REPORT ON EXAMINATION

OF

UNITED HEALTHCARE OF UPSTATE NEW YORK, INC.

AS OF

DECEMBER 31, 1999

DATE OF REPORT **OCTOBER 27, 2000**

EXAMINER **BRUCE BOROFSKY**

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

October 17, 2000

Honorable Neil D. Levin
Superintendent of Insurance
Albany, New York 12257

Sir:

Pursuant to instructions contained in Appointment Number 21711, dated February 16, 1999, attached hereto, I have made an examination into the condition and affairs of United HealthCare of Upstate New York, Inc., a health maintenance organization (HMO), as of December 31, 1999 and submit the following report thereon. A separate report has been submitted with regard to Market Conduct findings.

The examination was conducted at the Plan's office located at 450 Columbus Blvd., Hartford, CT 06115. United HealthCare of Upstate New York, Inc. is a wholly owned subsidiary of MetraHealth Care Network, Inc., which is a wholly owned subsidiary of the United Health Group.

Whenever the terms "the Plan", or "UHC-UNY" appear herein without qualification, they should be understood to mean United HealthCare of Upstate New York, Inc. Whenever the terms "the Parent", or "UHG" appear herein without qualification, they should be understood to mean United Health Group.

1. SCOPE OF EXAMINATION

The Plan was previously examined as of December 31, 1995. This examination covered the period from January 1, 1996 through December 31, 1999. Transactions subsequent to this period were reviewed where deemed appropriate by the examiner.

The examination comprised a complete verification of assets and liabilities as of December 31, 1999 in accordance with generally accepted accounting principles (GAAP), a review of income and disbursements deemed necessary for such verification and utilized to the extent considered appropriate, work performed by the Plan's independent certified public accountants. A review or audit was also made of the following items:

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

A review was also made to ascertain what action was taken by the Plan with regard to comments and recommendations in the prior report on examination.

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

2. DESCRIPTION OF PLAN

The Company was originally incorporated on June 26, 1985, as Whittaker Health Services of New York, Inc., pursuant to Section 805 of the Business Corporation Law of the State of New York. The Company was a wholly owned subsidiary of Whittaker Health Services, Inc.

On October 23, 1986, with the approval of the New York State Insurance Department and the Health Department, Whittaker was acquired by the Travelers Corporation. In October 1991, the corporate name of Travelers Health Network of New York, Inc. was adopted as the Plan became a wholly owned subsidiary of the Travelers Health Network, Inc., which was a wholly owned subsidiary of the Travelers Corporation. Effective December 31, 1993, the Travelers Corporation merged with Primerica Corporation; Primerica, as the surviving corporation, changed its name to the Travelers Insurance Group. In January 1995, the MetraHealth Companies, Inc. was formed by combining the group health care operations of Metropolitan Life Insurance Company and The Travelers Insurance Group. On October 2, 1995, the United Health Care Corporation acquired the MetraHealth Companies, Inc. and the Plan's name was changed to United HealthCare of Upstate New York, Inc.

On September 1, 1994, The Travelers Insurance Company ("TIC"), a subsidiary of The Travelers Group, Inc., and Metropolitan Life Insurance Company ("MET"), hereinafter being referred to collectively as the "Companies", signed definitive agreements on behalf of themselves and their affiliates to combine their respective group health insurance and managed care operations to form a jointly-owned but independently managed company. In November 1994, the Companies established The MetraHealth Companies, Inc., ("MHC"), a Delaware general business corporation. The Companies each contributed shares of various affiliates, cash and operating assets to MHC to begin operations effective as of January 3, 1995. The Company's shares along with those of its affiliated health maintenance organizations and Parent / Management Company (Travelers Health Network, Inc.) were included. The Company was an indirect wholly owned subsidiary of MHC.

On June 25, 1995, United Health Group Incorporated (formerly known as United HealthCare Corporation) ("UHG"), a Minnesota corporation, acquired MHC.

Effective October 2, 1995, after all regulatory approvals were obtained, MHC became a direct wholly-owned subsidiary of UHG. UHG then became the ultimate parent in the insurance holding company system. UHG is a publicly traded company, providing health care management services to purchasers, consumers, managers and providers of health care since 1977.

