

**United HealthCare of Colorado, Inc.**

6465 Greenwood Plaza Blvd., Suite 300  
Centennial, Colorado 80111



Conducted by:

DIVISION OF INSURANCE  
STATE OF COLORADO

COLORADO DIVISION OF INSURANCE

REPORT OF FINANCIAL EXAMINATION

OF

UNITED HEALTHCARE OF COLORADO, INC.

Main Administrative Office:  
6465 Greenwood Plaza Blvd., Suite 300  
Centennial, Colorado 80111

Primary Location of Books and Records:  
5901 Lincoln Drive  
Edina, Minnesota 55436

AS OF

DECEMBER 31, 2003

CONDUCTED BY

DIVISION OF INSURANCE  
STATE OF COLORADO

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Centennial, Colorado  
April 21, 2005

Honorable David F. Rivera, Commissioner  
Division of Insurance  
State of Colorado  
1560 Broadway, Suite 850  
Denver, Colorado 80202

Commissioner:

Pursuant to your instructions and in compliance with Sections 10-16-416 and 10-1-201 et seq., C.R.S., an examination has been made of the financial condition and affairs of:

**UNITED HEALTHCARE OF COLORADO, INC.**

Main Administrative Office:  
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Primary Location of Books and Records:  
5901 Lincoln Dr.  
Edina, Minnesota 55436

and the report thereon is respectfully submitted.

United HealthCare of Colorado, Inc., hereinafter referred to as the "Company," was last examined as of December 31, 1998. That examination and the current examination, were conducted by the Division of Insurance, State of Colorado.

With the exception of the following, all recommendations contained in the prior examination report have been adequately addressed by the Company:

Recommendation

Action by the Company

It is again recommended that the Company expand its review of intermediaries and providers to include all requirements set forth in Colorado Insurance Regulation 4-7-1(12)(E).

Issue still exists; refer to the "Plan of Operation" section of this report.

SCOPE OF EXAMINATION

This examination covers the period from January 1, 1999 through December 31, 2003. During the course of this examination, assets were verified and valued and all known liabilities were established as of December 31, 2003. Accounting and other pertinent records were reviewed to the extent deemed appropriate. The work performed was in accordance with statutory requirements and followed procedures prescribed in the Colorado Examiners Handbook and the Examiners Handbook published by the National Association of Insurance Commissioners (NAIC). The extent of review on any given account or activity was based on the results of a prescribed planning process that evaluated the effectiveness of internal controls in place at the Company, as well as other factors, which included an analytical review of financial data, the Company's financial performance during the period under examination, prior examination findings and materiality. Information contained in external audit reports was used on a limited basis.

The determination to reflect financial adjustments in the financial statements was dependent upon the materiality of a particular adjustment when compared to surplus and/or operating results, and when combined in the aggregate with all other adjustments, the materiality of the total when compared to surplus and/or operating results.

The examination did not address market conduct issues relating to policy forms, rates, policyholder treatment and claims settlement practices. These issues are addressed in separate market conduct examinations periodically performed by the Colorado Division of Insurance.

## HISTORY AND CAPITAL

### History

The Company was incorporated under the laws of the State of Colorado as a for-profit corporation on February 24, 1986 under the name "MetLife HealthCare Network of Colorado, Inc." On March 20, 1986, the Company was granted a certificate of authority by the Colorado Division of Insurance to operate as a health maintenance organization. On July 11, 1995 the Company changed its name to "MetraHealth Care Plan of Colorado, Inc."

UnitedHealth Group Incorporated acquired the Company in 1995 when it purchased the Company's parent, MetraHealth Care Management Corporation. The Colorado Division of Insurance approved the acquisition on September 1, 1995. On May 1, 1996, the Company's name was changed to "United HealthCare of Colorado, Inc."

### Capital

Since incorporation in 1986, the Company's authorized capital stock of \$100 has consisted of 10,000 shares of voting common stock with a par value of \$0.01 per share, and 10,000 shares of non-voting class B preferred stock with no par value.

