REPORT ON EXAMINATION

OF

UNITEDHEALTHCARE OF NEW YORK, INC.

AS OF

DECEMBER 31, 2018

DATE OF REPORT	**JUNE 24, 2020**
EXAMINERS:	**JOANNE CAMPANELLI, CFE** **JEFFREY L. USHER, CFE**

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NEW YORK STATE OF OPPORTUNITY. | Department of Financial Services

ANDREW M. CUOMO
Governor

LINDA A. LACEWELL
Superintendent

June 24, 2020

Honorable Linda A. Lacewell
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 31996, dated August 16, 2019, attached hereto, we have conducted an examination into the condition and affairs of UnitedHealthcare of New York, Inc., a for-profit health maintenance organization ('HMO") licensed pursuant to Article 44 of the New York Insurance Law, as of December 31, 2018, and submit the following report thereon.

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

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

Wherever the designation "UHICNY" appears herein, without qualification, it should be understood to indicate UnitedHealthcare Insurance Company of New York, Inc., a for-profit stock company licensed pursuant to the provisions of Article 42 of the New York Insurance Law.

Wherever the designation "AmeriChoice" appears herein, without qualification, it should be understood to indicate AmeriChoice Corporation, the direct parent of UHCNY.

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 UHICNY and UHCNY.

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

A concurrent examination was made of UHICNY an affiliate of UHCNY, and a separate report thereon has been submitted.

1. SCOPE OF THE EXAMINATION

We have performed our multistate examination of United Healthcare of New York, Inc. The previous examination was conducted as of December 31, 2013. This examination was a financial examination, as defined in the National Association of Insurance Commissioners ("NAIC") *Financial Condition Examiners Handbook, 2019 Edition* (the "Handbook"), and covered the five-year period January 1, 2014 through December 31, 2018. The examination was conducted observing the guidelines and procedures in the Handbook. Where deemed appropriate by the examiner, transactions occurring subsequent to December 31, 2018, were also reviewed.

The examiner planned and performed the examination to evaluate the Plan's current financial condition, as well as identify prospective risks that may threaten the future solvency of UHCNY.

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 Plan's organizational structure, business approach and control environment was utilized to develop the examination approach. The examination evaluated the Plan'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 Plan'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 Plan was audited annually for the years 2014 through 2018 by the accounting firm of Deloitte & Touche, LLP ("D&T"). The Plan 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 Plan.

During this examination, an Information Systems review was made of the Plan's computer systems and operations on a risk focused basis, in accordance with the provisions of the Handbook.

A review was made of the Plan'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. Furthermore, a review was made of compliance with Insurance Regulation 203 (11 NYCRR 82), "Enterprise Risk Management and Own Risk Solvency Assessment," which establishes the requirement that the ultimate controlling parent of an insurance company develop an Enterprise Risk function to define and mitigate risks within the organization. Insurance Regulation 203 (11 NYCRR 82) does not directly apply to the ultimate controlling parent of an HMO; however, the Regulation applies to UHG by virtue of UHG's capacity as ultimate controlling parent of UHCNY. The examiners also reviewed the corrective actions taken by the Plan with respect to the recommendations concerning financial issues contained in the prior report on examination. The results of the review are contained in Item 7 of this Report.

This examination was conducted as a coordinated examination, as such term is defined in the Handbook, of the insurance entities of UHG. The examination was led by the State of Nevada as the facilitating state with participation from six 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 UHG's insurance entities included within the examination scope. The examination team also assessed the relevant prospective risks as they relate to the various insurance entities.

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.

2. DESCRIPTION OF THE PLAN

UHCNY is a for-profit HMO licensed pursuant to Article 44 of the New York Public Health Law. UHCNY was originally incorporated on July 10, 1986, as MetLife HealthCare Network of New York, Inc., a HMO licensed in the State of New York. The Plan was an indirect wholly-owned subsidiary of Metropolitan Life Insurance Company and commenced business on January 1, 1987. The Plan 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 Plan changed its name to UnitedHealthcare of New York, Inc.

UHCNY 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, UHCNY began a market withdrawal of its commercial business. This withdrawal was completed on October 1, 2006, with the Plan 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 UHCNY. The merger was accounted for as a statutory merger in accordance with Statement of Statutory Accounting Principles ("SSAP") No. 68 – *Business Combinations and Goodwill*. As a result of the merger, the separate corporate existence of AC-NY ceased, and UHCNY continued as the surviving corporation. Effective

December 31, 2007, AmeriChoice became the sole shareholder of UHCNY.

Under the provisions of Part 98-1.11(f) of the Administrative Rules and Regulations of the New York State Department of Health ("Department of Health"), each HMO initiating operations under the authority of Article 44 of the Public Health Law shall establish a deposit in the form of an escrow account for the protection of enrollees in an amount equal to the greater of (i) five percent of the estimated expenditures for health care services (with certain adjustments to pharmacy expenses, based on the 2018 projections reported in the 2017 Annual New York Supplement), or (ii) $100,000. As of December 31, 2017, the Plan reported 2018 expenditures projection for health care services in the amount of $4,259,785,776 and an escrow deposit requirement of $213 million. Pursuant to Part 98-1.11(f) of the Administrative Rules and Regulations of the Department of Health, the Plan had established an escrow account with a bank that is qualified pursuant to Part 98-1.11(f), in the amount of $ 217.2 million (fair value) as of March 31, 2018.

