REPORT ON EXAMINATION

OF

UNITED HEALTHCARE OF NEW YORK, INC.

AS OF

DECEMBER 31, 1999

DATE OF REPORT **OCTOBER 17, 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 21710, dated February 16, 1999, attached hereto, I have made an examination into the condition and affairs of United HealthCare of 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 New York, Inc. is a wholly owned subsidiary of MetraHealth Care Management Corporation, which is a wholly owned subsidiary of the United Health Group.

Whenever the terms "the HMO", "the Plan" or "UHC-NY" appear herein without qualification, they should be understood to mean United HealthCare of 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, 1992. 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 HMO with regard to comments and recommendations made in the prior report on examination.

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

2. DESCRIPTION OF PLAN

The Company was originally incorporated on July 10, 1986, as MetLife HealthCare Network of New York, Inc., a health maintenance organization in the State of New York. The Company was an indirect wholly-owned subsidiary of Metropolitan Life Insurance Company and commenced business on January 1, 1987. The Company was granted a Certificate of Authority under the provisions of Article 44 of the New York State Public Health Law effective July 31, 1987 to operate a "for profit" individual practice association ("IPA") model health maintenance organization. Its operating territory included the five boroughs of New York City and the counties of Nassau, Suffolk and Westchester.

Effective November 1, 1990, a reissued Certificate of Authority was granted to the Plan under the provisions of Article 44 of the New York State Public Health Law to operate in the five boroughs of New York City and the counties of Dutchess, Nassau, Orange, Putnam, Rockland, Suffolk, Ulster and Westchester.

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 (MetraHealth Care Management Corporation formerly known as MetLife HealthCare Management Corporation) were included. The Company was an indirect wholly-owned subsidiary of MHC.

On May 1, 1995, the Company changed its name from MetLife HealthCare Network of New York, Inc. to MetraHealth Care Plan of New York, Inc.

On June 25, 1995, UnitedHealth Group Incorporated (formerly known as United HealthCare Corporation) (“UHG”), a Minnesota corporation, acquired control of MHC.

Effective October 2, 1995, 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 owned 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 January 2, 1997, the Company changed its name to United HealthCare of New York, Inc.

The Company is a direct wholly-owned subsidiary of MetraHealth Care Management Corporation (formerly known as MetLife HealthCare Management Corporation) and is 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

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

Director	Occupation
Steven B. Arkin Union City, NJ	Healthplan Operations United HealthCare of New York, Inc.
Camille Cava (MR) Wantagh, NY	Parsons Brinkerhoff New York, NY

Craig W. Keyes New York, NY	Chief Medical Officer, United HealthCare of New York, Inc.
Amy K. Knapp New York, NY	President and Chief Executive Officer, United HealthCare of New York, Inc.
Robert J. Sheehy Edina, MN	Executive Vice-President, United HealthCare of New York, Inc.

MR denotes member representative

A review of the meetings held during the period covered by this examination, indicated that board meetings were generally well attended with none of the directors noted for poor attendance.

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

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

B. Territory and Plan of Operation

The HMO has been granted a certificate of authority to operate in the five boroughs of New York City and the counties of Dutchess, Nassau, Orange, Putnam, Rockland, Suffolk, Ulster and Westchester.

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. 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. Other options available to members include dental and long-term care coverage written by affiliated insurers.

