REPORT ON EXAMINATION

OF

OXFORD HEALTH PLANS (NY), INC.

AS OF

DECEMBER 31, 2016

DATE OF REPORT **JULY 5, 2018**

EXAMINER **DAVID CRANDALL, CFE**

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Andrew M. Cuomo
Governor

Maria T. Vullo
Superintendent

July 5, 2018

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

Madam:

Pursuant to the requirements of the New York Insurance Law, and the New York State Public Health Law, acting in accordance with the instructions contained in Appointment Number 31568, dated February 1, 2017, attached hereto, I have made an examination into the condition and affairs of Oxford Health Plans (NY), Inc., a for-profit health maintenance organization ("HMO") issued a certificate of authority under the provisions of Article 44 of the New York Public Health Law, as of December 31, 2016. The following report is respectfully submitted thereon.

The examination was conducted at the administrative office of UnitedHealth Group Incorporated, the ultimate parent of Oxford Health Plans (NY), Inc., located at 185 Asylum Street, Hartford, CT.

Wherever the designations "OHP-NY" or the "Plan" appear herein, without qualification, they should be understood to indicate Oxford Health Plans (NY), Inc.

Wherever the designation "OHI" appears herein, without qualification, it should be understood to indicate Oxford Health Insurance, Inc., a for-profit stock company licensed pursuant to Article 42 of the New York Insurance Law. A concurrent examination was made of OHI and a separate report thereon has been submitted. OHI is an affiliate of OHP-NY.

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

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

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

1. SCOPE OF THE EXAMINATION

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

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

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 2013 through 2016 by the accounting firm of Deloitte & Touche, LLP ("D&T"). The Plan received an unqualified 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.

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, and all references to MAR within this report may be interpreted as references to Regulation 118. The examiner 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 examiner's review are contained in Item six of this report.

This examination was conducted as a coordinated examination, as such term is defined in the Handbook (an examination of one insurer or a group of insurers performed by examiners from more than one state whereby the participating states share resources and allocate work among the examiners), of the insurance subsidiaries of UnitedHealth Group, Inc. The examination was led by the State of Connecticut with participation from eight additional states. Since the Lead and Participating states, as such terms are defined in the Handbook, are accredited by the NAIC, the states deemed it appropriate to rely on each other's work. The examination team representing the Lead and Participating states, identified and assessed the risks for key functional activities across all of UnitedHealth Group, Inc.'s insurance subsidiaries. The examination team also assessed the relevant prospective risks as they relate to the various insurance entities.

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

OHP-NY is a for-profit health maintenance organization ("HMO") that was incorporated on April 19, 1985, under New York State Law for the purpose of providing comprehensive health care services on a prepaid basis and for the purpose of establishing and operating a health maintenance organization and health care delivery system. The Plan was granted a Certificate of Authority pursuant to the provisions of Article 44 of the New York Public Health Law and commenced business on June 1, 1986. The Plan has been deemed a Competitive Medical Plan by the Centers for Medicare & Medicaid Services ("CMS") for purposes of the Federal Medicare Program. The Plan's primary business is the provision of medical expense coverage for comprehensive healthcare services to its members on a pre-paid basis.

On July 29, 2004, the Plan's parent, Oxford Health Plans, LLC, was acquired by UnitedHealth Group, Inc. and became a subsidiary of UHG.

Under the provisions of Part 98-1.11(f) of the Administrative Rules and Regulations of the New York State Department of Health (10 NYCRR 98-1.11(f)), each health maintenance organization 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 five percent of the estimated expenditures for health care services for the year, or $100,000. As of December 31, 2016, the Plan had estimated expenditures for health care services in the amount of $1,436,758,897 and an escrow deposit requirement of

$72,960,485. Pursuant to Part 98-1.11(f) of the Administrative Rules and Regulations of the New York State Department of Health, the Plan had established an escrow account in the amount of $213,486,977 (book/adjusted carrying value), as of December 31, 2016.

The Plan's authorized control level Risk-Based Capital ("RBC") was $58,262,240 as of December 31, 2016. Its total adjusted capital was $282,434,338, yielding an RBC ratio of 484.8% as of December 31, 2016.

