REPORT ON EXAMINATION

OF

UNITEDHEALTHCARE OF NEW YORK, INC.

AS OF

DECEMBER 31, 2008

DATE OF REPORT	**JUNE 29, 2010**
EXAMINERS	**DOUGLAS BARTLETT, CFE**
	JEFFREY USHER

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

David A. Paterson
Governor

James J. Wrynn
Superintendent

June 29, 2010

Honorable James J. Wrynn
Superintendent of Insurance
Albany, New York 12257

Sir:

Pursuant to the requirements of the New York Insurance Law, and acting in accordance with the instructions contained in Appointment Number 30394, dated November 30, 2009, attached hereto, we have made an examination into the condition and affairs of UnitedHealthcare of New York Inc., a health maintenance organization licensed pursuant to the provisions of Article 44 of the New York Public Health Law, as of December 31, 2008, and submit the following report thereon.

The examination was conducted at the office of UnitedHealthcare of New York Inc. located at 450 Columbus Boulevard, Hartford, CT.

Wherever the designations "UHC NY" or the "HMO" appear herein, without qualification, they should be understood to indicate UnitedHealthcare of New York, Inc.

UnitedHealthcare of New York, Inc. is a wholly-owned subsidiary of AmeriChoice Corporation, and its ultimate parent is UnitedHealth Group Incorporated.

Wherever the designation "UHG" appears herein, without qualification, it should be understood to indicate the operations of the UnitedHealth Group Incorporated holding company, the HMO's ultimate parent.

A concurrent examination was made of United HealthCare Insurance Company of New York, an affiliated accident and health insurance company, licensed under the provisions of Article 42 of the New York Insurance Law. A separate report thereon has been submitted.

Wherever the designation "UHIC NY" appears herein, without qualification, it should be understood to indicate United HealthCare Insurance Company of New York.

Wherever the designation the "Department" appears herein, without qualification, it should be understood to indicate the New York State Insurance Department.

1. SCOPE OF THE EXAMINATION

The HMO was previously examined as of December 31, 2003. This examination of the HMO is a financial examination as defined in the National Association of Insurance Commissioners ("NAIC") *Financial Condition Examiners Handbook, 2009 Edition* (the "Handbook") and it covers the five-year period from January 1, 2004 through December 31, 2008. The examination was conducted observing the guidelines and procedures in the Handbook and, where deemed appropriate by the examiners, transactions occurring subsequent to December 31, 2008 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 examiners' assessment of risk in the HMO's operations and utilizes that evaluation in formulating the nature and extent of the examination. The risk-focused examination approach was included in the Handbook for the first time in 2007; thus, this was the first such type of examination for the HMO. The examiners planned and performed the examination to evaluate the HMO's current financial condition, as well as identify prospective risks that may threaten the future solvency of UHC NY.

The examiners 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 annual statement instructions.

Information concerning the HMO's organization structure, business approach and control environment were utilized to develop the examination approach. The examination evaluated the HMO'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 HMO was audited annually, for the years 2004 through 2008, by the accounting firm of Deloitte & Touche LLP ("D&T"). The HMO received an unqualified opinion in each of those years. Certain audit workpapers of D&T were reviewed and relied upon in conjunction with this examination. A review was also made of the ultimate parent company's Internal Audit function and Enterprise Risk Management program, as they relate to the HMO.

The examiners reviewed the corrective actions taken by the HMO with respect to the recommendations concerning financial issues contained in the prior report on examination. The results of the examiners' review are contained in Item 6 of this report.

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

2. DESCRIPTION OF THE HMO

UHC NY is a for-profit HMO licensed pursuant to Article 44 of the New York Public Health Law. UHC NY was originally incorporated on July 10, 1986, as MetLife HealthCare Network of New York, Inc., a health maintenance organization licensed in the State of New York. The HMO was an indirect wholly-owned subsidiary of Metropolitan Life Insurance Company and commenced business on January 1, 1987. The HMO was granted a certificate of authority under the provisions of Article 44 of the New York Public Health Law, effective July 31, 1987, to operate as a for-profit independent practice association ("IPA") model HMO. On January 2, 1997, the HMO changed its name to UnitedHealthcare of New York, Inc.

