominator

According to Title 45 CFR §158.22(c), the denominator of the MLR calculation is comprised of premium revenue, as defined in 45 CFR §158.130, minus federal and state taxes and licensing and regulatory fees, described in 45 CFR §158.161(a), and 45 CFR §158.162(a)(1) and (b)(1).

Earned Premiums

The examiner reviewed the accuracy and appropriateness of the amounts reported within earned premiums as defined by Title 45 §CFR 158.130, including the verification of the data used by the Company to calculate earned premium and the validation of a sample of policy premium reported by the Company. In addition, the examiner reviewed the accuracy of the Company's policies and procedures for determining and assigning market classification as defined by the requirements of Title 45 §CFR 158.220.

Based on the procedures performed, the Company's earned premiums were accurately and appropriately reported and the Company's market classification policies and procedures were consistent with the requirements of Title 45 §CFR 158.220 for each market segment on the New York, Connecticut and New Jersey MLR Annual Reporting Forms.

Federal and State Taxes and Licensing or Regulatory Fees

The examiner reviewed the accuracy and appropriateness of Federal and State taxes and licensing or regulatory fees, including confirmation that the allocation methodology was reasonable and complied with the requirements set forth by Title 45 CFR §158.170 and that taxes were reported in accordance with the provisions of Title 45 CFR §158.161 and Title 45 CFR §158.162.

Based on the procedures performed, the Company's allocation methodology is reasonable and the Federal and State taxes and licensing / regulatory fees were accurately and appropriately reported for each market segment on the New York, Connecticut and New Jersey MLR Annual Reporting Forms.

C. Credibility Adjustment

According to Title 45 CFR§158.232, the credibility adjustment is the product of the base credibility factor multiplied by the deductible factor. The examiner reviewed the underlying data utilized in the determination of the base credibility and deductible factors, tested the accuracy of the calculation of the base credibility and deductible factors and the resulting credibility adjustment for the individual, small and large group markets. The Company elected to use a deductible factor of 1.0, in lieu of calculating a deductible factor for all market segments on the

New York, Connecticut and New Jersey MLR Annual Reporting Forms, which has no impact on the Credibility-Adjusted MLR.

Based on the procedures performed, the Company's base credibility factor, deductible factor and credibility adjustment were accurately calculated and reported for each market segment on the New York, Connecticut and New Jersey MLR Annual Reporting Forms.

D. Credibility-Adjusted MLR

According to Title 45 CFR §158.221(a), the calculation of the MLR is the ratio of the numerator to the denominator, plus the credibility adjustment. The examiner recalculated the credibility-adjusted MLR for all market segments on the New York, Connecticut and New Jersey MLR Annual Reporting Forms in accordance with 45 CFR Part 158 and the applicable MLR Annual Reporting Form Filing Instructions and determined the Company's credibility-adjusted MLR amounts were accurately calculated for each market segment on the New York, Connecticut and New Jersey MLR Annual Reporting Forms.

E. Rebate Disbursement and Notice

According to Title 45 CFR §158.240, a rebate is required to be paid no later than September 30, following the MLR reporting year if an insurer's credibility-adjusted MLR is less than the MLR standard (82% in the individual and small group markets and 85% in the large group market for the state of New York and 80% in the individual and small group markets and 85% in the large group market for the states of Connecticut and New Jersey).

Based on the examiner's review of the credibility-adjusted MLR for each market segment on the New York, Connecticut and New Jersey MLR Annual Reporting Forms, the Company

exceeded the MLR standard for the individual and small group markets for the state of New York, the individual, small group and large group markets for the state of Connecticut and the small group market for the state of New Jersey, and thus was not required to pay rebates to its enrollees. The Company did not exceed the MLR standard for the large group market for the state of New York and the individual and large group markets for the state of New Jersey, and thus was required to pay rebates to its enrollees. The examiner reviewed the accuracy and timeliness of the rebate payments as defined by Title 45 §CFR 158.240, including the recalculation of a sample of rebates payments made to enrollees by the Company.

Based on the procedures performed, the Company's rebate payments were accurately calculated and paid in accordance to Title 45 §CFR 158.240.