The Plan's authorized control level Risk-Based Capital ("RBC") was $179,798,302 as of December 31, 2018. Its total adjusted capital was $612,960,314, yielding an RBC ratio of 340.9% as of December 31, 2018.

A. Corporate Governance

Pursuant to the Plan's charter and by-laws, management of the Plan is to be vested in a Board of Directors (the "Board"), 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 an HMO in the State of New York, no less than 20 percent (20%) of the directors of the corporation shall be enrollees of the corporation.

As of December 31, 2018, the members of the Board of Directors and their principal business affiliations were as follows:

Name and Residence	Principal Business Affiliation
Pasquale H. Celli Cutchogue, NY	President, New York Health Plan, United Healthcare Services, Inc.
Allison M. Davenport Philadelphia, PA	Chief Executive Officer, United Healthcare Services, Inc.
Philip R. Franz Middletown, NJ	Chief Executive Officer, NY and NJ Markets United Healthcare Services, Inc.
Arlee Griffin, Jr.* Brooklyn, NY	Resident Director and Pastor, Berean Baptist Church
Thomas D. Morales, Sr.* New Paltz, NY	President California State University San Bernadino
Joseph F. Wagner Cockeysville, MD	Regional Chief Financial Officer United Healthcare Services, Inc.

*Enrollee representative – Part 98-1.11(g) of the Administrative Rules and Regulations of the Health Department (10 NYCRR 98-1.11(g)), requires that a minimum of twenty percent (20%) of the Board of an HMO be comprised of enrollee representatives. The Plan was in compliance with said Regulation, as of December 31, 2018.

Section 1.1 of UHCNY's by-laws states in part:

> *"…There shall be an annual meeting of the stockholders at such date and time as shall be designated from time to time by the Board of Directors and stated in the notice of the meeting, for the election of directors and for the transaction of such other business as may come before the meeting..."*

A review of the Plan's minutes of the Board meetings held during the period under examination demonstrated that the meetings were generally well attended.

The principal officers of the Plan as of December 31, 2018, were as follows:

Name	Title
Pasquale H. Celli	President
Peter M. Gill	Treasurer
Richard D. Peters	Chief Financial Officer
Christina R. Palme-Krizak	Secretary
Nyle B. Cottington	Vice President
Steven M. Burstein	Assistant Secretary
Heather A. Lang	Assistant Secretary
Jessica L. Zuba	Assistant Secretary

It should be noted that certain members of the Plan's Board and senior management of UHCNY are also members of the Board and senior management of its other affiliated companies.

B. Enterprise Risk Management

UHG is a publicly traded, diversified health company subject to the Sarbanes-Oxley Act of 2002 ("SOX") and is required to be compliant with Insurance Regulation 203 (11 NYCRR 82)-Enterprise Risk Management ("ERM") and Own Risk and Solvency Assessment ("ORSA"). ERM and Internal Audit are enterprise-wide functions; thus, unless otherwise noted, references to UHG are applicable to the Plan.

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 examiners as guidance for assessing corporate governance. Overall, it was determined that the Plan'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 Plan's management has an adequate approach to identifying

and mitigating risks across the organization, including prospective business risks. The Plan deals proactively with its areas of risk, and its management is knowledgeable about mitigation strategies. Through risk discussions and other measures, the Plan'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. It was determined that the Plan'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 examiners relied upon the work performed by the IAD, as required by the Handbook.

D. Territory and Plan of Operation

UHCNY was licensed as a for-profit HMO under Article 44 of the New York Public Health Law on July 10, 1986 and began operations on January 1, 1987. The Plan offers its enrollees a variety of managed care programs and products through contractual 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.

At December 31, 2018, UHCNY was authorized to transact business in the following fifty-one (51) counties in the State of New York:

Albany	Essex	Monroe	Queens	Tioga
Bronx	Franklin	Nassau	Rensselaer	Ulster
Broome	Fulton	New York	Richmond	Warren
Cayuga	Genesee	Niagara	Rockland	Wayne
Chautauqua	Greene	Oneida	St. Lawrence	Westchester
Chemung	Herkimer	Onondaga	Saratoga	Wyoming
Chenango	Jefferson	Ontario	Schenectady	Yates
Clinton	Kings	Orange	Seneca	
Columbia	Lewis	Orleans	Steuben	
Dutchess	Livingston	Oswego	Suffolk	
Erie	Madison	Putnam	Sullivan	

The Plan serves as a plan sponsor, offering Medicare Advantage and 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 seven (7) separate elements of payment received by the Plan during the year; CMS premium, member premium, CMS low-income premium subsidy, CMS catastrophic reinsurance subsidy, CMS low-income member cost-sharing subsidy, CMS risk share and CMS coverage gap discount program.

The Medicare Advantage product offered by the Plan in the State of New York includes complete individualized care planning and care benefits for aging, disabled, and chronically ill individuals. Medicare Advantage offers these long-term care services in nursing homes, community-based settings, and private homes.