UnitedHealthcare of New York, Inc. and UnitedHealthcare of Upstate New York, Inc. (formerly known as Travelers Health Network, Inc.) merged, effective December 31, 2002. The merged company retained the name UnitedHealthcare of New York, Inc. and was authorized to write commercial business in nineteen counties of New York State and Medicaid in eleven counties of New York State.

In October 2005, UHC NY began a market withdrawal of its commercial business. This market withdrawal was completed on October 1, 2006, with the HMO removing this business from its certificate of authority.

Further, effective December 31, 2007, the Department approved the merger of AmeriChoice of New York, Inc. ("AC-NY") into UHC NY. The merger was accounted for as a statutory merger in accordance with Statement of Statutory Accounting Principles ("SSAP") No. 68 – *Business Combinations and Goodwill*. The statutory basis financial statements as of, and for the years ended December 31, 2008 and 2007, include the combined accounts of UHC NY and AC-NY.

As a result of the merger, the separate corporate existence of AC-NY ceased, and UHC NY continued as the surviving corporation. Effective December 31, 2007, AmeriChoice Corporation became the sole shareholder of UHC NY. Also on this date, AC-NY had 10,000 shares of authorized common stock cancelled, and all rights in respect thereof ceased to exist.

The HMO's operating territory as of the examination date included the five boroughs of New York City and the counties of Nassau, Suffolk and Westchester. Its administrative office is located at 48 Monroe Turnpike, Trumbull, CT 06611.

A. Management and Controls

Pursuant to the HMO's Charter and By-laws, management of the HMO is to be vested in a Board of Directors ("BOD"), subject to the following: the number of directors shall be fixed by action of a majority of the shareholders; no decrease in the authorized number of directors shall have the effect of shortening the term of any incumbent director; at all times, no less than one-third (1/3) of the directors shall be residents of the State of New York; and (as required by Part 98-1.11(g)(1) of the Administrative Rules and Regulations of the Health Department (10 NYCRR 98-1.11)) within one year of the corporation receiving its certificate of authority to transact business as a health maintenance organization in the State of New York, no less than 20 percent (20%) of the directors of the corporation shall be enrollees of the corporation.

The following individuals were members of the BOD of the HMO as of December 31, 2008:

Name and Residence	Principal Business Affiliation
Steve Auerbach Bloomfield, CT	Executive Vice President, UnitedHealth Group Incorporated
Arlee Griffin, Jr. Brooklyn, NY	Pastor, Berean Baptist Church
Arthur Hill Hollis, NY	Retired, Vice President of Public Affairs, United Parcel Service
Jose Maldonado Brooklyn, NY	Vice President of Operations, AmeriChoice Corporation
Rita Johnson Mills Eden Prairie, MN	Senior Vice President, Account Management, AmeriChoice Corporation
Tomas David Morales, Sr. Baldwin, NY	President, College of Staten Island/CUNY
Dennis Patrick O'Brien Cos Cob, CT	Regional Vice President, United Health Networks

The BOD minutes and members' attendance were reviewed for the period under examination for UHC NY.

The principal officers of UHC NY as of December 31, 2008 were as follows:

Name	Title
Pasquale Celli	President, Chairman and Chief Executive Officer
Kara Jean Rios	Chief Financial Officer
Christina R. Palme-Krizak	Secretary
Robert W. Oberrender	Treasurer

B. Corporate Governance

UHG is a publicly traded, diversified health company subject to the Sarbanes-Oxley Act of 2002. Enterprise Risk Management ("ERM") and Internal Audit are enterprise-wide functions, thus, unless otherwise noted, references to UHG are applicable to the HMO.

UHG has adopted an ERM framework for proactively addressing and mitigating risks, including prospective business risks. Exhibit M of the Handbook (*Understanding the Corporate Governance Structure*) was utilized by the examiners as guidance for assessing corporate governance. Overall, it was determined that the HMO'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 HMO's BOD and key executives encourage integrity and ethical behavior throughout the HMO, and that the senior management promotes a corporate culture that acknowledges, understands and maintains an effective control environment.