On May 31, 1996, MHC was merged with and into its direct wholly owed subsidiary, United HealthCare Insurance Company (formerly known as Travelers Insurance Company of Illinois and The MetraHealth Insurance Company), a Connecticut stock corporation. As a result of the merger, MHC ceased to exist as a separate legal entity, and United HealthCare Insurance Company (then known as The MetraHealth Insurance Company) became a direct wholly-owned subsidiary of UHG.

On November 29, 1995, the Company changed its name to MetraHealth Care Plan of Upstate New York, Inc. On January 1, 1997, the Company changed its name to United HealthCare of Upstate New York, Inc.

The Plan is a direct wholly-owned subsidiary of MetraHealth Care Network, Inc. (formerly known as Travelers Health Network, Inc.). and an indirect wholly owned subsidiary of United HealthCare Insurance Company, which became an indirect wholly owned subsidiary of UHG effective as of June 30, 2000.

A. Management

The composition of the board is in compliance with the requirements of Part 98 of the Administrative Rules and Regulations issued by New York State Health Department (10 NYCRR 98).

At December 31, 1999, the six members of the Board of Directors were as follows:

Director	Principal Business Affiliation
Theo G. Daly (MR) Liverpool, NY	Disability Management Services Syracuse, NY
Eric A. Leibundgut (MR) Manlius, NY	Leibundgut Capital Manlius, NY
Amy K. Knapp New York, NY	President and Chief Executive Officer, United HealthCare of Upstate New York, Inc.
William A. Munsell Wayzata, MN	Vice President and Assistant Treasurer, United HealthCare of Upstate New York, Inc.
Jeannine M. Rivet Minnestrista, MN	Chief Executive Officer United HealthCare, Inc.
Robert J. Sheehy Edina, MN	Executive Vice President United HealthCare of Upstate New York, Inc.

(MR denotes Member Representative)

The principal officers of the Plan as of December 31, 1999 were as follows:

Name	Title
Amy K. Knapp	President
Brian K. Beutner	Secretary
Allen J. Weiss	Treasurer

After one board meeting, the Plan adopted a procedure where the board would no longer physically meet. Instead, the directors would sign off on each executive decision made by the sole shareholder. It is noted, however, that the by-laws of the Company dictate that meetings are to take place at least quarterly. As such, it is recommended that the board comply with the by-laws and hold quarterly meetings.

Part 98 of the Administrative Rules and Regulations issued by New York State Health Department (10 NYCRR 98) requires that at least 20% of the Board be an enrollee in the HMO and not be an employee of the HMO. The Plan failed to comply with this for a brief period during the examination, but has since corrected the situation. Nevertheless, it is recommended that the board of directors maintain a composition whereby at least 20% of the members are enrollees and not employees of the HMO.

B. Territory and Plan of Operation

On October 31, 1985, the Company was authorized by the New York State Health Department to operate as a health maintenance organization pursuant to Article 44 of the New York Public Health Law in Cayuga, Herkimer, Madison, Oneida, Onondaga and Oswego Counties.

The Plan provides coverage by means of its subscriber contracts. Subscribers to the Plan select a participating physician who acts as their primary care physician (PCP). This PCP refers subscribers to other participating Plan physicians when particular medical specialties are required. Plan PCPs contract individually or by group with the Plan by means of participating agreements. Payments to primary care physicians are both fee-for-service and capitation.

The Plan also contracts with independent professional associations (IPAs), hospitals and other ancillary providers to render health care services to the enrollees of its

employer groups. The Plan pays capitation or negotiated fees for services rendered by these providers.

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

Subscriber contracts provide for emergency treatment and/or hospitalization, without authorization from the primary care physician, when the subscriber's medical condition requires such treatment. The Plan reserves the right to determine if such treatment was required on an emergency basis. Emergency treatment may be acquired within or outside the Plan's operating area.

Plan members may opt for out-of-network coverage through the purchase of a Point of Service (POS) Plan. This plan provides coverage through an affiliate, United HealthCare Insurance Company of New York, Inc.