Changes in capital paid up and gross paid-in and contributed surplus since incorporation follow:

<u>Year</u>	<u>Description</u>	<u>Shares Issued</u>	<u>Par Value</u>	<u>Capital Paid Up</u>	<u>Paid-in and Contributed Surplus</u>	<u>Surplus Note</u>
1986	At Organization:					
	Common Stock	5,000	\$0.01	\$50	\$ 199,950	
	Preferred Stock	5,000	No Par	50	199,950	
	Contribution				836,000	
1986	Contribution by Parent				1,480,000	
1987	Contribution by Parent				784,000	
1988	Contribution by Parent				4,835,542	
1989	Contribution by Parent				1,003,859	
1998	Contribution by UHS				4,000,000	
1998	Surplus Note					
	Contribution by UHIC					\$5,000,000
1999	Surplus Note					
	Contribution by UHIC					5,000,000
1999	Contribution by Parent				11,000,000	
2000	Contribution by UHS				8,000,000	
2001	Contribution by UHS				15,000,000	
2002	Contribution by UHS				18,000,000	
	Totals as of December 31, 2003	<u>10,000</u>		<u>\$100</u>	<u>\$65,339,301</u>	<u>\$10,000,000</u>

### Dividends to Stockholders

The articles of incorporation allow for the payment of dividends in cash or property. The Company did not pay any shareholder dividends during the examination period.

### Subordinated Debentures

On December 23, 1998, the Company issued a surplus debenture in the amount of \$5,000,000 to United HealthCare Insurance Company (UHIC). The subordinated debenture stipulates that repayment cannot commence until prior written approval is obtained from the Colorado Commissioner of Insurance. Repayment cannot be made unless, after the repayment, surplus exceeds the greater of \$2,500,000 or 2.5 times the authorized control level of the most recent risk based capital calculation. The debenture complies with Section 10-3-239, C.R.S. and was approved by the Colorado Division of Insurance on December 18, 1998.

A second surplus debenture, in the amount of \$5,000,000, was issued to UHIC on March 19, 1999. The terms of this debenture are the same as those of the first debenture. This debenture was approved by the Colorado Division of Insurance on April 2, 1999.

In 2004, the Colorado Division of Insurance granted the Company permission to repay both debentures plus the accrued interest in the amount of \$3,396,164.

<u>Date</u>	<u>Amount of the Debenture</u>	<u>Note Holder</u>	<u>Date the DOI Approved the Debenture</u>	<u>Date Repayment was Approved by the DOI</u>	<u>Date Repaid</u>	<u>Amount of Accrued Interest Paid</u>	<u>Form of Payment</u>
12/23/1998	\$5,000,000	UHIC	12/18/1998	7/27/2004	7-29-2004	\$1,679,178	Cash
3/19/1999	5,000,000	UHIC	4/2/1999	11/22/2004	12-8-2004	1,716,986	Cash
Total	<u>\$10,000,000</u>					<u>\$3,396,164</u>	

### AFFILIATED COMPANIES

#### Parent, Subsidiaries and Affiliates

The Company is a direct, wholly owned subsidiary of UnitedHealthcare, Inc. (UHC), which is a wholly owned subsidiary of United HealthCare Services, Inc. (UHS). UHS is directly owned by UnitedHealth Group Incorporated.

As the ultimate controlling person, UnitedHealth Group Incorporated (United), is a publicly traded company listed on the New York Stock Exchange. Over 620 million shares were outstanding on March 1, 2004. United is a Minnesota corporation, incorporated in January 1977. United provides health care management services through organized health systems and insurance products, including health maintenance organizations, point-of-service plans, preferred provider organizations and managed indemnity programs. United, through its subsidiaries, operates in all 50 states, the District of Columbia, Puerto Rico and internationally. On a consolidated basis, as of year-end 2003, United had assets of \$17.6 billion, shareholders equity of \$5.1 billion, and revenues in excess of \$28 billion.