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") consisting of no more than ten members, at least twenty percent (20%) of whom shall be comprised of individuals ("enrollee-representatives") who are enrolled in the prepaid health care program operated by the Plan, and at least one-third (1/3) of whom shall be persons who reside in New York State. As of the examination date, the board was comprised of five members. The board met at least four times during each calendar year for the period under examination.

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

Name and Residence	Principal Business Affiliation
William John Golden North Point, NY	President and Chief Executive Officer, United HealthCare Service, Inc.
Kathleen Macias -Torres* Mohegan Lake, NY	Enrollee, Consumer Director, Community Resource Center for the Developmentally Disabled, Inc.

Name and Residence	Principal Business Affiliation
Michael McGuire Wycoff, NJ	Health Plan CEO Northeast, United Health Group, Inc.
Sandra Denise Bruce Nichols, MD North Potomac, MD.	Chief Medical Examiner – Northeast Region, United HealthCare Services, Inc.
Randall Harrison Weinstock Hartford, CT	Chief Operations 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 directors of a health maintenance organization be comprised of enrollee representatives. The Plan was in compliance with said requirement, as of 12/31/16.

A review of the minutes of the attendance records at the Plan's board meetings held during the period under examination demonstrate the meetings were well attended with all board members attending at least one-half of the meetings they were eligible to attend.

The principal officers of OHP-NY as of December 31, 2016 were as follows:

Name	Title
William John Golden	President
Timothy Callahan Archer	Chief Financial Officer
Robert Worth Oberrender	Treasurer
Michael McGuire	Chairman of the Board
Nyle Brent Cottington	Vice President
Sanford Paul Cohen	Chief Medical Director and Executive Vice President
Randall Harrison Weinstock	Chief Operating Officer
Carmel Colica	Secretary

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

B. Enterprise Risk Management

UHG is a publicly traded, diversified health company subject to the Sarbanes-Oxley Act of 2002, and is required to be compliant with Insurance Regulation No. 203 (11 NYCRR 82) "Enterprise Risk Management and Own Risk and Solvency Assessment". Enterprise Risk Management ("ERM") and Internal Audit are enterprise-wide functions; thus, unless otherwise noted, references to UHG are applicable to the 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 examiner as guidance for assessing corporate governance. Overall, it was determined that the Plan's corporate governance structure is strong, 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. 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 established an 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, with the outsourced assistance from EY, 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.

Insurance Regulation 118

A review was made of the Plan's compliance with the provisions of Insurance Regulation 118 (11 NYCRR 89), "Audited Financial Statements". Under Part 89.1 of Insurance Regulation 118 (11 NYCRR 89.1), the audit committee for UHG, a SOX-compliant company, is considered independent, as defined in the Sarbanes-Oxley Act of 2002. Insurance Regulation 118 is based on the Model Audit Rule ("MAR"), as established by the NAIC.

It was noted by OHP-NY's independent certified accountants that during calendar years 2013 and 2014, OHP-NY had accounting misstatements that were the result of significant control deficiencies. Although the deficiencies were remediated prior to their respective year-ends, there

was no evidence that the independent audit committee was apprised of these matters either before or after remediation.

It is recommended that the Plan adopt a formal process for the timely communication of significant control deficiencies and their remediation to the independent audit committee.

D. Territory and Plan of Operation

OHP-NY was licensed as a for-profit health maintenance organization under Article 44 of the New York Public Health Law on June 1, 1986, and began operations on that date. At December 31, 2016, OHP-NY was authorized to transact business in the following counties in the state of New York:

Bronx	Nassau	Putnam	Rockland	Ulster
Dutchess	New York	Queens	Suffolk	Westchester
Kings	Orange	Richmond	Sullivan	

OHP-NY maintains a Point-of-Service ("POS") product, called the "Freedom Plan," which is available to members in conjunction with its affiliate, OHI. The Freedom Plan combines the benefits and coverage of the Plan with conventional health insurance provided by OHI. The Freedom Plan enrollees pay a composite rate for their health coverage, which is developed from the community rate for the health maintenance organization coverage and a separate rate for the indemnity (out-of-plan) coverage. Larger groups have a manual rate that is derived by blending in the group's own experience. A totally experience-rated contract is also available to groups with more than 100 members.