C. Reinsurance

At January 1, 2000, the Plan had a ceding reinsurance agreement in effect with a licensed insurer, Continental Assurance Co. The reinsurer provides coverage as follows:

90% in excess of $250,000 per member per diem for commercial members subject to a $1,000,000 lifetime cap.

90% in excess of $150,000 per member per diem for Medicare and Child Health Plus members subject to a $1,000,000 lifetime cap.

There is no reinsurance coverage for Medicaid members.

The Plan's cost in regard to the agreement is $.34 per Commercial member per month, $1.25 per Medicare Member per month, and $.72 per Child Health Plus Member per month.

The agreement contains all of the standard clauses required by the New York State Insurance Department and has been approved by the Superintendent.

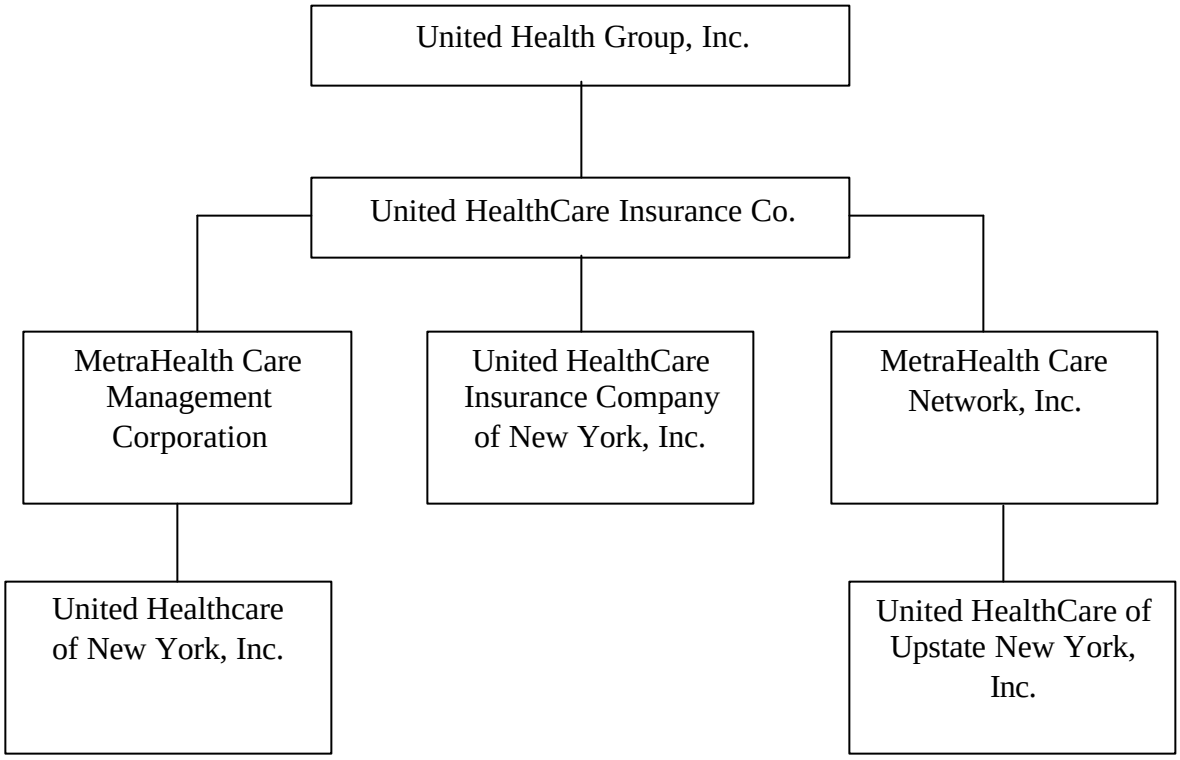
D. Enrollment

During the period January 1, 1997 through December 31, 1999, the HMO experienced a net decrease in enrollment of 2,762 insureds. An analysis of the decrease in enrollment is set forth below:

	1996	1997	1998	1999
Enrollment, Jan. 1	28,892	31,667	28,212	22,340
Net gain	2,775	(3,455)	(5,872)	3,790
Enrollment, Dec. 31	31,667	28,212	22,340	26,130

E. Holding Company System

The Company is a wholly owned subsidiary of United Health Insurance Company. The ultimate Parent is United Health Group, Inc. The following chart depicts the HMO and its affiliated New York entities in relationship with its parent companies and its affiliated New York-licensed HMOs at the examination date:



The Parent has an additional 113 subsidiaries not shown within this diagram. Those entities range from HMOs registered and operating in other states to health care providers and reinsurers.