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

UHG has an established Internal Audit Department ("IAD") function, which is independent of management, to serve the UHG Audit Committee of the BOD (the "Audit Committee" or "AC"), which is comprised entirely of external directors.

By 2008, approximately sixty-five percent (65%) of UHG's internal audit work was outsourced to, and therefore executed by, Ernst & Young ("E&Y"), a "Big Four" accounting firm. E&Y has experience consistent with industry norms, and all E&Y manager-level and

above resources maintain applicable industry certifications. The IAD directs and supervises all internal audit work performed by E&Y. 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 examiners relied upon the work performed by the IAD, as prescribed by the Handbook.

The examination noted the following reportable items related to Corporate Governance:

1. Enterprise Risk Management Function

As part of the examiners' assessment of the overall Corporate Governance environment, the HMO's Enterprise Risk Management ("ERM") process was reviewed. The examiners noted certain ERM processes that could be enhanced. These are as follows:

- A formally documented ERM policies and/or procedure manuals, including documentation for both qualitative and quantitative risk aspects, do not exist within the HMO.
- The inherent risk assessment is not documented in the "Risk Assessor" (a key report related to risk management efforts) as a stand-alone rating.
- The ERM framework does not address opportunities; rather, it only focuses on risk.

The HMO has informed the Department that subsequent to the examination date, it implemented projects that address some of the above items. As part of the risk-focused surveillance approach, as described in the Handbook, the Department will follow up on key initiatives of the HMO.

2. General Auditor Compensation Approval

Based on the Institute of Internal Auditors ("IIA") Standard 1110, at least once a year, the AC should review the performance of the Chief Audit Executive ("CAE") and approve this individual's annual compensation and salary adjustment. Although it was noted in the 2008 UHG AC minutes that, "The Committee reviewed the performance of the Internal Auditor during its executive session…", such minutes reviewed by the examiners did not explicitly document nor state the approval of the General Auditor's compensation. The documentation of conformity with a best practice should be to explicitly state the approval of the General Auditor compensation in the minutes.

It is recommended that the AC's review and approval of the General Auditor's compensation be explicitly stated in the minutes going forward.

3. Quality Assurance Review

Based on IIA Standard 1300, "the chief audit executive should develop and maintain a quality assurance and improvement program that covers all aspects of the internal audit activity and continuously monitor its effectiveness." A Quality Assurance Review ("QAR") is a best practice and is a component used to determine the IAD's compliance with IIA Standards.

UHG has not had a QAR performed to date (a QAR includes a self-assessment first by the IAD followed by an external review performed by a qualified third party).

Management has indicated tentative plans for a QAR during the 2010-2011 timeframe.

It is recommended that in accordance with IIA Standard 1300, UHG's IAD implement a QAR process, including a self-assessment by the IAD, followed by an external review performed by a qualified third party.

4. New York Legal Entities Audit Committee Self-Assessment

The American Institute of Certified Public Accountants ("AICPA") and the IIA recommend that an audit committee conduct an annual self-assessment and report the results to the BOD as a best practice. Currently, the HMO's (legal entity) Audit Committee does not require a periodic self-assessment.

It is recommended that the HMO's (legal entity) Audit Committee perform a periodic self-assessment, with results documented and communicated to the UHIC NY board.

5. HMO Board of Directors Self-Assessment

Similar to the item above, it is a best practice to perform a periodic self-assessment of a company's board of directors. Currently, the HMO's BOD does not require a periodic self-assessment.

It is recommended that the HMO's BOD perform a periodic self-assessment and that the results of such self-assessment be documented.

6. Enhancements to Internal Audit Methodology Documentation

The examiners reviewed the IAD's written methodology/guidelines and noted that several items appeared to be in place in terms of process, but were not fully documented within

the IAD's written methodology and guidelines, as provided. Documentation of these guidelines would provide for a consistent and proper application of standards that can be measured and audited.

It is recommended that the IAD consider modifying its written methodology/guidelines to more accurately reflect the comprehensive methodologies, processes and guidelines it has in place.

7. The HMO's Compliance Testing

The HMO is subject to the Department's Regulation 118 (11 NYCRR 89) – *Audited Financial Statements*, which is closely patterned upon the NAIC's Annual Financial Reporting Model Regulation, otherwise known as the Model Audit Rule ("MAR"). Regulation 118 (revision of existing Regulation 118), which applies certain requirements to the Department's regulated entities, was promulgated on an emergency basis in December 2009 and was effective beginning January 1, 2010.