The Liberty Plan is also an OHP-NY POS health care product that is available to groups/members. This plan offers lower premiums than the Freedom Plan since members choose from a smaller network of in-network providers. The Plan also offers Medicare and Healthy NY products.

The following schedule shows direct premiums earned during the four-year examination period:

Year	Direct Premiums Earned
2013	$2,524,610,771
2014	$2,028,350,069
2015	$1,793,371,053
2016	$1,707,656,470

The following chart shows the Plan's members by line of business during the examination period:

	HMO		Point of Service			Government		Total
	Group	Ind.	Large Group	Small Group	Ind.	Healthy NY	Medicare	
2013	191,657	2,600	22,758	24,427	2,980	33,431	72,856	350,709
2014	125,116	10,783	11,994	57	835	15,397	70,708	234,890
2015	85,737	18,667	14,730	0	720	12,355	71,427	203,636
2016	69,362	15,170	8,671	0	0	5,890	81,526	180,619

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

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

During the Department's walkthrough of controls over the application of the New York Health Care Reform Act ("NYHCRA") surcharge (the "Surcharge"), it was noted that there were

insufficient controls to ensure the system properly identified all of the facilities that were surcharge-eligible. At the request of the examiner, the Plan performed an analysis and noted that, between 2014 through 2016, there were a total of two hundred thirty-eight (238) facilities within the Claim Adjudication System where a surcharge was due but not paid.

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

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

E. Reinsurance

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

statutory basis Statements of Admitted Assets, Liabilities, and Capital and Surplus. The Reinsurance Program was terminated after the plan year ended in 2016.

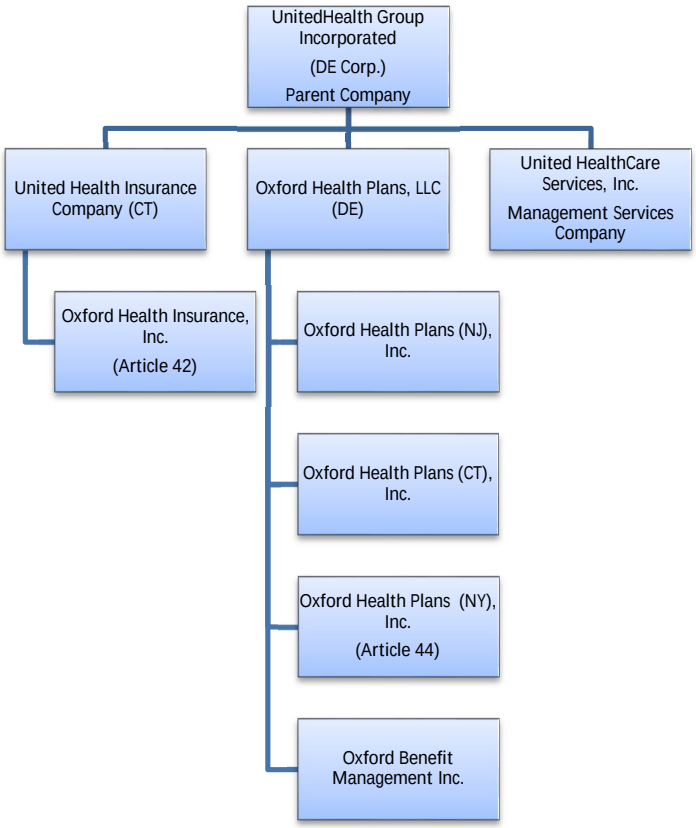
During a review of the OHP-NY 2016 annual statement, it was noted that there was no disclosure regarding the New York market stabilization stop-loss pool in the Reinsurance (#23) footnote. Although there were no changes to this reinsurance arrangement during the exam period, the corresponding footnote disclosure that was included in the 2015 annual statement was omitted from the 2016 disclosure.