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

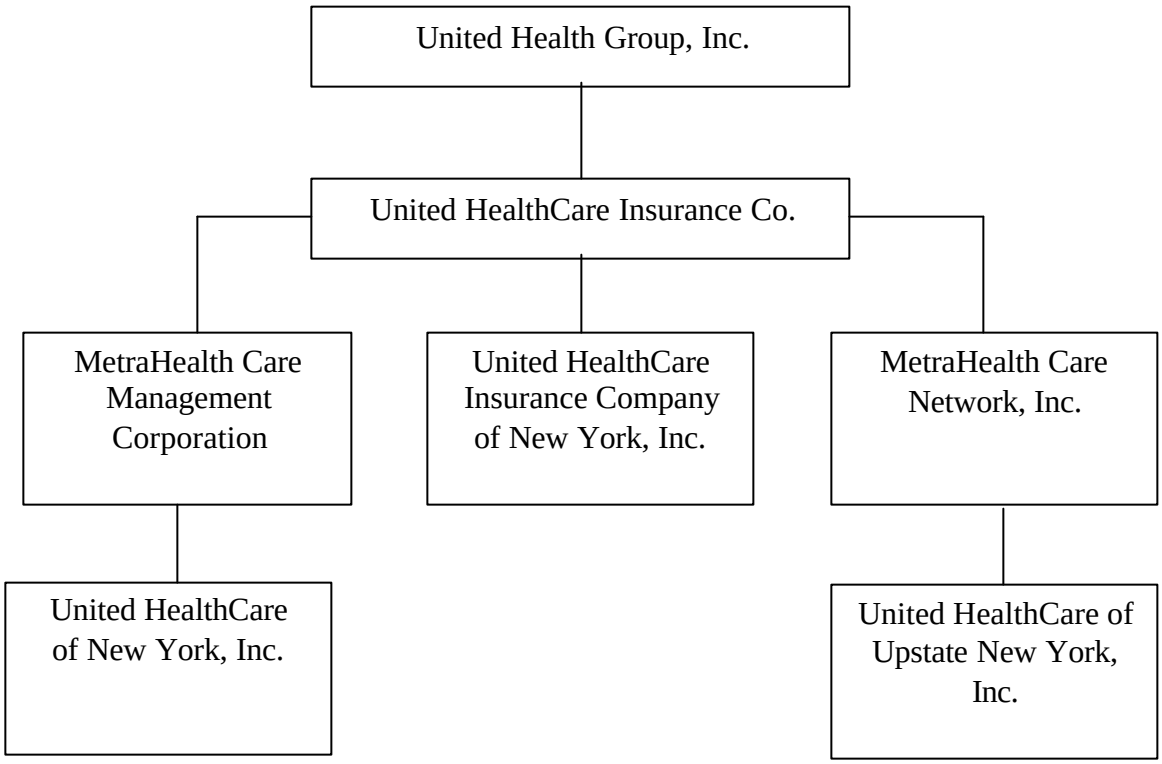
D. Enrollment

During the period January 1, 1993 through December 31, 1999, the HMO experienced a net increase in enrollment of 36,914 insureds. An analysis of the increase in enrollment is set forth below:

	1993	1994	1995	1996	1997	1998	1999
Enrollment, Jan. 1	52,992	59,801	56,685	52,723	73,134	83,399	96,209
Net gain	6,809	(3,116)	(3,962)	20,411	10,265	12,810	(6,303)
Enrollment, Dec. 31	59,801	56,685	52,723	73,134	83,399	96,209	89,906

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 a description 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 Company.

- 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.

- Evercare, Inc., is available as an option to Plan subscribers for long-term care.

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 cost 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	$722,537,554	86.2%
Administrative expenses	123,582,962	14.7%
Underwriting gain/(loss)	(7,414,439)	(0.9%)
Premium Income	$838,706,077	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. Secondly, 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 shows the assets, liabilities, and net worth as determined by this examination and as reported by the Company as of December 31, 1999:

Current Assets	Plan	Examination	Difference
Cash and short-term investments	$ 21,504,962	$ 21,504,962	$
Premiums receivable	6,951,647	6,951,647	
Investment income receivable	516,494	516,494	
Health care receivables	3,399,929	3,399,929	
Amounts due from affiliates	6,783,001	6,783,001	
Reinsurance recoverable on paid losses	602,701	602,701	
Other current assets	1,094,144	1,094,144	
Total current assets	$ 40,852,878	$ 40,852,878	$
Other assets			
Restricted cash and other assets		$ 10,327,643	$ 10,327,643
Bonds	$ 33,635,853	23,308,210	(10,327,643)
Total other assets	$ 33,635,853	$ 33,635,853	$
Total assets	$ 74,488,731	$ 74,488,731	$

Current liabilities			
Accounts payable	$ 68,702	$ 68,702	$
Claims payable	42,844,133	42,844,133	
Accrued medical incentive pool	2,518,424	2,518,424	
Unearned premiums	6,666,354	6,666,354	
Other current liabilities	1,901,797	1,901,797	
Total current liabilities	$ 53,999,410	$ 53,999,410	$
Other liabilities			
Other liabilities	$ 110,473	$ 110,473	$
Total other liabilities	$ 110,473	$ 110,473	$
Total liabilities	$ 54,109,883	$ 54,109,883	$
Net worth			
Common stock	$ 100	$ 100	
Preferred stock	8,000,000	8,000,000	
Paid in surplus	3,459,187	3,459,187	
Surplus notes	5,500,000	5,500,000	
Contingency reserves	9,842,175	10,327,643	$ 485,468
Retained earnings/fund balance	(6,422,614)	(6,908,082)	(485,468)
Total net worth	$ 20,378,848	$ 20,378,848	$
Total liabilities and net worth	$ 74,488,731	$ 74,488,731	$

B. Statement of Revenue and Expenses

Operations for the period from January 1, 1993 to December 31, 1999 produced an increase in net worth of $9,991,846 developed as follows:

Income		
Premiums	$ 829,696,304	
Title XVIII – Medicare	6,429,696	
Title XIX – Medicaid	2,580,077	
Investments	15,326,335	
Other revenues	(2,938)	
Total revenue		$ 854,029,474
Expenses		
Medical and hospital expenses		
Physicians' services	$ 357,808,720	
Other professional services	10,158,338	
Emergency room, out-of-area	6,308,112	
Inpatient	222,294,570	
Incentive pool and withhold adjustments	(442,443)	
Other medical and hospital expenses	129,148,681	
Less:		
Reinsurance expenses, net of recoveries	2,738,424	
Total Medical and hospital expenses		$ 722,537,554
Plan Administration		
Other	$ 123,582,962	
Total plan administration expenses		123,582,962
Total operating expenses		$ 846,120,516
Net operating income		7,908,958
Federal income taxes incurred		$ 1,826,966
Net income		$ 6,081,992