During the examination, the examiners inquired of the HMO about its plans to ensure that specific legal entities are scoped into testing on a regular basis. Based on discussions with the HMO's General Auditor, it was understood that the IAD is in the process of refining its testing approaches related to UHC NY, as part of its initiatives for compliance with Department Regulation 118.

It is recommended that the IAD continue to design and document its test plan to ensure that the HMO is regularly scoped into its compliance testing, relative to the laws and regulations

applicable to the HMO. Consideration should be given to the (specific) frequency of such testing.

C. Territory and Plan of Operation

UHC NY is a for-profit health maintenance organization that offers its enrollees a variety of managed care programs and products through contractual arrangements with health care providers. The HMO has entered into arrangements with physicians, hospitals, and other health care providers, in which such providers deliver medical care to its enrollees primarily on a capitated or modified fee-for-service basis for Medicaid and Medicare recipients.

UHC NY offers its "Evercare" long-term care product in the state of New York. Evercare, which is available to Medicaid and Medicare recipients, offers complete, individualized care planning and care benefits for aging, disabled, and chronically ill individuals. Evercare offers these long-term care services in nursing homes, community-based settings, and private homes.

UHC NY serves as a plan sponsor, offering Medicare Part D prescription drug insurance coverage under a contract with the Centers for Medicare and Medicaid Services ("CMS"). Under the Medicare Part D program, there are six separate elements of payment received by UHC NY during the plan year; these payment elements are CMS premium, member premium, low-income premium subsidy, catastrophic reinsurance subsidy, low-income member cost-sharing subsidy, and CMS risk share.

UHC NY has contracts with the State of New York, Office of Health Insurance Programs and the City of New York, Department of Health and Mental Hygiene to provide services to eligible beneficiaries for Medicaid, Family Health Plus and Child Health Plus (programs for uninsured adults and children), and AmeriChoice Personal Care Plus – Medicare (dual eligible

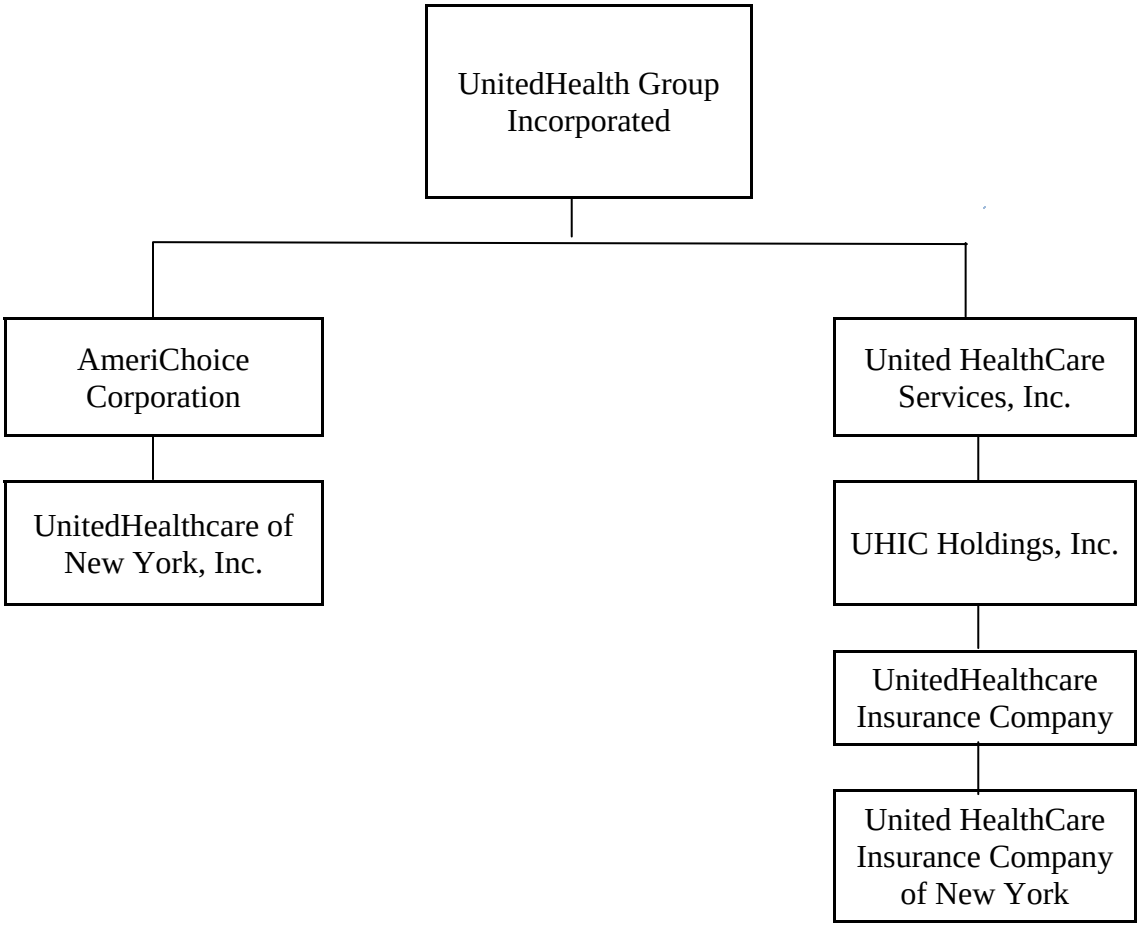
Medicare/Medicaid beneficiaries). The State and City Medicaid/Family Health Plus contracts are effective through September 30, 2010, and are subject to periodic amendments thereafter.