It is recommended that management add a description of the New York Stop Loss Agreement in the Reinsurance footnote of the Annual Statement and disclose the amounts recoverable.

F. Holding Company System

As a member of a holding company system, OHP-NY is required to file registration statements pursuant to the requirements of Part 98-1.16(e) of the Administrative Rules and Regulations of the New York State Health Department (10 NYCRR 98-1.16). All such filings made during the examination period were reviewed, and no exceptions were noted.

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



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

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

- UHS, provides administrative, financial, management, accounting, underwriting, marketing, legal, medical provider, member services, medical management, agency development, employee management and benefit, information systems, and other general and administrative services to affiliated companies within UHG's holding company system. Most of the directors and officers of Oxford and various UHG companies are considered employees of UHS rather than the individual insurers under UHG's holding company system.

- Oxford Health Plans, LLC is a Delaware corporation and the parent corporation of Oxford Health Plans (NY), Inc. and various other Oxford companies, including OHI.

- Oxford Health Insurance, Inc. is a for-profit accident and health insurer licensed in New York and is a subsidiary of United Health Insurance Company. OHI provides the out-of-network benefit for the Plan's point-of-service product.

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

Management Services Agreement

Pursuant to the terms of a management services agreement, UHS will provide management services to the Plan until the agreement is terminated upon the written agreement of both parties for a fee based on cost reimbursement. Management fees under this agreement are included in general administrative expenses and claims adjustment expenses in the accompanying statement of revenue and expenses. Direct expenses not included in the management services agreement, such as broker commissions, examination fees, and premium taxes are paid by UHS on behalf of the Plan. UHS is reimbursed by the Plan for these direct expenses.

Tax Allocation Agreement

On July 29, 2004, OHP-NY entered into a Tax Allocation Agreement (the "Tax Agreement") with UHG, the ultimate controlling parent and Oxford. The Tax Agreement establishes a formal method for the allocation and payment of federal, state and local income tax liabilities related to the consolidated federal income tax returns filed each year. The Tax Agreement was submitted for review and approval to both, the New York Insurance Department (now DFS) and Department of Health, on August 17, 2004, and was retroactively approved to July 29, 2004 on September 8, 2004.

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

G. Significant Operating Ratios

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

Underwriting Ratios	2016
Net Change in Capital and Surplus	(40.5%)
Liquid Assets & Receivables to Current Liabilities	170.9%
Premium and Risk Revenue to Capital and Surplus	6.0 to 1
Medical Loss Ratio	84.0%
Combined Loss Ratio	98.0%
Administrative Expense Ratio	14.0%

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

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

	Amounts	Ratios
Total hospital and medical	$ 6,696,416,281	83.1%
Other claim adjustment expenses	115,145,409	1.4%
Cost containment expenses	148,484,502	1.9%
General administrative expenses	792,990,003	9.9%
Increase in reserves	(6,602,000)	(0.1%)
Net underwriting gain	307,554,168	3.8%
Net premium income	$ 8,053,988,363	100.0%

3. MEDICAL LOSS RATIO REPORTING

The Plan's 2016 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 NY large group market).

This is the first examination of the Plan's MLR Annual Reporting Form performed by the Department. This examination of the Plan's 2016 MLR Annual Reporting Form covered the reporting period of January 1, 2014 through December 31, 2016, including 2014 and 2015 experience and claims run-out through March 31, 2017.

The examination was conducted in accordance with the NAIC's 24 MLR Agreed Upon Procedures ("MLR AUPs"). The MLR AUPs set forth the procedures for performing an examination to evaluate the validity and accuracy of the data elements and calculated amounts reported on the MLR Annual Reporting Form, and the accuracy and timeliness of any rebate payments. The examination included assessing the principles used and significant estimates made by the 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 is to be submitted to the Secretary of HHS by July 31st of the year following the end of an MLR reporting year, on a form and in the manner prescribed by the Secretary of HHS. Based on the examiner's review, the 2016 MLR Annual Reporting Form filed by the Plan contains some elements that are not fully compliant with the requirements of Title 45 CFR §158, as more fully described in the sections below.