The Plan has a contract with the State of New York Office of Health Insurance Programs to provide health care services to Medicaid, Family Health Plus, Child Health Plus, Medicaid Advantage (programs for uninsured children and adults) and UnitedHealthcare Dual Advantage – Medicare & Medicaid (dual eligible Medicare/Medicaid beneficiaries).

Effective December 2012, the Plan began offering a Managed Long-Term Care product for New York non-custodial eligible beneficiaries. Managed Long-Term Care Plans provide long-term care services like home health and nursing home care and ancillary and ambulatory services (including dentistry and medical equipment) and receives Medicaid payments for these services. Members receive services from their primary care physicians and inpatient hospital services using their Medicaid and/or Medicare cards.

Total Revenue during the five-year examination period were as follows:

Year	Total Revenue
2018	$ 5,344,153,001
2017	$ 4,412,633,060
2016	$ 3,870,213,256
2015	$ 3,025,169,787
2014	$ 2,481,103,269

E. Growth of the Plan

As of December 31, 2018, the Plan had 794,302 members. The Plan's members, by line of business during the examination period were as follows:

Year	Long-Term Care	Essential Plan	HARP	Medicare	Medicaid	Child Health Plus	HMO	Total
2018	4,158	110,450	9,038	142,371	468,956	52,730	6,599	794,302
2017	3,679	100,168	6,213	92,606	471,727	47,695	5,883	727,971
2016	2,626	87,472	4,754	69,341	461,855	41,610	8,230	675,888
2015	1,596	0	2,151	51,385	475,027	33,591	9,871	573,621
2014	1,131	0	0	35,864	438,318	30,564	5,857	511,734

The Plan's net admitted assets, capital and surplus, total revenues and net income during the period under examination were as follows:

Year	Net Admitted Assets	Capital and Surplus	Total Revenue	Net Income
2018	$ 1,295,798,718	$ 612,960,314	$ 5,344,153,001	$ 46,641,453
2017	$ 1,195,015,849	$ 570,803,671	$ 4,412,633,060	$ 107,134,302
2016	$ 1,096,249,169	$ 568,005,040	$ 3,870,213,256	$ 115,182,511
2015	$ 846,115,374	$ 455,854,822	$ 3,025,169,787	$ 106,034,702
2014	$ 648,157,256	$ 363,008,308	$ 2,481,103,269	$ 112,260,717

F. Reinsurance

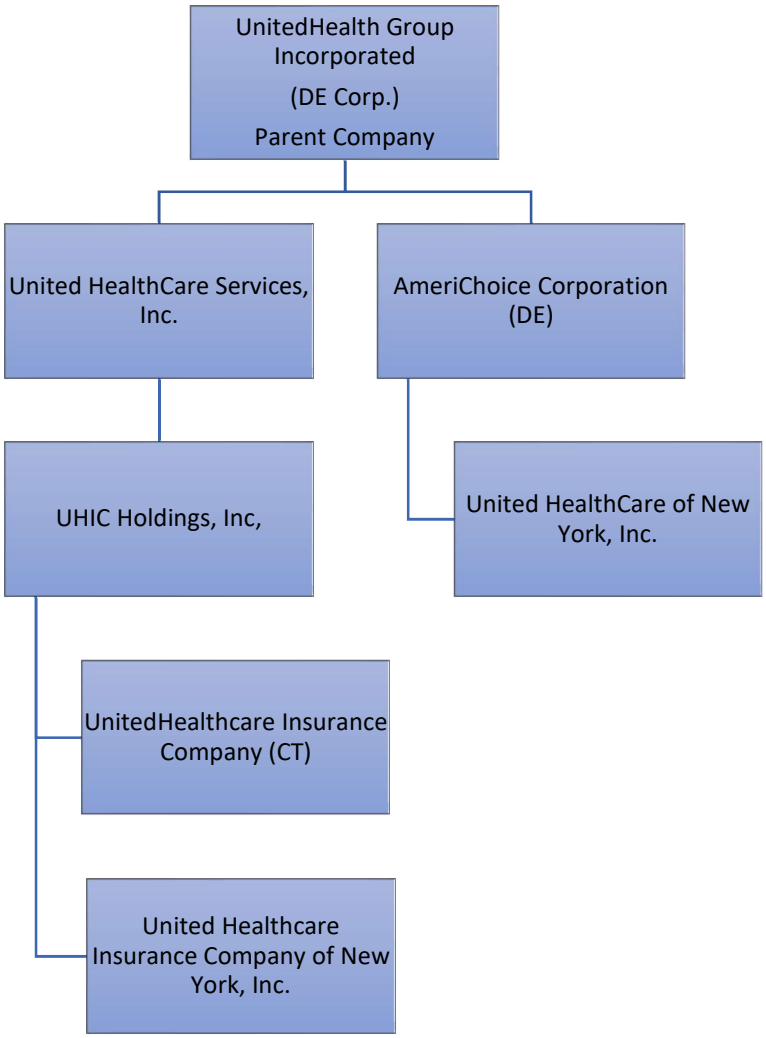
There was no significant reinsurance assumed or ceded during 2018.

G. Holding Company System

UHCNY is a wholly-owned subsidiary of AmeriChoice, and its ultimate parent is UHG, a publicly traded corporation domiciled in the State of Delaware.