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

- United HealthCare Services, Inc. (UHSC) provides administrative, financial and managerial services to the Company for a fee based on estimates of actual costs of providing the services. In addition, UHSC pays, on the Plan's behalf, certain selling, general and administrative expenses not covered within the scope of the management agreement. UHSC is reimbursed for these expenses by the Plan.

- United Behavioral Health, Inc. provides employee assistance, mental health and substance abuse services for the Plan's enrollees.

- OPTUM, Inc. provides consumer information and resources that address health and well being issues for enrollees. Under this agreement, OPTUM provides a 24-hour call-in service called NurseLine and an Employee Assistance Program.

- United Resource Network provides access to a network of transplant providers.

Where required pursuant to Part 98.10 of the Department of Health Rules and Regulations {10NYCRR98}, each of these agreements has been approved by the Superintendent.

F. Management Agreement

As detailed elsewhere in this report, under the terms of a management agreement between UHSC and the Plan, UHSC provides financial, accounting, legal systems, provider, member, medical management, marketing, development, employee

management and benefit, information systems and other general and administrative services to the Plan. The Plan pays UHSC a management fee equal to the costs of UHSC to provide these services.

G. Underwriting Ratios

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

	Amounts	Ratios
Medical Expenses	$139,854,863	87.0%
Administrative expenses	23,038,915	14.4%
Underwriting gain/(loss)	(2,274,597)	(1.4%)
Premium Income	$160,619,181	100.0%

H. Abandoned Property Report

During the period covered by this examination, the Plan complied with Section 1316 of the New York Abandoned Property Law. Attempts were made to locate payees and appropriate filings were delivered to the state comptroller.

I. Custodial Agreement

The Plan maintains a custodial agreement with State Street Bank to protect its securities. Review of that agreement revealed that it does not contain all of the safeguards recommended by the Department. First, the agreement does not require the bank to maintain in-force Bankers Bond Insurance. Second, the agreement does not specify that written instructions from the Plan to the bank be signed by two authorized

officers. Finally, the custodial agreement should allow the insurer the opportunity to obtain the most recent report on the review of the custodian's system of internal controls.

Such flaws in the custodial agreement do not provide the Plan with sufficient security against the completion of unauthorized transactions.

It is recommended that the Plan amend its custodial agreement to include the following:

- A provision requiring the bank to have and maintain Bankers Blanket Bond Insurance of the broadest form available for commercial banks. Further, the bank should be required to give 60 days written notice to the Plan of any material change in the form or amount of such coverage.

- A provision indicating to the bank that written instructions given to the bank by the Plan are to be signed by at least two of its Authorized Officers. Said officers will be authorized in a list that will be furnished to the bank as necessary and signed by the treasurer or an assistant treasurer and certified under the corporate seal by the secretary or an assistant secretary.

- A provision that would give the insurer the opportunity to secure the most recent report on the review of the custodian's system of internal controls, pertaining to custodian record keeping, issued by internal or independent auditors.

3. FINANCIAL STATEMENTS

A. Balance Sheet

The following schedule shows the assets, liabilities and net worth as determined by this examination, as of December 31, 1999. It differs in a number of respects from the balance sheet reported by the Plan in its filed 1999 annual statement.