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

MLR Components	Individual	Small Group	Large Group
Adjusted Incurred Claims	$658,522,943	$1,771,454,893	$262,009,791
Plus: Quality Improvement Expenses	$3,324,802	$20,003,253	$2,440,604
Less: Cost-sharing reductions	$0		
Less: Federal Transitional Reinsurance Program payments expected from HHS	$94,149,553		
Less: Federal Risk Adjustment Program net payments expected from (payable to) HHS	$184,781,536	($65,111,116)	
Less: Federal Risk Corridors Program net payments (charges)	$0	$0	
MLR Numerator	**$382,916,657**	**$1,856,569,262**	**$264,450,395**
Premium Earned	$438,146,641	$2,316,287,492	$333,517,397
Less: Federal & State Taxes and Licensing/Regulatory Fees	$35,577,874	$224,163,346	$52,144,791
MLR Denominator	**$402,568,767**	**$2,092,124,146**	**$281,372,606**
Preliminary MLR	95.1%	88.7%	94.0%
Credibility Adjustment	0.7%	0.0%	1.3 %
Credibility–Adjusted MLR	**95.8%**	**88.7%**	**95.3%**
MLR Standard	82%	82%	85%
Rebate Amount	**$0**	**$0**	**$0**

A. MLR Numerator

According to Title 45 CFR §158.221(b), the numerator of the MLR calculation is comprised of incurred claims, as defined in Title 45 CFR §158.140, expenditures for activities that improve health care quality as defined in Title 45 CFR §158.150, and Title 45 CFR §158.151, Cost Sharing Reductions Program as defined in Title 45 CFR §158.140(b)(1)(iii) and Federal Transitional Reinsurance, Federal Risk Adjustment and Federal Risk Corridor Programs as defined by Title 45 CFR §158.140(b)(4)(ii).

Incurred Claims

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

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

Quality Improvement Activities ("QIA")

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

The examiner reviewed the accuracy and reasonableness of health care quality improvement expenses, including the validation of a sample of the QIA amounts reported, to ensure they are in conformity with the definition of Healthcare Quality Improvement Expenses

as defined by Title 45 CFR §158.150 and Title 45 CFR §158.151, and to confirm that the allocation methodology is reasonable and complies with the requirements set forth by Title 45 CFR §158.170.

Management Fee QIA

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

> "(b) Except as otherwise required by law or regulation, an insurer shall maintain:
> 8) Any other record for six calendar years from its creation or until after the filing of a report on examination or the conclusion of an investigation in which the record was subject to review."

Title 45 CFR Part 158 requires issuers to maintain all documents and other evidence necessary to verify that the data submitted is in compliance with the definitions and criteria set forth in Title 45 CFR Part 158 and that the MLR and any rebates owed are calculated and provided in accordance with the regulation. In addition, such records are required to be maintained under Part 243.2 (b)(8) of Insurance Regulation No. 152 (11 NYCRR 243.8), cited above. In testing for compliance with these requirements, it was noted that, in violation of the cited regulations, the Plan did not maintain adequate documentation to support the percentages reported in the internal cost center/department survey.

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

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

It is recommended that the Plan only classify overhead expenses as QIA when such items are allowed pursuant to Federal Regulation 45 CFR §158.150 and the 2016 NAIC Annual Statement Instructions – Health.

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

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

External Vendors QIA

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

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

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

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

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

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

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

It is recommended that the Plan treat direct and indirect external vendors consistently and obtain surveys for external vendors regardless of whether the expense is indirectly allocated as part of the management fee QIA process. Further, the external vendor survey results should

be provided to the applicable departments for consideration in the determination of the department level management fee QIA percentage.

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

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

Affiliated Vendors QIA

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

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

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

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

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

Cost Sharing Reductions ("CSR")

The Plan correctly reported that there were no advanced payments of CSR received from HHS as a deduction from incurred claims on the MLR Annual Reporting Form.