As a member of a holding company system, UHCNY is required to file registration statements pursuant to the requirements of Part 98-1.16(e) of the Administrative Rules and Regulations of the Health Department (10 NYCRR 98-1.16) and Insurance Regulation 52 (11 NYCRR 80). All pertinent filings made regarding the aforementioned statutes during the examination period were reviewed, and no exceptions were noted.

The following is an excerpt of the organizational chart of the Plan's holding company system as of December 31, 2018:



The following is a summary of UHCNY's relationship with several of the entities shown above:

- UHG is a Delaware corporation that is publicly traded and the ultimate parent of UHCNY UHICNY, AmeriChoice Corporation, UnitedHealthcare Services, Inc. ("UHS"), and over one hundred and fifty (150) other affiliated companies.
- 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 the Plan and various UHG companies are considered employees of UHS rather than the individual insurers under UHG's holding company system.
- AmeriChoice Corporation is a Delaware corporation and the parent corporation of UHCNY and various other companies.

H. Intercompany Transactions and Agreements

The Plan is party to numerous intercompany 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, revolving credit, pharmacy benefits management, and reinsurance.

A brief summary of the Plan's key agreements is as follows:

Management and Administrative Services Agreement

Effective January 1, 2014, UHCNY entered into a Management Services Agreement with UHS whereby UHS provides management and operational support to UHCNY. This Management Services Agreement replaced and superseded the Management Agreement and First Amendment (effective January 1, 2008). The Management fees and all allocations to UHCNY appear to be fair, reasonable and in conformity with required customary insurance accounting practices.

The Management Services Agreement was submitted the Department on September 25, 2013 and was approved on March 27, 2014. The Management Services Agreement was approved by the Department of Health on January 6, 2014.

Effective January 1, 2015, UHCNY entered into the First Amendment to the Management Services Agreement (the "First Amendment") with UHS. The First Amendment reflects modifications in the Third-Party Administrator and other services provisions, Medicare provisions, Medicaid – other state program provisions, the addition of an Exchange Regulatory Appendix provisions and other provisions. The First Amendment was submitted to the Department on November 12, 2014 and was approved on December 24, 2014.

Effective November 1, 2017, UHCNY entered into the Second Amendment to the Agreement (the "Second Amendment"). The Second Amendment implemented an updated methodology for calculating management fees, specifically, a current year true-up. The Second Amendment was submitted to the Department on January 17, 2017 and was approved on February 15, 2017. Additionally, the Amendment was approved by the Department of Health on October 3, 2017. Although the amendment was filed with the Department requesting an effective date of March 1, 2017, the effective date was changed to November 1, 2017, due to the timing of the Department of Health's approval.

Subsequent to the as of date of the examination, the Plan entered into a Third Amendment (the "Third Amendment"), whereby the term of the agreement was extended to December 31, 2023. The Third Amendment was submitted to the Department on November 12, 2018, and was approved on December 18, 2018. The Third Amendment was approved by the Department of Health on November 20, 2018.

Premium Allocation Agreement

Effective June 1, 2001, UHCNY and UHICNY entered into a Premium Allocation Agreement. Pursuant to the Premium Allocation Agreement, UHICNY sells group medical insurance and out-of-network insurance coverage for point-of-service products marketed in conjunction with HMO contracts offered by its HMO affiliate, UHCNY. Both UHCNY and UHICNY are entitled to receive consideration for insurance coverage marketed and issued in conjunction with products marketed and issued by UHCNY. The Premium Allocation Agreement was submitted to the Department on July 1, 2004 and approved on December 17, 2004.

Facility Participation Agreement

Effective June 1, 2016, UHCNY entered into a Facility Participation Agreement (the "Agreement") with AxelaCare Intermediate Holdings, LLC. ("AxelaCare"). Under the terms of the Agreement, AxelaCare provides home infusion therapy services, including per diem nursing services and the cost of drugs. The Agreement is available to be used by all products offered by UHCNY. The Agreement was submitted to the Department on December 22, 2015 and was approved on January 15, 2016.

Subsequent to the examination date, the Plan entered into the First Amendment (the "First Amendment") of the Facility Participation Agreement. The Amendment was submitted to the Department of Health and was approved on February 27, 2019. The total administrative costs for this agreement is less than 25% of the Plan's total costs, therefore, it does not meet the threshold for review under Part 98-1.11 of the Administrative Rules and Regulations of the Health Department (10 NYCRR 98-1.11). The executed Agreement was filed with the Department on April 30, 2019.

Subordinated Revolving Credit Agreement

The Plan holds an $8,000,000 subordinated revolving credit agreement ("Credit Agreement") with UHG at an interest rate of London InterBank Offered Rate ("LIBOR") plus a margin of 0.50%. This Credit Agreement is subordinate to the extent that it does not conflict with any credit facility held by either party. The aggregate principal amount that may be outstanding at any time is the lesser of 3% of the Plan's admitted assets or 25% of the Plan's policyholder surplus as of December 31st of the preceding year. The Credit Agreement is for a one-year term and automatically renews annually, unless terminated by either party.