UHS functions as an indirect holding company for most of the health plans and insurance companies owned by United, and also provides management services to these health plans and insurance companies. UHS is a Minnesota corporation, which is qualified to do business in all 50 states, the District of Columbia and Puerto Rico. It is not licensed as a health maintenance organization or as an insurance company, but is licensed in several states as a preferred provider organization or third party administrator. UHS employs substantially all United personnel, rents most of the office space used by United personnel and owns the furniture and equipment used by United personnel.

UHC is an intermediate holding company for nineteen health maintenance organizations owned by United including the Colorado health plan. UHC does not function in any other capacity except to facilitate United's ownership interest in these health plans.

United HealthCare Insurance Company (UHIC) was organized in 1972 in the State of Connecticut. It offers group health coverage, and provides the indemnity coverage for the point-of-service plans offered to employers in conjunction with the managed care products offered by the Company and other health maintenance organizations owned by United. At December 31, 2003, UHIC reported assets of \$5.78 billion, liabilities of \$4.4 billion, surplus of \$1.38 billion and premium revenues in excess of \$10.89 billion. UHIC is licensed in all states except New York, and through its reinsurance program, provides excess of loss coverage to the Company and other affiliated health maintenance organizations.

#### Acquisitions, Mergers or Sales

On November 1, 1999, the Colorado Division of Insurance granted United permission to transfer ownership of the Company from MetraHealth Care Management Corporation to UHC. This transfer had no effect on United's ownership interest in the Company.

#### Holding Company Filings

Pursuant to Sections 10-16-421 and 10-3-801(4), C.R.S., the Company is a member of an insurance holding company system and is therefore subject to the registration requirements of Section 10-3-804, C.R.S. and Colorado Insurance Regulation 3-4-1.

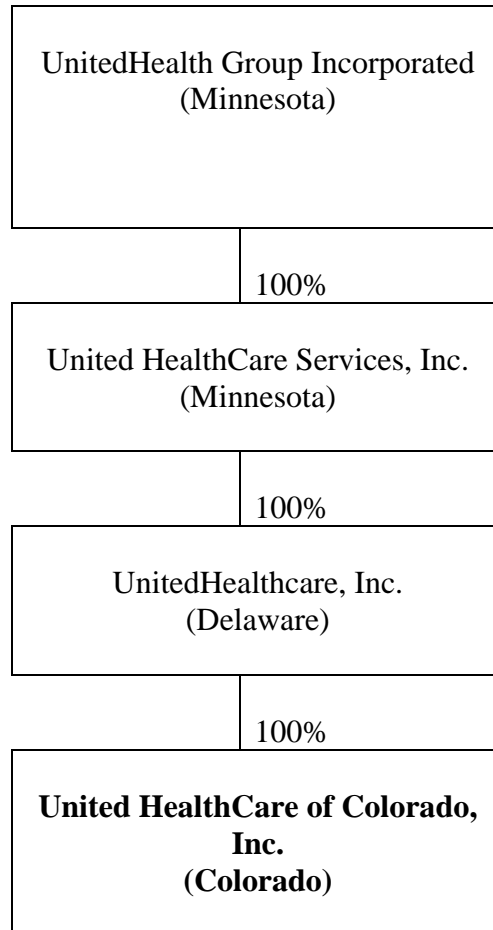
As defined in Section 10-3-801(3), C.R.S., the ultimate controlling person, as of December 31, 2003, was UnitedHealth Group Incorporated (United). As a publicly held company, United's stock is traded on the New York Stock Exchange. Based on the annual report to shareholders, no one person held more than 10% of United's capital stock.

The Company has made the annual form B and C filings as required by Section 10-3-804, C.R.S. and Colorado Insurance Regulation 3-4-1. Generally, the filings contained the required information pertaining to transactions, relationships and agreements with affiliates.

Organizational Chart

An abbreviated organizational chart depicting the Company's relationship with its parent, as of December 31, 2003, is presented below.