Current Assets	Plan	Examination	Surplus Increase/ (Decrease)
Cash and short-term investments	$ 11,715,942	$ 11,715,942	$
Premiums receivable	3,096,469	3,096,469	
Investment income receivable	74,201	74,201	
Health care receivables	193,804	193,804	
Amounts due from affiliates	677,071	677,071	
Reinsurance recoverable on paid losses	71,478	0	(71,478)
Other current assets	186,400	186,400	
Total current assets	$ 16,015,365	$ 15,943,887	$ (71,478)
Other assets			
Restricted cash and other assets	$ 3,378,100	$ 1,644,117	$ (1,733,983)
Bonds		1,733,983	1,733,983
Total other assets	$ 3,378,100	$ 3,378,100	$
Total assets	$ 19,393,465	$ 19,321,987	$ (71,478)

Current liabilities	Plan	Examination	Surplus Increase/ (Decrease)
Accounts payable	$ 4,285	$ 4,285	
Claims payable	7,135,629	5,639,973	$ 1,495,656
Accrued medical incentive pool	553,974	553,974	
Unearned premiums	211,228	211,228	
Other current liabilities	2,391,934	2,391,934	
Total current liabilities	$ 10,297,050	$ 8,801,394	$ 1,495,656
Other liabilities			
Other liabilities	$ 5,344	$ 5,344	
Total other liabilities	$ 5,344	$ 5,344	
Total liabilities	$ 10,302,394	$ 8,806,738	$ 1,495,656
Net worth			
Common stock	$ 1,000	$ 1,000	
Paid in surplus	14,999,000	14,999,000	
Contingency reserves	1,904,128	1,904,128	
Retained earnings/fund balance	(7,813,057)	(6,388,879)	$ 1,424,178
Total net worth	$ 9,091,071	$ 10,515,249	$ 1,424,178
Total liabilities and net worth	$ 19,393,465	$ 19,321,987	$ (71,478)

B. Statement of Revenue, Expenses and Net Worth

Net worth increased $684,944 during the examination period, January 1, 1996 through December 31, 1999, detailed as follows:

Income		
Premiums	$ 155,389,652	
Fee for service	311,096	
Title XIX – Medicaid	4,918,433	
Investments	2,639,594	
Other revenues	119,960	
Total revenue		$ 163,378,735
Expenses		
Medical and hospital expenses		
Medical expenses	140,319,301	
Less:		
Reinsurance expenses, net of recoveries	(346,200)	
Co-payments	810,638	
Total Medical and hospital expenses		$ 139,854,863
Plan Administration		
Other	$ 23,038,915	
Total plan administration expenses		23,038,915
Total operating expenses		$ 162,893,778
Net operating income		$ 484,957
Federal income taxes incurred		$ (355,803)
Net income		$ 840,760

Change in Net Worth

	Gains	Losses	
Net worth per examination as of December 31, 1995			$ 9,830,305
Net income	$ 840,760	$	
Change in non-admitted assets		(155,816)	
	$ 840,760	$(155,816)	
Net increase in net worth			$ 684,944
Net worth per examination as of December 31, 1999			$10,515,249

4. REINSURANCE RECOVERABLE ON PAID LOSSES

The examination non-admitted the $71,478 reported by the Plan in its 1999 filed Annual Statement.

Prior to December 31, 1999, the Plan had an experience-rated reinsurance agreement with Lincoln National Health and Casualty Insurance Company, a licensed insurer. During 1999, the reinsurer notified the Parent that one of the Plan's affiliates had submitted a misleading experience report to the reinsurer and indicated an additional amount of premium was due. The reinsurer then withheld payments to all United HealthCare affiliates to compensate for the additional amount owed. For this reason, $71,478 of stop-loss reimbursements have been withheld by the reinsurer.

Because the claims are overdue by greater than six months, it appears likely that collection is in doubt and as a result, such overdue recoverables should not be included in the account total.

It is recommended that reinsurance recoverables due over 90 days be reported as part of the allowance for bad debts in the Plan's balance sheet.

5. RESTRICTED CASH AND OTHER ASSETS

The examination admitted asset of $1,644,117 is $1,733,983 less than the $3,378,100 reflected by the Plan in its filed 1999 Annual Statement.

Part 98.11(e) of the Department of Health Rules and Regulations {10NYCRR98} requires that the Plan establish a deposit in the form of an escrow account for the protection of its enrollees in an amount equal to five percent of the estimated expenditures for health care services for the year.

This requirement results in the Plan's having to establish an escrow account in the amount of $1,644,117, a sum which is five percent of the Plan's anticipated 2000 medical expense of $32,882,340. It is this sum that is to be recorded in the Annual Statement as Restricted Cash and Other Assets. Instead the Plan listed a different number.