Effective June 1, 2012, the Plan entered into an amended and restated Subordinated Revolving Credit Agreement ("Amended Credit Agreement") with UHG. This Amended Credit Agreement replaces and supersedes the original Credit Agreement. Pursuant to the Amended Credit Agreement, UHG provides the Plan with a short-term borrowing facility where UHCNY may borrow funds upon demand from UHG up to a maximum of $100,000,000, at an interest rate equal to LIBOR plus 50 basis points. The Amended Credit Agreement was submitted to the Department on April 11, 2012 and was approved on May 21, 2012. The same was also submitted to the Department of Health on April 11, 2012 and approved on September 20, 2012.

No amounts were outstanding under the Amended Credit Agreement at December 31, 2018.

Pharmacy Benefits Management

Effective January 1, 2013, the Plan entered into a Pharmaceutical Benefits Management ("PBM") Agreement with an affiliated entity, OptumRx. Pursuant to this agreement, OptumRx provides UHCNY with core prescription drug benefit services and mail order pharmacy services. Under the core prescription drug benefit services, OptumRx establishes and maintains a network of

pharmacies to service the benefit plans, provide claims processing services, benefits administration and support, marketing and sales support, account management services, rebate administration, clinical services and finance and analytical support services. Under the mail order pharmacy services, OptumRx provides UHCNY with mail order network prescription services. UHCNY remains ultimately responsible for the pharmacy benefit administration services provided to its members. Fees related to the PBM Agreement are calculated on a per-claim basis.

The PBM agreement was submitted to the Department on November 29, 2012 and approved on May 29, 2013; it replaced UHCNY's previous agreement with Medco Health Solutions, Inc.

Effective January 1, 2018, the above agreement was replaced with the First Amended and Restated Medicare Prescription Drug Benefit Administration Agreement with the same parties as the previous agreement. The agreement was submitted to the Department on November 30, 2017 and was acknowledged January 2, 2018 and approved on February 12, 2018. The agreement was also been filed with the Department of Health and is still pending approval.

Tax Sharing Agreement

On October 1, 1996, the Plan became a party to a Tax Sharing Agreement ("TSA") with UHG and as a result, is included in a consolidated federal income tax return with UHG and some of its affiliates. Federal income taxes are paid to/or refunded by UHG pursuant to the terms of the TSA and equate to approximately the amount each party to the agreement would be responsible for, with the exception of net operating losses and capital losses. For these losses, the Plan receives a benefit at the federal rate in the current year for taxable losses incurred in that year, to the extent losses can be utilized in the consolidated federal income tax return of UHG. UHG currently files

income tax returns in the U.S. federal jurisdiction, various states, and foreign jurisdictions. The original TSA was approved by the Department on February 7, 1996.

In addition to the agreements described above, the Plan maintains several other agreements with its affiliates.

I. Accounts and Records

Evaluation of Controls in Information Systems

The Plan'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 UHCNY. UHG is responsible for maintaining the overall technology infrastructure utilized for data processing by the business segments within the Plan.

The IS portion of the examination was performed in accordance with the Handbook, utilizing the Exhibit C (*Evaluation of Controls in Information Technology*) approach. The examiners' review of the 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 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 examiners concluded 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 Plan.

There were no significant deficiencies or material adverse findings as a result of the review.

J. Significant Operating Ratios

The following ratios have been computed as of December 31, 2018, based upon the results of this examination:

Description	Ratio
Net Change in Capital and Surplus	7.40%
Liquid Assets & Receivables to Current Liabilities	182.9%
Premium and Risk Revenue to Capital and Surplus	8.7 to 1
Medical Loss Ratio	84.6%
Combined Loss Ratio	98.9%
Administrative Expense Ratio	14.3%

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

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

	Amounts	Ratios
Claims	$15,948,402,260	83.4%
Claim adjustment expenses	715,059,207	3.7%
General administrative expenses	1,724,283,243	9.0%
Net underwriting gain	745,527,663	3.9%
Premiums written	$19,133,272,373	100.0%

3. MEDICAL LOSS RATIO

UHCNY's 2018 Medical Loss Ratio ("MLR") Annual Reporting Form for the State of New York was 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 New York large group market).

This examination of the Plan's 2018 MLR Annual Reporting Form covered the reporting period January 1, 2016 through December 31, 2018, including 2016, 2017 and 2018 experience and claims run-out through March 31, 2019.

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, if applicable. The examination included assessing the principles used and significant estimates made by the Plan, 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 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 examiners' review, the 2018 MLR Annual Reporting Form filed by the Plan is fully compliant with the requirements of Title 45 CFR §158.

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 (82% in the individual and small group markets and 85% in the large group market, for the State of New York).