The following table displays UHC NY's net admitted assets, capital and surplus, net premium income and net income during the period under examination:

	Net Admitted Assets	Capital and Surplus	Net Premium Income	Net Income
2008	$358,845,052	$198,426,527	$730,572,429	$4,112,380
2007	337,873,038	193,972,584	666,089,892	10,917,030
2006	205,895,146	116,332,393	667,494,803	20,224,891
2005	191,930,365	109,285,443	434,804,127	31,178,033
2004	172,033,639	79,786,357	425,447,759	23,299,492

D. Holding Company System

UHC NY is a wholly-owned subsidiary of AmeriChoice Corporation, and its ultimate parent is UnitedHealth Group Incorporated, a publicly traded corporation domiciled in the State of Minnesota. The following chart depicts the HMO's holding company system as of December 31, 2008:



Inter-company Agreements

The HMO is a party to numerous inter-company agreements, with its affiliates, which are subject to the Department's review and approval. These agreements involve activities such as administrative services, cash management, investment management, tax allocation, and reinsurance. The most significant of those agreements is the management agreement between United HealthCare Services, Inc. ("UHS") and the HMO. UHS provides the following services to the HMO: 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. UHS also provides claims services, including case management services and review of claim services to

the HMO, through Uniprise, Inc., a UHG Company. The HMO pays UHS 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 HMO on an equitable basis in conformity with the allocation of cost provisions of the contract.

The management contract states, "Plan shall pay Manager the monthly fee on or before the tenth calendar day of each month. Within fifteen (15) calendar days of the Plan's receipt of (i) its audited annual financial statements, and (ii) a detailed accounting of the annual expenses incurred by Manager on behalf of the Plan, Plan will reconcile the total management fee paid to Manager during the previous calendar year to the actual cost of services rendered and make the appropriate adjustments. Payments by Plan to Manager of additional amounts required by such adjustments, or repayments by Manager to Plan of previously credited fees, shall be made within thirty (30) calendar days of the determination of the calculated adjustments."

During 2008 and 2009, there was no "true up" (i.e., reconciliation) of actual management service fee expense to the estimated management fee charged during the year. The total adjustment to the 2008 and 2009 management fee according to the HMO's analysis would be $20,607,000 and $10,605,545, respectively.

The examination financial statements contained herein have been adjusted to reflect the 2008 management fee. The examiners consider this to be a material weakness in the HMO's internal control environment (see item F "Internal Controls" - herein.).

It is recommended that the HMO comply with the terms of its management services agreement with UHS.