Abbreviated  
Organizational Chart  
December 31, 2003



## MANAGEMENT AND CONTROL

The business and affairs of the Company are managed by a board of directors, which consists of three members. The board is assigned the power to exercise general supervision over the business affairs of the Company.

### Shareholder Meetings

The by-laws provide that the annual meeting of shareholders is to be held at such time and place as determined by the board for the election of directors and the transaction of such other business as may come before the board.

Special meetings of shareholders may be called by the president, by the board of directors, or by holders of at least 10% of all shares entitled to vote at meetings. Written notice of each meeting, stating the time and place, and in the case of special meetings, the purpose or purposes for the meeting, must be delivered to each shareholder not more than 50 days and not less than 10 days before such meetings. Any action required to be taken by the shareholders may be taken without a meeting if written consent for such action is given by all shareholders entitled to vote on such matters.

A majority of the outstanding shares, represented in person or by proxy, constitutes a quorum for the transaction of business. If a quorum is present, the affirmative vote of a majority of the shareholders carries the action.

Each share is entitled to vote on any matter brought before the meeting. Cumulative voting is not allowed in the election of directors.

The Company held five annual shareholder meetings and one special meeting during the examination.

### Board of Directors

The corporate powers, business and property of the Company are exercised, conducted and administered by the board of directors. The by-laws provide that the shareholders determine the number of directors. The board is currently comprised of three members.

Directors are elected at the annual meeting of shareholders. Any vacancy occurring on the board of directors may be filled by a majority vote of the remaining directors. A director elected to fill a vacancy serves for the unexpired term of his or her predecessor.

The by-laws provide that the board of directors meet after the annual meeting of shareholders for the purpose of organizing the board, electing the officers and conducting such other business as is brought before the meeting. Regular meetings of the board are held, without notice, at such times and places as determined by resolution of the directors. Special meetings may be called by the president or by any director. Any action required to be taken by the board may be taken without a meeting if written consent for such action is given by all members entitled to vote on such matters.

A majority of directors constitutes a quorum for the transaction of business. The action of a majority of the directors present at a meeting in which a quorum exists represents the act of the board of directors.

During the period under review, the board of directors held five annual meetings and 31 regular meetings.

Directors duly elected and serving at December 31, 2003, together with their state of residence and principal business affiliations, are presented as follows:

Directors

Business Affiliations

Victor Lazzaro, Jr.  
Denver, Colorado

Director, President and Chief Executive Officer of  
United HealthCare of Colorado, Inc

William A. Munsell  
Wayzata, Minnesota

Vice President of United HealthCare Services, Inc.;  
Director, Executive Vice President, Assistant Treasurer  
and Chief Administrative Officer of UnitedHealthcare,  
Inc.; Director and Senior Vice President of United  
HealthCare Insurance Company; Vice President and  
Assistant Treasurer of UnitedHealthcare International  
Asia, LLC; Director and/or officer of other various  
United subsidiaries

Robert J. Sheehy  
Edina, Minnesota

Vice President of United HealthCare Services, Inc.;  
Director, President and Chief Executive Officer of  
UnitedHealthcare, Inc.; Director of Americhoice  
Corporation; Manager, President and Chief Executive  
Officer of UnitedHealthcare International Asia, LLC;  
Director and/or officer of other various United  
subsidiaries

With the exception of Victor Lazzaro, Jr, who was replaced by Craig W. Keyes, M.D. and William Munsell who was replaced by David S. Wichmann, all of the above directors are currently serving on the board.

Officers

The operations of the Company and general supervision of its business affairs are under the direction of its corporate officers. The by-laws provide that the board of directors annually elect a chairman of the board, a president, a treasurer, a secretary, and one or more assistant treasurers and secretaries. In addition, the board may annually elect other officers and assistant officers as may be deemed necessary. Any two or more offices may be held by the same person, except for the offices of president and secretary, which may not be held by the same person.

The chairman of the board presides at all meetings of the shareholders and the board of directors and has general authority over the business affairs of the Company, subject to control by the board. The president is the chief executive officer and is responsible for the administration of the Company, its agents and its employees, and has general charge of the business affairs, subject to control by the board.