Federal Premium Stabilization Programs

The examiner 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, the Plan's Federal premium stabilization programs amounts were accurately reported on the MLR Annual Reporting Form.

B. MLR Denominator

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

Earned Premiums

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

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

Federal and State Taxes and Licensing or Regulatory Fees

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

Based on the procedures performed, the 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 MLR Annual Reporting Form.

C. Credibility Adjustment

According to Title 45 CFR§158.232, the credibility adjustment is the product of the base credibility factor multiplied by the deductible factor. The examiner reviewed the underlying data utilized in the determination of the base credibility and deductible factors, tested the accuracy of the calculation of the base credibility and deductible factors and the resulting credibility adjustment for the individual, small and large group markets. The 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, the Plan's base credibility factor, deductible factor and credibility adjustment were accurately calculated and reported for each market segment on the MLR Annual Reporting Form.

D. Credibility-Adjusted MLR

According to Title 45 CFR §158.221(a), the calculation of the MLR is the ratio of the numerator to the denominator, plus the credibility adjustment. The examiner recalculated the credibility-adjusted MLR in accordance with 45 CFR Part 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 MLR Annual Reporting Form.

E. Rebate Disbursement and Notice

According to Title 45 CFR §158.240, a rebate is required to be paid no later than September 30, following the MLR reporting year if an insurer's credibility-adjusted MLR is less than the MLR standard (82% for the individual and small group markets and 85% for the large group market). Based on the examiner's review of the credibility-adjusted MLR for each market segment, the Plan exceeded the New York MLR standard, and thus was not required to pay rebates to its enrollees.

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

F. Impact on Risk-Based Capital

According to Title 45 CFR §158.270(a), rebate payments having any adverse impact on the Plan's Risk-Based Capital ("RBC") level requires notification by the Department to the Secretary of the HHS. Based on the examiner's review, the Plan's credibility-adjusted MLR exceeded the minimum percentage for all market segments, and no rebates were issued, therefore there was no impact on the RBC level that would warrant notification to the Secretary of HHS.

4. FINANCIAL STATEMENTS

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

Independent Accountants

The firm Deloitte & Touche, LLP ("D&T") was retained by OHP-NY 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 HMO at the respective audits. Balances reported in these audited financial statements were reconciled to the corresponding years' annual statements with no discrepancies noted.

A. Balance Sheet

Assets

Bonds	$ 361,901,019
Common stock	0
Cash and short-term investments	23,864,709
Investment income due and accrued	2,409,334
Uncollected premiums and agents' balances in the course of collection	1,583,555
Accrued retrospective premiums and contracts subject to redetermination	113,296,233
Amounts recoverable from reinsurers	25,129,401
Amounts receivable relating to uninsured plans	4,295,344
Current federal and foreign income tax recoverable and interest thereon	22,913,076
Net deferred tax asset	7,147,141
Receivable from parent, subsidiaries and affiliates	11,386,504
Health care and other amounts receivable	35,673,672
Aggregate write-ins for other than invested assets	5,206,756
Total assets	$ 614,806,744

Liabilities

Claims unpaid	$ 220,139,369
Accrued medical incentive pools and bonus amounts	22,623,470
Unpaid claims adjustment expenses	1,897,903
Aggregate health policy reserves	14,768,877
Aggregate health claim reserves	136,614
Premiums received in advance	36,562,775
General expenses due or accrued	7,849,030
Ceded reinsurance premiums payable	194,155
Amounts withheld or retained for the account of others	151
Remittance and items not allocated	876,149
Liability for amounts held under uninsured accident	26,272,773
Aggregate write-ins for other liabilities	1,051,140
Total liabilities	$ 332,372,406

Capital and surplus

Common capital stock	19
Gross paid in and contributed surplus	61,684,743
NYS Contingent Reserve	213,486,977
Unassigned funds	7,262,599
Total capital and surplus	$ 282,434,338
Total liabilities, capital and surplus	$ 614,806,744

Note: The Internal Revenue Service has not conducted any audits of the income tax returns filed on behalf of the Plan through tax year 2016. The examiner is unaware of any potential exposure of the Plan to any tax assessments and no liability has been established herein relative to such contingency.