The Plan's three-year aggregate numerator and denominator for its individual market, the only segment in which the Plan wrote health coverage subject to MLR reporting and rebate requirements, along with the resulting Credibility-Adjusted MLR and rebate obligation, for the 2018 MLR Annual Reporting Form, as verified during the examination, were as follows:

MLR Components	Filed
Adjusted Incurred Claims	$ 192,447,255
Plus: Quality Improvement Expenses	1,017,128
Less: Cost-sharing reductions	239,550
Less: Federal Transitional Reinsurance Program payments expected from HHS	3,733,351
Less: Federal Risk Adjustment Program net payments expected from (payable	35,447,067
Less: Federal Risk Corridors Program net payments (charges)	0
MLR Numerator	**$ 154,044,415**
Premium Earned	$ 162,397,894
Less: Federal and State Taxes and Licensing/ Regulatory Fees	4,734,541
MLR Denominator	**$ 157,663,353**
Preliminary MLR before Credibility-Adjustment	97.7%
Credibility-Adjustment	1.9%
Credibility–Adjusted MLR	**99.7%**
MLR Standard	82%
Rebate Amount	**$ 0**

A. Market Classification

According to Title 45 CFR §158.103, the applicable definitions of individual market, small group market and large group market according to Section 2791(e) of the Public Health Service Act ("PHS Act") are codified and applicable to the MLR calculation. Section 2791(e) of the PHS Act requires that small and large group market classifications be based on the *average number of employees on the business days of the calendar year preceding the coverage effective date*. In addition, according to Title 45 CFR §158.120, the MLR report must aggregate data for each entity licensed within the state where each health care coverage contract was issued, aggregated separately for the large group market, the small group market and the individual market.

The Plan reported that it only wrote health coverage subject to MLR reporting and rebate requirements in the individual market. The examiners reviewed a sample of individual policies to verify that the appropriate group size and market classification determination was applied by the Plan in accordance with 45 CFR §158.103. The samples of all policies, claims and other items tested during the examination were correctly assigned to the appropriate state, market and lines of business in accordance with Title 45 CFR §158.103 and Title 45 CFR §158.120.

B. 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), as applicable.

Incurred Claims

The examiners 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 Plan to calculate adjusted incurred claims and the validation of a sample of incurred claims reported by the Plan.

Based on the procedures performed, it was determined that the Plan's incurred claims were accurately reported on the MLR Annual Reporting Form.

Quality Improvement Activities ("QIA")

In accordance with Title 45 CFR §158.221(b)(8), effective with the 2018 MLR reporting year, the Plan reported QIA expenses equal to 0.8 percent of earned premium in all markets in lieu of reporting the actual expenditures for activities that improve health care quality, as defined in Title 45 CFR §158.150 and Title 45 CFR §158.151.

The examiners reviewed the calculation of health care QIA expenses reported on the 2018 MLR form, to ensure conformity with Title 45 CFR §158.221 and the 2018 MLR Annual Reporting Form Filing Instructions, and to confirm consistency with the calculation among the Plan's individual market and all affiliated issuers.

Based upon the procedures performed, it was determined that the Plan properly calculated and reported its QIA expenses in accordance with Title 45 CFR §158.221.

Cost Sharing Reductions ("CSR")

In accordance with Title 45 CFR §158.140(b)(1)(iii), cost-sharing reduction payments received from HHS must be deducted from incurred claims to the extent not reimbursed to the provider furnishing the item or service.

Based on the procedures performed, it was determined that the Plan properly reported the advances payments of cost sharing reductions received from HHS as a deduction from incurred claims in accordance with Title 45 CFR §158.140(b)(1)(iii).

Federal Premium Stabilization Programs

The examiners reviewed the accuracy of the amounts reported in connection with the Federal Transitional Reinsurance, Federal Risk Adjustment and Federal Risk Corridor Program as defined by Title 45 CFR §158.140(b)(4)(ii), including the verification of amounts to HHS program summary reports and the Plan's transactional records.

Based on the procedures performed, it was determined that the Plan's Federal Premium Stabilization Programs amounts were accurately reported on the Plan's MLR Annual Reporting Form.

C. MLR Denominator

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

Earned Premiums

The examiners 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 Plan to calculate earned premium and the validation of a sample of policy premium reported by the Plan.

Based on the procedures performed, it was determined that the Plan's earned premiums were accurately and appropriately reported on a direct basis and the data elements underlying the 2016, 2017 and 2018 premiums, as reported on the Plan's 2018 MLR Annual Reporting Form, were compliant with Title 45 CFR §158.130.

Federal and State Taxes and Licensing/ Regulatory Fees

The examiners reviewed the accuracy and appropriateness of Federal and State Taxes and Licensing/ 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, it was determined that the Plan'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 Plan's MLR Annual Reporting Form.

D. Credibility-Adjustment

In accordance with Title 45 CFR §158.232, the Credibility-Adjustment is the product of the base credibility factor multiplied by the deductible factor. The examiners 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 Plan elected to use a deductible factor of 1.0, in lieu of calculating a deductible factor, which has no impact on the Credibility-Adjusted MLR.

Based on the procedures performed, it was determined that the Plan's base credibility factor, deductible factor and Credibility-Adjustment were accurately calculated and reported for each market segment on the Plan's MLR Annual Reporting Form.

E. Credibility-Adjusted MLR

In accordance with 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 examiners calculated the Credibility-Adjusted MLR in accordance with Title 45 § CFR 158 and the applicable MLR Annual Reporting Form Filing Instructions and determined the Plan's Credibility-Adjusted MLR amounts were accurately calculated for each market segment on the Plan's MLR Annual Reporting Form.

F. Rebate Disbursement and Rebate Notice

In accordance with Title 45 CFR §158.240, a rebate is required to be paid, no later than September 30th, following the MLR reporting year if an insurer's Credibility-Adjusted MLR is less than the MLR standard (82% for the individual and small groups and 85% for the large groups, in the State of New York).