E. Accounts and Records

Evaluation of Controls in Information Systems

The HMO's Information Systems ("IS") applies to UHG and all of its wholly-owned subsidiaries. The IS function is managed broadly and includes the operations of UHC NY. UHG is responsible for maintaining the overall technology infrastructure utilized for data processing by the business units within the HMO.

The IS portion of the examination was performed in accordance with the Handbook, utilizing the new Exhibit C (*Evaluation of Controls in Information Technology*) approach. The examiners' review of IS controls included: IS management and organizational controls; application and operating system software change controls; system and program development controls; overall systems documentation; logical and physical security controls; contingency planning; local and wide area networks; personal computers and; mainframe controls.

The examiners evaluated the IS internal control testing performed by UHG's Sarbanes-Oxley ("SOX") function, the IAD and its independent auditors, D&T, and performed a review of end user computing and IS outsourcing controls. As a result of the procedures performed, the examination team obtained reasonable assurance that Information Technology ("IT") general controls and general application controls were functioning as management intended and that an effective system of internal controls is in place and conducive to the accuracy and reliability of financial information processed and maintained by the HMO.

However, the examiners noted certain reportable items related to the review of IS controls. These are as follows:

1. Windows Server Password Controls

A prior audit finding of an affiliate, related to weak password controls in UHG's Windows Active Directory ("WAD") environment is included herein due to the pervasive nature of WAD at UHG. This finding was formally reported to UHG in September 2009.

The stated recommendation of that audit was as follows:

> *"We recommend that the Company modify its baseline security standards to enforce strong passwords without exemption, based upon Microsoft's recommendations and other widely accepted best practices."*

UHG's response to the above recommendation was, "UnitedHealth Group agrees with the recommendation to modify baseline security standards to enforce strong passwords. The current UnitedHealth Group policy regarding complex password standards requires two of the following: Uppercase, Lowercase, Number, and Special Characters. UnitedHealth Group also realizes that industry standard calls for three. UnitedHealth Group will begin efforts to have the modified baseline security standards implemented in Active Directory and in the standards."

Although no changes had been made to the Active Directory baseline security standards related to this finding prior to the examiners' review, subsequent to completing the fieldwork, UHG informed the examiners that this issue will be remedied in the third quarter of 2010.

It is recommended that UHG modify its baseline security standards to enforce strong passwords without exemption, based upon Microsoft's recommendations and other widely accepted best practices.

2. Responses to Initial Information Gathering

The examiners made a considerable effort to employ a strategy that relied on prior audit work, including management testing, the IAD and external auditors, and submitted detailed information gathering questionnaires to UHC NY prior to the commencement of fieldwork. The examiners identified that certain responses provided by the HMO were incomplete and/or inaccurate in certain aspects. The incomplete pre-examination questionnaire responses from UHC NY may have been due to the examiners' use of the updated NAIC Exhibit C, as this is the first time the HMO had to complete the exhibit.

It is recommended that UHC NY update its set of IT questionnaire responses. Such updating of responses may increase the efficiency of future examinations.

F. Internal Controls

The NAIC Risk Surveillance approach to financial examinations relies on the review of mitigating controls applicable to the inherent risks of the companies examined. In the case of UHC NY, the mitigating controls are housed in "United Compliance", an internally developed system that, among other things, houses the documentation of the Sarbanes-Oxley control testing. These controls, related to UHG's SOX processes are tested and monitored by UHG. Within UHG's SOX records, the internal controls applicable to UHC NY were identified by its management.

The examiners only reviewed internal controls applicable to the HMO. It was noted that during 2008, there were no specific regulations around SOX stipulated by the NAIC. A thorough review of these internal controls was an important component of the examination process. The examiners identified a material weakness and D&T identified a significant control deficiency. In

addition, there were some other internal control observations noted by the examiners during the review of the HMO's internal controls that warrant attention. These are as follows:

The examiners considered the following item to be a material weakness in the internal control environment as of December 31, 2008:

- The examiners reviewed the original NAIC MAR section 11, the Department's Regulation 118, Part 89 (the Department's version of the MAR) and the MAR implementation guide. The Department's version of the MAR (i.e., Regulation 118, Part 89) does not define a "material weakness"; however, the NAIC's version of the MAR has a definition of material weakness, which in turn refers to SAS 60 - *Communication of Internal Control related Matters Noted in an Audit*. SAS 60 was superseded by SAS 112 - *Communicating Internal Control Related Matters Identified in an Audit*, which defines a material weakness as "a significant deficiency, or combination of significant deficiencies, that results in more than a remote likelihood that a material misstatement of the financial statements will not be prevented or detected." This is the same definition the external auditors use for their annual statutory internal control letters.