Change in Net Worth

Net worth per examination as of December 31, 1995			$ 10,387,004
	Gains in Net Worth	Losses in Net Worth	
Net income	$ 6,081,992		
Net increases in paid in surplus	5,500,000		
Change in non-admitted assets		$ (1,518,084)	
Other changes in net worth		(72,062)	
Net increase in net worth			$ 9,991,846
Net worth per examination as of December 31, 1999			$ 20,378,848

4. REINSURANCE RECOVERABLE ON PAID LOSSES

Prior to December 31, 1999, the Plan had an experience-rated reinsurance agreement with Lincoln National Health and Casualty Insurance Company, a licensed reinsurer. During 1999, the reinsurer determined that the Plan had submitted a misleading experience report to the reinsurer and indicated an additional amount of premium was due. The reinsurer then proceeded to withhold payments to the Plan to compensate for the additional amount owed. For this reason, $602,701 of stop-loss reimbursements have been withheld by the reinsurer. Currently, the matter is in the hands of the Plan's attorney's. While the claims have been in dispute, the Plan continues to carry an asset for the recoverable balance. Because the recoveries are more than six months overdue, it appears likely that collection is in doubt. For this reason, the overdue recoverables should be placed into an allowance for doubtful accounts.

No financial change was made herein due to the immateriality of the amount in relation to the Plan's net worth. However, 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. CONTINGENCY RESERVES

The examination increased the $9,842,175 reported by the Plan as a contingency reserve in its 1999 filed Annual Statement to $10,327,643.

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 $10,327,643, a sum which is five percent of the Plan's anticipated 2000 medical expense of $206,552,872. As a result of this calculation, the examination increased the Plan's recorded contingency reserve by $485,468. As an offset to this transaction, retained earning were reduced by that same amount.

An additional account, Restricted Cash and Other Assets, was established for the full amount of the escrow account in the asset section of the balance sheet. When advised of their need to establish this account, the Plan indicated it would reduce its bonds by an amount equal to the restricted account. As a result, the Bond account was also reduced by $10,327,643.

It is recommended that the Plan exercise more care in the calculation of its escrow account.

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

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 contained eight comments and recommendations as follows (page numbers refer to the prior report):

ITEM		PAGE NO.
A.	In May 1989, the Bureau of Alternative Delivery Systems conducted an operational survey to review the Plan's overall operations. The Bureau determined that the Plan had maintained and utilized a provider network, and had enrolled 2,367 persons within the unapproved areas of Dutchess, Orange, Putnam, Rockland, Sullivan and Ulster. As a result of these findings and in light of previous disapprovals of certification in these areas, a Stipulation and Order was issued against the Plan on July 6, 1990. The Plan has complied with the Stipulation and Order.	3
B.	It is again recommended that the Plan elect an independent enrollee representative to its board of directors in accordance with the provisions of Part 98.11(f) of the Administrative Rules and Regulations of the Health Department. [10NYCRR 98.11(f)]. The Plan has complied with this recommendation.	6-7
C.	It is recommended that the Plan re-calculate its reinsurance premiums for the period under examination in accordance with the provisions of the reinsurance agreement. The Plan has complied with this recommendation.	9-10

D. It is recommended that the Plan adhere to the provisions of its reinsurance agreement in calculating its reinsurance premiums. 9-10

The Plan has complied with this recommendation.

E. It is recommended that the Plan bill subscribers the premium rates approved by the Department in accordance with the provisions of Section 4308(b) of the New York Insurance Law. 12

In the Department's separate Market Conduct examination of the Plan, it was found that, in some cases, the Plan charged rates not approved by the Department. That examination repeats this recommendation.

F. It is recommended that the Plan immediately employ the appropriate community premium rates as approved by the Department on all new and renewal business. 21

In the Department's separate Market Conduct examination of the Plan, it was found that, in some cases, the Plan charged rates not approved by the Department. That examination repeats this recommendation.

G. It is recommended that the Plan adhere to the terms and conditions of the Stipulation and Order dated July 6, 1990 executed by and between the Plan and the New York State Department of Health and approved by the Commissioner of Health. 22

The Plan has complied with the Stipulation and Order.

H. It is recommended that the Plan immediately disenroll all enrollees who reside outside its approved service area. 22

The Plan has complied with this recommendation.

8. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM		PAGE NO.
A.	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
B.	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.	17
C.	It is recommended that the Plan exercise more care in the calculation of its escrow account.	19
D.	It is recommended that the Plan establish and maintain a Restricted Cash and Other Assets account equal to the calculated escrow account.	19

Respectfully submitted,

_____/s/_____

Bruce Borofsky

Senior Insurance Examiner

STATE OF NEW YORK)

) SS.

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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. 21710

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 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]