Based on the examiners' review of the Credibility-Adjusted MLR for each market segment, it was determined that the Plan exceeded the New York MLR minimum percentage for each of its market segments, and as a result was not required to pay any rebates.

In accordance with Title 45 CFR §158.250, for each MLR reporting year, an issuer must provide each policyholder who receives a rebate, and subscribers whose policyholder receives a rebate, a Rebate Notice. Based on the examiners review of the 2018 Credibility-Adjusted MLR, the Plan exceeded the New York MLR standard of 82% in the individual market, and thus was not required to pay rebates to its enrollees in these markets.

Since the Plan's Credibility-Adjusted MLR for its individual market exceeded the MLR standard in New York, a Rebate Notice was not required to be issued by the Plan.

G. Impact on Risk-Based Capital

In accordance with Title 45 CFR §158.270(a), rebate payments having any adverse impact on a company's RBC level requires notification by the Department to the Secretary of the HHS. Based on the examiners review, the Plan's Credibility-Adjusted MLR exceeded the minimum percentage for the individual market, the only segment in which the Plan wrote health coverage subject to MLR reporting and rebate requirements. Therefore, no rebates were issued and there was no impact on the Plan's RBC level that would warrant notification to the Secretary of the HHS.

4. FINANCIAL STATEMENTS

The following statements show the assets, liabilities, and surplus as of December 31, 2018, as contained in the Plan's December 31, 2018 filed annual statement, a condensed summary of operations and a reconciliation of the surplus account for each of the years under review. The examiners' review of a sample of transactions did not reveal any differences which materially affected the Plan's financial condition as presented in its financial statements contained in the December 31, 2018 filed annual statement.

Independent Accountants

The firm Deloitte & Touche, LLP ("D&T") was retained by UHCNY to audit the Plan's combined statutory basis statements of financial position as of December 31st 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 Plan at the respective audit dates. Balances reported in these audited financial statements were reconciled to the corresponding years' annual statements with no discrepancies noted.

A. Balance Sheet

Assets	
Bonds	$ 848,292,158
Cash and short-term investments	143,223,786
Investment income due and accrued	5,447,277
Uncollected premiums and agents' balances in the course of collection	17,143,637
Accrued retrospective contracts and contracts subject to redetermination	88,727,851
Amounts recoverable from reinsurers	18,033
Amounts receivable relating to uninsured plans	41,624,278
Current federal and foreign income tax recoverable and interest thereon	26,315,197
Net deferred tax asset	10,804,450
Healthcare and other amounts receivable	104,137,973
Aggregate write-ins for other than invested assets	10,064,078
Total assets	$ 1,295,798,718
Liabilities	
Claims unpaid	$ 502,271,213
Accrued medical incentive pools and bonus amounts	59,486,153
Unpaid claims adjustment expenses	4,757,613
Aggregate health policy reserves	30,355,755
Aggregate health claim reserves	2,781,027
Premiums received in advance	21,016,199
General expenses due or accrued	6,175,840
Amounts withheld or retained for the account of others	3,652,570
Remittance and items not allocated	12,477
Amounts due to parent, subsidiaries and affiliates	47,948,264
Payable for securities	1,140,490
Liability for amounts held under uninsured plans	2,513,710
Aggregate write-ins for other liabilities	727,093
Total liabilities	$ 682,838,404
Capital and surplus	
Common capital stock	140
Preferred capital stock	8,000,000
Gross paid in and contributed surplus	58,708,292
Aggregate write-ins for other than special surplus funds	474,395,741
Unassigned funds (surplus)	71,856,141
Total capital and surplus	$ 612,960,314
Total liabilities, capital and surplus	$ 1,295,798,718

Note 1: The Internal Revenue Service has conducted audits of the income tax returns filed on behalf of the Plan through tax year 2016. Calendar years 2017, 2018 and 2019 are under review by the IRS under its Compliance Assurance Program. The examiners are unaware of any potential exposure of the Plan to any tax assessments, and no liability has been established herein relative to such contingency.

Note 2: UHCNY files its tax returns on a consolidated basis with other affiliated companies within the UHG holding company.

B. Statement of Revenue and Expenses and Capital and Surplus

The Plan's capital and surplus increased by $267,770,090 during the five-year examination period, January 1, 2014 through December 31, 2018, detailed as follows:

Revenue		
Net premium income	$ 19,156,756,701	
Change in unearned premium reserves	(23,484,328)	
Total revenue		$ 19,133,272,373
Hospital and Medical Expenses		
Hospital/medical benefits	$ 12,617,905,832	
Other professional services	469,611,319	
Prescription drugs	2,441,405,091	
Incentive pools, withhold adjustments and bonus amounts	435,658,466	
Net reinsurance recoveries	(15,834,448)	
Total hospital and medical expenses	$ 15,948,746,260	
Claims adjustment expenses	715,059,207	
General administrative expenses	1,724,283,243	
Increase in reserves for life and accident and health contracts	(344,000)	
Total underwriting deductions		18,387,744,710
Net underwriting gain		$ 745,527,663
Net investment income earned		70,205,758
Net realized capital gain		5,003,944
Net investment gain		75,209,702
Net loss from agents' premium balances charged off		(1,420,294)
Aggregate write-ins for other income or expenses		(354,075)
Net income before federal and foreign income taxes		$ 818,962,996
Federal and foreign income taxes incurred		331,709,311
Net income		$ 487,253,685