  Internal controls were not designed or operating effectively to detect statutory basis financial statement errors related to the proper accounting of the management service fee paid to UHS in 2008 and 2009. This resulted in an understatement of the HMO's general and administrative expenses of $20,607,000 (approximately 9.4% of capital and surplus) and $10,605,545 (approximately 6.3% of capital and surplus) for 2008 and 2009, respectively.

D&T considered the following item to be a significant deficiency in the internal control environment as of December 31, 2008:

- Internal controls were not designed or operating effectively to detect statutory basis financial statement errors related to the proper accounting and presentation treatment of accrued interest on a surplus note paid in 2008. This resulted in the overstatement of net income by $2,057,110 and a presentation error on the equity statement as this amount was debited directly to unassigned funds.

  The HMO corrected the misstatement prior to the issuance of the 2008 statutory basis financial statements. The surplus note was fully paid off in 2009.

3. FINANCIAL STATEMENTS

A. Balance Sheet

The following compares the assets, liabilities and capital and surplus as determined by this examination with those reported by UHC NY in its filed annual statement as of December 31, 2008:

Assets	Examination	HMO	Surplus Increase/ (Decrease)
Bonds	$264,473,388	$264,473,388	
Cash and cash equivalents	43,975,885	43,975,885	
Short-term investments	28,854,843	28,854,843	
Interest income due and accrued	2,948,516	2,948,516	
Uncollected premiums and agents' balances in the course of collection	13,698,511	13,698,511	
Accrued retrospective premiums	33,510	33,510	
Amounts recoverable from reinsurers	1,894,384	1,894,384	
Net deferred tax asset	1,550,933	1,550,933	
Healthcare and other amounts receivable	1,113,906	1,113,906	
Aggregate write-ins	301,176	301,176	
Total assets	$358,845,052	$358,845,052	

	Examination	HMO	Surplus Increase/ (Decrease)
Liabilities			
Claims unpaid	$110,302,555	$110,302,555	
Unpaid claims adjustment expenses	1,662,922	1,662,922	
Aggregate health policy reserves	1,076,203	1,076,203	
Aggregate health claim reserves	238,388	238,388	
Premiums received in advance	1,176	1,176	
General expenses due and accrued	15,657,639	15,657,639	
Current federal and foreign income tax payable	4,587,136	4,587,136	
Amounts withheld for the account of others	80	80	
Remittances and items not allocated	98,729	98,729	
Amounts due to parents, subsidiaries and affiliates	25,768,428	5,161,428	$ 20,607,000
Liability for amounts held under uninsured plans	461,173	461,173	
Aggregate write-ins for other liabilities	564,096	564,096	
Total liabilities	$160,418,525	$139,811,525	$ 20,607,000
Capital and Surplus			
Common capital stock	$ 140	$ 140	
Preferred capital stock	8,000,000	8,000,000	
Gross paid-in and contributed surplus	28,095,743	28,095,743	
Aggregate write-ins for other than special surplus funds	62,098,656	62,098,656	
Unassigned funds	100,231,988	120,838,988	(20,607,000)
Total capital and surplus	$198,426,527	$219,033,527	$(20,607,000)
Total liabilities, capital and surplus	$358,845,052	$358,845,052	

NOTE: The Internal Revenue Service ("IRS") has completed audits of UHG's consolidated Federal Income Tax returns for fiscal year 2007 and prior. UHG's 2008 Federal Income Tax return is under advance review by the IRS under its Compliance Assurance Program. The examiners are unaware of any potential exposure to the HMO for any tax assessment and no liability has been established herein relative to such contingency.