OHP-NY files its tax returns on a consolidated basis with other affiliated companies within the UHG holding company.

B. Statement of Revenue, Expenses and Capital and Surplus

Capital and surplus decreased $893,373,594 during the four-year examination period, January 1, 2013 through December 31, 2016, detailed as follows:

Revenue		
Net premium income	$ 8,045,593,792	
Change in unearned premium reserves and reserves for rate credits	8,394,571	
Aggregate write-ins for other health care related revenues	0	
Total revenues		$ 8,053,988,363
Hospital and Medical Expenses		
Hospital/medical benefits	$5,360,117,708	
Other professional services	92,898,226	
Outside referrals	0	
Emergency room and out-of-area	507,433,667	
Prescription drugs	850,663,167	
Incentive pools, withhold adjustments and bonus amounts	53,116,430	
Net reinsurance recoveries	(167,812,917)	
Total hospital and medical	$ 6,696,416,281	
Administrative expenses		
Claims adjustment expenses	263,629,911	
General administrative expenses	792,990,003	
Increase in reserves for A&H contracts	(6,602,000)	
Total underwriting deductions		$ 7,746,434,195
Net underwriting gain		$ 307,554,168
Net investment income earned		49,142,003
Net realized capital gains		11,259,363
Net loss from agents or premium balances charged off		(2,314,668)
Aggregate write-ins for other income or expenses		149,752
Net income before federal income taxes		$ 365,790,618
Federal and foreign income taxes incurred		150,828,765
Net income		$ 214,961,853

Change in Capital and Surplus

	Gains in Surplus	Losses in Surplus	
Capital and Surplus, per report on examination, as of December 31, 2012			$ 1,175,807,932
Net income	$ 214,961,853		
Change in net unrealized capital gains		651,105,591	
Change in net deferred income tax		8,200,860	
Change in non-admitted assets	10,149,044		
Surplus adjustments		20,500,000	
Dividends to stockholders		380,000,000	
Aggregate write-ins for gains or losses in surplus		58,678,040	
Net decrease in capital and surplus			(893,373,594)
Capital and Surplus, per report on examination, as of December 31, 2016			$ 282,434,338

5. AGGREGATE RESERVES AND CLAIMS UNPAID

The examination liability of $220,129,369 for the above captioned account is the same as the amount reported by the Plan as of December 31, 2016.

The examination analysis of the claims unpaid reserve was conducted in accordance with generally accepted actuarial principles and practices and was based on statistical information contained in the Plan's internal records and 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 the Plan's past experience in projecting the ultimate cost of claims incurred on or prior to December 31, 2016.

6. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

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

ITEM NO.		PAGE NO.
1.	Accounts and Records	
	It is recommended that management should 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. *The HMO has complied with this recommendation.*	28
2.	Internal Controls	
	It is recommended that the Plan change its approach to the documenting and testing of internal controls to enact best practices. It is noted that the definition of "Best Practice" may differ among authoritative sources. *The HMO has complied with this recommendation.*	28
3.	Reinsurance Disclosure	
	It is recommended that management add a description of the New York Stop Loss Agreement in the Reinsurance footnote of the Annual Statement and disclose the recoverable amount. Subsequent to the examination period, the Plan complied with this recommendation. *The HMO has not complied with this recommendation. The reinsurance disclosure was inadvertently left off the December 31, 2016 annual NAIC filed report.*	28

7. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM **PAGE NO.**

Respectfully submitted,

_____
David Crandall

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

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

_____
David Crandall

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

APPOINTMENT NO. 31568

NEW YORK STATE

DEPARTMENT OF FINANCIAL SERVICES

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

Risk and Regulatory Consulting, LLC

as a proper person to examine the affairs of the

Oxford Health Plans (NY), Inc.

and to make a report to me in writing of the condition of 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 1st day of February, 2017

MARIA T. VULLO
Superintendent of Financial Services

By:

Lisette Johnson
Bureau Chief
Health Bureau