Changes in Capital and Surplus

	Gains in Surplus	Losses in Surplus	
Capital and surplus, per report on examination, as of December 31, 2013			$ 345,190,224
Net income	$ 487,253,685		
Change in net deferred income tax	5,173,427		
Change in non-admitted assets		$ 23,957,022	
Dividends to stockholders		200,700,000	
Net gain in capital and surplus			267,770,090
Capital and surplus, per report on examination, as of December 31, 2018			$ 612,960,314

5. AGGREGATE RESERVES AND CLAIMS UNPAID

The examination liability of $535,407,995 for the above captioned account is the same as the amount reported by UHCNY in its filed annual statement as of December 31, 2018.

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 UHCNY'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 UHCNY's past experience in projecting the ultimate cost of claims incurred on or prior to December 31, 2018.

6. SUBSEQUENT EVENTS

A. Impairment

As of December 31, 2019, UHCNY's reported net worth was $542.8 million, with a required minimum contingent reserve of $484.3 million. As of December 31, 2019, UHCNY's net worth exceed the required contingent reserve by $58.5 million. However, it should be noted that $98.3 million of the $542.8 million surplus was segregated for Section 9010 ACA fees.

On January 1, 2020 UHCNY was impaired by $39.8 million when the $98.3 million segregated surplus was recognized as an expense.

On March 24, 2020, UHCNY received a capital infusion of $25 million from its direct parent, AmeriChoice. As of March 31, 2020 UHCNY's Capital and Surplus was $504.8 million and $20.4 above its required contingency reserve of $484.3 million.

B. Coronavirus (COVID-19)

On March 11, 2020, the World Health Organization declared the spreading coronavirus (COVID-19) outbreak a pandemic. On March 13, 2020, COVID-19 was declared a national emergency in the United States. The epidemiological threat posed by COVID-19 is having disruptive effects on the global supply chain as well as the demand for labor, products and services in the U.S. The economic disruptions caused by COVID-19 and the increased uncertainty about its magnitude has also caused extreme volatility in the financial markets. While the full effect of

COVID-19 is still unknown at the time of this report, the Department and all insurance regulators, with the assistance of the NAIC, are monitoring the situation through a coordinated effort and will continue to assess the impacts of COVID-19 on U.S. insurers.

7. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on examination as of December 31, 2013, contained the following four (4) comments and recommendations pertaining to the financial portion of the examination (page number refers to the prior report on examination):

ITEM NO.		PAGE NO.
	No Annual Shareholders Meeting for 2009	
1.	It is recommended that the Plan comply with by-laws and have the required annual shareholders meeting. *The Plan has complied with this recommendation.*	8
	Corporate Governance	
2.	It is noted that Part 89.12 of Insurance Regulation No. 118 (11 NYCRR 89.12) includes a clause permitting insurers to request a hardship waiver to the requirement that the Audit Committee be independent, as defined in that regulation. The Plan submitted such a request for waiver on March 4, 2013. *The Plan has complied with this recommendation.*	11
	Information Systems	
3.	It is recommended that management: a) 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; and b) incorporate a monitoring component into the policy to ensure that the ASK database remains up to date and to ensure that any new data elements (i.e., from M&A activity or enhancements to existing applications) are incorporated into the database timely to ensure policy compliance. *The Plan has complied with this recommendation.*	25

ITEM NO.		PAGE NO.
4.	It is recommended that the Plan extend its current approach for managing EUC risks by implementing a formal policy regarding EUC management, as well as procedures to support an effective approach for evaluating the risk and control conclusions reached by process owners. The EUC policy, procedures and related tool(s) should be the responsibility of the Plan's management and not Internal Audit. These procedures, supported by the EUC tool, should focus on applying IT-type controls (security, change management, backup, etc.) to EUC files. Deviations from controls recommended by the EUC tool should be investigated and approved by qualified internal management resources to ensure that they are appropriate. Deviations from recommended controls should also be reviewed on a periodic basis. *The Plan has complied with this recommendation.*	26

8. SUMMARY OF COMMENTS AND RECOMMENDATIONS

There are no comments and recommendations for this report on examination.

Respectfully submitted,

_____
Joanne Campanelli, CFE

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

Joanne Campanelli being duly sworn deposes and says that the foregoing report submitted by her is true to the best of her knowledge and belief.

_____
Joanne Campanelli, CFE

Subscribed and sworn to before me
this _____ of _____ 2020.

Respectfully submitted,

_____
Jeffrey Usher, CFE

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

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

_____
Jeffrey Usher, CFE

Subscribed and sworn to before me
this _____ of _____ 2020.

APPOINTMENT NO. **31996**

NEW YORK STATE

DEPARTMENT OF FINANCIAL SERVICES

I, ***LINDA A. LACEWELL****, 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:*

Exam Resources, LLC

as a proper person to examine the affairs of the

UnitedHealthCare of New York, Inc.

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

HMO

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 16th day of August, 2019

LINDA A. LACEWELL
Superintendent of Financial Services

By: _____

Lisette Johnson
Bureau Chief
Health Bureau