The officers serving at December 31, 2003, follow:

<u>Officer</u>	<u>Position</u>
This office has not been appointed.	Chairman of the Board
Victor Lazzaro, Jr.	President and Chief Executive Officer
Robert W. Oberrender	Treasurer
Michael J. McDonnell	Secretary
William A. Munsell	Vice President and Assistant Treasurer
Brian C. Murry	Vice President and Assistant Treasurer
Jacqueline E. Stiff, M.D.	Vice President and Medical Director
John W. Kelly	Vice President of Tax Services
Christina R. Palme-Krizak	Assistant Secretary
David J. Lubben	Assistant Secretary

The following officers were serving as of the date of this report:

<u>Officer</u>	<u>Position</u>
This office has not been appointed.	Chairman of the Board
Craig W. Keyes, M.D.	President and Chief Executive Officer
Robert W. Oberrender	Treasurer
Michael J. McDonnell	Secretary
Jacqueline E. Stiff, M.D.	Vice President and Medical Director
Timothy G. Caron	Assistant Secretary
David J. Lubben	Assistant Secretary
Mary L. Stanislav	Assistant Secretary
John W. Kelly	Vice President of Tax Services
George L. Mikan, III	Vice President of Finance and Assistant Treasurer
David S. Wichmann	Vice President and Assistant Treasurer

### Committees

The by-laws provide for the designation of an executive committee and one or more other committees as deemed necessary. To date, the board has not formally appointed any committees.

However, there is a structure of interfacing committees that are organized at the holding company level. These committees address the quality of care provided to enrollees, the credentialing of providers and other aspects related to improving the quality and delivery of health care services.

### Conflict of Interest

The Company has an established procedure for the disclosure of any material interest or affiliation that might conflict with the respective duties of all directors, officers and responsible employees. Directors, officers and key employees annually complete conflict of interest statements. A review of the annual affidavits indicates that no material conflicts exist.

Service and Management Agreements

Service Agreements:

The Company's second tier parent, United HealthCare Services, Inc. (UHS), provides management services to the Company. UHS provides underwriting, premium billing and collection, claims settlement, investment, accounting, pricing, actuarial and marketing services, as well as most other services incidental to the operations of a health maintenance organization. These functions are performed in various locations, however, most are performed outside the State of Colorado. Per the management agreement, the fee is 12% of premium revenue. In accordance with the agreement, the Company paid management fees of approximately \$20,966,000 and \$28,251,000 in 2003 and 2002, respectively.

The management agreement was submitted to the Colorado Division of Insurance in March 1999 in accordance with Colorado Insurance Regulation 4-7-1. The agreement was accepted, as filed, by the Colorado Division of Insurance on May 4, 1999.

The Company also has agreements with affiliates that perform certain administrative functions related to the delivery of health care to members. The agreements compensate the affiliate based on a per member, per month charge. These affiliates are not directly responsible for the delivery of health care services to members, and have not assumed the risk for providing health care services. Providers contracted on a fee for service basis actually provide the medical services to members and are directly compensated by the Company. The schedule below summarizes these agreements and the type of administrative services provided.

<u>Affiliate Providing Services</u> (Compensation Paid to the Affiliate in 2003)	<u>Contract Executed by</u>	<u>Administrative Services Provided</u>
ACN Group, Inc. (\$198,000)	UHS on behalf of Company	Access services and network management, utilization management and risk management services for chiropractic care and physical therapy benefits
Coordinated Vision Care, Inc. (\$53,000)	UHS on behalf of Company	Access services and network management, credentialing, claims administration and other services related to vision benefits
UHS on behalf of United Resource Networks (\$120,000)	Company	Access to network of providers that provide transplant, congenital heart health and oncology benefits and related data management
UHS on behalf of United Health Networks, Inc. (\$137,000)	Company	Management and administrative services related to pharmacy benefits

Federal Income Tax Allocation:

Since incorporation, the Company has filed a consolidated federal tax return. Since becoming a subsidiary of UnitedHealth Group Incorporated (United) in October 1995, the Company has filed as a member of the United holding company. Under this agreement, the allocation of the group's tax liability is based on a member's separate tax liability calculation. Any tax savings or additional tax charges

resulting from the filing of a consolidated tax return are allocated to the member generating the savings or charges on a stand-alone basis.