According to Title 45 CFR §158.251, a notice of rebate is required when the credibility-adjusted MLR does not exceed the MLR standard. Since the Company's credibility-adjusted MLR exceeded the MLR standard for the individual and small group markets for the state of New York, the individual, small group and large group markets for the state of Connecticut and the small group market for the state of New Jersey, a notice of rebate was not required to be issued by the Company.

The Company did not exceed the MLR standard for the large group market for the state of New York and the individual and large group markets for the state of New Jersey, and thus a notice of rebate was required to be issued by the Company to its enrollees. The examiner reviewed the accuracy of the notice of rebate as defined by Title 45 §CFR 158.240 for a sample of rebate payments made to enrollees by the Company.

Based on the procedures performed, the Company issued the notice of rebate in accordance with Title 45 §CFR 158.251.

F. Impact on Risk-Based Capital

According to Title 45 CFR §158.270(a), rebate payments having any adverse impact on the Company's Risk-Based Capital ("RBC") level requires notification by the Department to the Secretary of the HHS. Based on our review of the New York, Connecticut and New Jersey MLR Annual Reporting Forms, the payment of rebates did not cause the Company's RBC level to fall below a Company Action Level RBC, as defined by the NAIC's RBC for Insurers Model Act, therefore no notification to the Secretary of HHS is warranted.

4. FINANCIAL STATEMENTS

The following statements show the assets, liabilities, and surplus as of December 31, 2016, as contained in the Company's 2016 filed annual statement, a condensed summary of operations and a reconciliation of the surplus account for each of the years under review. The examiner's review of a sample of transactions did not reveal any differences which materially affected the Company's financial condition as presented in its financial statements contained in the December 31, 2016 filed annual statement.

Independent Accountants

The firm Deloitte & Touche, LLP ("D&T") was retained by OHI to audit the Company's combined statutory basis statements of financial position as of December 31 of each year in the examination period and the related statutory basis statements of operations, surplus, and cash flows for the year then ended.

D&T concluded that the statutory financial statements presented fairly, in all material respects, the financial position of the Company at the respective audits. Balances reported in these audited financial statements were reconciled to the corresponding years' annual statements with no discrepancies noted.

A. Balance Sheet

Assets

Bonds	$ 1,441,197,199
Cash and short-term investments	275,535,862
Other invested assets	38,565,947
Receivable for securities	9,343
Investment income due and accrued	12,217,214
Uncollected premiums and agents' balances in the course of collection	13,435,449
Accrued retrospective contracts and contracts subject to redetermination	279,381,076
Amounts recoverable from reinsurers	11,265,014
Other amounts receivable under reinsurance contracts	17,606
Current federal and foreign income tax recoverable and interest thereon	7,940,944
Net deferred tax asset	23,059,690
Healthcare and other amounts receivable	100,921,356
Aggregate write-ins for other than invested assets	7,240,064
Total assets	$ 2,210,786,764

Liabilities	
Claims unpaid	$ 604,250,844
Accrued medical incentive pools and bonus amounts	52,357,784
Unpaid claims adjustment expenses	4,857,124
Aggregate health policy reserves	27,254,187
Premiums received in advance	176,121,898
General expenses due or accrued	78,602,414
Ceded reinsurance premiums payable	5,027,395
Remittance and items not allocated	7,898,344
Amounts due to parent, subsidiaries and affiliates	17,248,361
Payable for securities	19,199,142
Funds held reinsurance treaties with unauthorized reinsurers	24,556,880
Aggregate write-ins for other liabilities	818,694
Total liabilities	$ 1,018,193,067
Capital and surplus	
Common capital stock	1,000,000
Gross paid in and contributed surplus	44,610,000
Aggregate write-ins for other than special surplus funds	210,000
Unassigned funds (surplus)	1,146,773,697
Total capital and surplus	$ 1,192,593,697
Total liabilities, capital and surplus	$ 2,210,786,764

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 2016. 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: OHI files its tax returns on a consolidated basis with other affiliated companies within the UHG holding company.