B. Statement of Revenue and Expenses and Capital and Surplus

Capital and surplus increased $142,013,654 during the five-year examination period, January 1, 2004 through December 31, 2008, detailed as follows:

Revenue		
Premium income		$ 2,924,409,010
Change in unearned premium reserve		(2,094,471)
Total revenue		2,922,314,539
Hospital and medical expense		
Hospital / medical expenses	$ 2,144,882,904	
Other professional services	127,485,423	
Emergency room and out of area	30,667	
Prescription drugs	163,121,167	
Aggregate write-ins for other hospital and medical	11,615,860	
Incentive pool, withheld adjustments and bonus amounts	(317,796)	
Net reinsurance recoveries	(7,194,880)	
Total hospital and medical expenses	$ 2,439,623,345	
Claims adjustment expenses	74,108,097	
General administrative expenses	325,072,529	
Increase in reserves for life and accident and health contracts	(6,713,490)	
Total underwriting expenses		2,832,090,481
Net underwriting gains (or losses)		$ 90,224,058
Net investment gains (or losses)		48,245,273
Aggregate write-ins for other income		(1,416,743)
Net income before federal and foreign income taxes		$ 157,659,588
Federal and foreign income taxes incurred		47,320,762
Net income		$ 89,731,826

Change in Capital and Surplus

Capital and surplus, per report on examination as of December 31, 2003			$ 56,412,873
	Gains in Surplus	Losses in Surplus	
Net income	$ 89,731,826		
Change in net deferred income tax	183,111		
Change in non-admitted assets	5,075,219		
Change in surplus notes		3,500,000	
Aggregate write-ins for gains (or losses) to surplus		3,324,297	
Increase in surplus due to restatement after merger	53,847,795		
Net change in capital and surplus			$ 142,013,654
Capital and surplus, per report on examination as of December 31, 2008			$ 198,426,528

4. CLAIMS UNPAID

The examination liability of $110,302,555 for the above captioned account is the same as the amount reported by the HMO in its filed annual statement as of December 31, 2008. 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 the HMO's internal records and in its filed annual statements as verified by the examiners. 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 the HMO's experience in projecting the ultimate cost of claims incurred on or prior to December 31, 2008.

5. AMOUNTS DUE TO PARENT, SUBSIDIARIES AND AFFILIATES

The examination liability of $25,768,428 is $20,607,000 more than the $5,161,428 reported by the HMO as of December 31, 2008.

As discussed in Item 2D of this report, the above examination change was caused by the HMO not performing a "true up" (i.e., reconciliation) of actual management service fee expense to the estimated management fee charged for the year ended December 31 2008 as called for in the management agreement. The issue also impacted the liability for 2009, which resulted in an understatement of an additional $10,605,545 for the year ended December 31, 2009. No change was made to the financial statements contained herein to reflect the $10,605,545.

6. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on examination as of December 31, 2003, contained the following five (5) comments and recommendations pertaining to the financial portion of the examination. (page number refers to the prior report on examination):

ITEM NO.		PAGE NO.
	Custodial Agreement	
1.	It is recommended that the HMO amend its custodial agreement to include that 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. *The HMO has complied with this recommendation.*	12
2.	It is recommended that the HMO has 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 HMO has complied with this recommendation.*	12
3.	It is recommended that 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. *The HMO has complied with this recommendation.*	12

ITEM NO.		PAGE NO.
	Accounts and Records	
4.	It is recommended that the HMO report its interest due and accrued on page 2 line 11 of its annual statement. *The HMO has complied with this recommendation.*	14
5.	It is recommended that the HMO comply with the requirements of SSAP No. 5 and expense capitation fees when they are withheld. *The HMO has complied with this recommendation.*	14

7. SUMMARY OF COMMENTS AND RECOMMENDATIONS

Appointment No. **30394**

STATE OF NEW YORK
INSURANCE DEPARTMENT

I, **James J. Wrynn**, Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:

RSM McGladrey, Inc.

as a proper person to examine into the affairs of the

Unitedhealthcare of New York, Inc.

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

Company

with such other information as it shall deem requisite.

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

this 30th day of November, 2009

James J. Wrynn
Superintendent of Insurance

STATE OF NEW YORK ★ SUPERINTENDENT OF INSURANCE ★ EXCELSIOR