When notified that it had established its restricted cash account at a level above that required, the Plan indicated it would move the excess funds to the bond account. That intent is reflected in the examination balance sheet.

It is recommended that the Plan establish and maintain a Restricted Cash and Other Assets account equal to the calculated escrow account.

5. CLAIMS PAYABLE

The examination admitted asset of $5,639,973 is $1,495,656 less than the $7,135,629 reported by the Plan in its 1999 filed Annual Statement. The adjustment was made to more accurately reflect the expected year-end 1999 liability of the Plan for its unpaid claims.

The examination reserve was based upon actual payments made through June 30, 2000 plus an estimate for claims remaining unpaid at that date. Such estimate was calculated based on actuarial principles, which utilized the Plan's past experience in projecting the ultimate cost of claims incurred on or prior to December 31, 1999, that were still outstanding at June 30, 2000.

It is recommended that the Plan review its reserving practices in order to develop more accurate claim reserves.

6. TREATMENT OF POLICYHOLDERS AND CLAIMANTS

In the course of this examination, a review was made of the manner in which the Plan conducts its business practices and fulfills its contractual obligations to policyholders and claimants. A separate report was issued in regard to these findings.

7. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on examination included three recommendations detailed as follows (The page numbers refer to the prior report):

ITEM		PAGE NO.
A.	Audited Financial Statements	
	It is recommended that the Plan contract with CPA firms that can produce required filings in a timely fashion and thereby comply with Section 307(b) of the Insurance Law.	8
	The Plan has complied with this recommendation.	
B.	Premiums Receivable	
	It is recommended that the Plan, by revising its computer system and any rate changes, report the proper premiums receivable in future financial statements submitted to this Department.	12
	The Plan has complied with this recommendation.	
C.	Claims Payable	
	It is recommended that the Plan review its reserving practices in order to develop more accurate claim reserves.	13
	The Plan has not complied with this recommendation and a similar recommendation is contained herein.	

8. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM		PAGE NO.
A.	It is recommended that the board comply with the by-laws and hold quarterly meetings.	6
B.	It is recommended that the board of directors maintain a composition whereby at least 20% of the members are enrollees and not employees of the HMO.	7
C.	It is recommended that the Plan amend its custodial agreement to include the following: • A provision requiring the bank to have and maintain Bankers Blanket Bond Insurance of the broadest form available for commercial banks. Further, the bank should be required to give 60 days written notice to the Plan of any material change in the form or amount of such coverage. • A provision indicating to the bank that written instructions given to the bank by the Plan are to be signed by at least two of its Authorized Officers. Said officers will be authorized in a list that will be furnished to the bank as necessary and signed by the treasurer or an assistant treasurer and certified under the corporate seal by the secretary or an assistant secretary. • A provision that would give the insurer the opportunity to secure the most recent report on the review of the custodian's system of internal controls, pertaining to custodian record keeping, issued by internal or independent auditors.	12-13
D	It is recommended that reinsurance recoverables due over 90 days be reported as part of the allowance for bad debts in the Plan's balance sheet.	18
E.	It is recommended that the Plan establish and maintain a Restricted Cash and Other Assets account equal to the calculated escrow account.	19
F.	It is recommended that the Plan review its reserving practices in order to develop more accurate claim reserves.	20

Respectfully submitted,

_____/s/_____

Bruce Borofsky

Senior Insurance Examiner

STATE OF NEW YORK)

) SS.

)

COUNTY OF NEW YORK)

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

_____/s/_____

Bruce Borofsky

Subscribed and sworn to before me

This _____ day of _____2001

Appointment No. 21711

STATE OF NEW YORK
INSURANCE DEPARTMENT

I, NEIL D. LEVIN *, Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:*

Bruce Borofsky

as a proper person to examine into the affairs of the

UNITED HEALTHCARE OF UPSTATE NEW YORK, INC.

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

Company

with such other information as he shall deem requisite.

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

this 16th *day of* February *1999*

NEIL D. LEVIN
Superintendent of Insurance

(by) Gregory Serio
First Deputy Superintendent

[redacted]