B. Statement of Revenue, Expenses and Capital and Surplus

Capital and surplus increased $470,768,065 during the four-year examination period, January 1, 2013 through December 31, 2016, detailed as follows:

Revenue		
Net premium income	$ 20,045,134,138	
Change in unearned premium reserves and reserve for rate credits	(9,864,976)	
Total revenues		$ 20,035,269,162
Hospital and Medical Expenses		
Hospital/medical benefits	$ 13,719,920,398	
Other professional services	145,134,347	
Outside referrals	0	
Emergency room and out-of-area	1,929,476,874	
Prescription drugs	2,671,345,406	
Incentive pools, withhold adjustments and bonus amounts	106,881,012	
Net reinsurance recoveries	(3,044,733,459)	
Total medical and hospital expenses	$ 15,528,024,578	
Claims adjustment expenses	474,346,947	
General administrative expenses	$ 2,228,776,018	
Total underwriting deductions		18,231,147,543
Net underwriting gain		$ 1,804,121,619
Net investment income earned		86,643,771
Net realized capital gains		22,836,636
Net gain from agents' or premium balances charged off		(6,601,553)
Aggregate write-ins for other income or expenses		35,619
Net income before federal income taxes		$ 1,907,036,092
Federal and foreign income taxes incurred		746,605,051
Net income		$ 1,160,431,041

Change in Capital and Surplus

Capital and surplus, per report on Examination, as of December 31, 2012			$ 721,825,632
	Gains in Surplus	Losses in Surplus	
Net income	$1,160,431,041		
Change in net deferred income tax		$ 3,559,428	
Change in non-admitted assets	20,896,452		
Dividends to stockholders		707,000,000	
Net change in capital and surplus			470,768,065
Capital and surplus, per report on Examination, as of December 31, 2016			$ 1,192,593,697

5. AGGREGATE RESERVES AND CLAIMS UNPAID

The examination liability of $604,250,844 for the above captioned account is the same as the amount reported by OHI in its 2016 filed annual statement.

The examination analysis of the claims unpaid reserve was conducted in accordance with generally accepted actuarial principles and practices and was based on statistical information contained in OHI's internal records and in its filed annual statements as verified during the examination. The examination reserve was based upon actual payments made through a point in time, plus an estimate for claims remaining unpaid at that date. Such estimate was calculated based on actuarial principles, which utilized OHI's past experience in projecting the ultimate cost of claims incurred on or prior to December 31, 2016.

7. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on examination as of December 31, 2012 contained the following two (2) comments and recommendations pertaining to the financial portion of the examination (page number refers to the prior report on examination):

ITEM NO.		PAGE NO.
1.	Accounts and Records	
	It is recommended that management continue to make progress related to aligning operational Information Technology practices with existing policies, including the introduction of processes and technologies that can help ensure policy compliance.	6
	The Company has complied with this recommendation.	
2.	Internal Controls	
	It is recommended that the Company change its approach to the documenting and testing of internal controls to enact best practices. It is noted that the definition of "Best Practice" may differ among authoritative sources.	19
	The Company has complied with this recommendation.	

7. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM **PAGE NO.**

Respectfully submitted,

_____
David Crandall

STATE OF NEW YORK)
)SS.
)
COUNTY OF NEW YORK)

David Crandall, being duly sworn deposes and says that the foregoing report submitted by him is true to the best of his knowledge and belief.

_____
David Crandall

Subscribed and sworn to before me
this _____ of _____ 2018.

APPOINTMENT NO. 31569

NEW YORK STATE

DEPARTMENT OF FINANCIAL SERVICES

I, ***MARIA T. VULLO****, Superintendent of Financial Services of the State of New York, pursuant to the provisions of the Financial Services Law and the Insurance Law, do hereby appoint:*

Risk and Regulatory Consulting, LLC

as a proper person to examine the affairs of the

Oxford Health Insurance, Inc.

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

Company

with such other information as they shall deem requisite.

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

this 1st day of February, 2017

MARIA T. VULLO
Superintendent of Financial Services

By:

Lisette Johnson
Bureau Chief
Health Bureau