### CORPORATE RECORDS

The articles of incorporation, by-laws, and all amendments thereto, and minutes of the meetings of the shareholders and the board of directors were reviewed for the period under examination. Based on the review of the minutes, meetings are well attended and the minutes adequately record the deliberations and determinations made.

The articles of incorporation were not amended during examination period. The by-laws were amended and restated on August 25, 2000. The nature of the by-law amendments were administrative in nature.

The Company has a formal investment policy, which it revised in late 1999 and again in March 2000. The board delegates the authority to make investment decisions to individuals employed by an independent investment management company. Per the investment management agreement, the investment company must consider the Company's investment policy and must manage the investment portfolio in accordance with the investment laws of the State of Colorado. A permanent written record of all investment transactions is maintained, and the board of directors reviews and approves all investment transactions on a quarterly basis. As such, the Company has complied with the requirements of Section 10-3-234, C.R.S.

### FIDELITY BOND AND OTHER INSURANCE

#### Fidelity Bond

The Company is a named insured on a fidelity bond issued to UnitedHealth Group Incorporated. The bond provides \$25,000,000 in protection for employee dishonesty with a \$500,000 deductible, and as such, complies with the coverage amounts set forth in Colorado Insurance Regulation 3-1-1. The bond is written by a company licensed to do business in the State of Colorado.

#### Other Insurance

The Company is also a named insured on other policies that provide protection in connection with its business activities. These policies include workers' compensation, general liability, directors and officers, errors and omissions, and commercial property coverages.

### EMPLOYEES' AND AGENTS' WELFARE AND PENSION PLANS

In that the Company contracts with United HealthCare Services (UHS), Inc. for management services, it does not have any direct employees. All personnel work for UHS and/or an affiliated company. (See "Service and Management Agreements")

### TERRITORY AND PLAN OF OPERATION

#### Territory

The Company is licensed to transact business as a health maintenance organization with an approved service area within the State of Colorado. The Company's geographical service area includes the following counties:

Adams	Denver	Otero
Arapahoe	Douglas	Park
Boulder	El Paso	Pueblo
Broomfield	Jefferson	Teller
Clear Creek	Larimer	Weld
Crowley	Lincoln	

The Company's Certificate of Authority was reviewed and found to be in proper order and effect.

Plan of Operation

The Company operates as a for-profit, network model, closed panel health maintenance organization. Marketing efforts target group enrollment. These groups consist principally of private and government employers.

Membership enrollment as of December 31, 2003 is as follows:

<u>Source of Enrollment</u>	<u>Membership</u>	<u>Per Cent of Total</u>
Groups	48,845	99.9%
Medicare Risk	0	
Medicaid Risk	0	
Individual	54	0.1%
Other	0	
Total	<u>48,899</u>	<u>100%</u>

Business is marketed through brokers and direct writing producers. The commission structure for small and medium employers may be a function of premium collected, or it may be based on a fixed amount per employee per month. Bonus incentives based on new enrollment and persistency are also paid. For large employer groups, the commission is negotiated and is also subject to a bonus incentive program based on new enrollment and persistency.

It is noted that the company does not always have written agreements with its producers. For some markets it publishes and pays in accordance with a commission schedule, and for other markets the commission is negotiated, without a formal written agreement.

**RECOMMENDATION:**

No. 1

It recommended that the Company implement procedures to ensure that it executes written agreements with all producers.

The Company contracts directly with individual primary care physicians, group practices, individual specialists, specialty group practices, hospitals and ancillary providers. Such services are generally compensated on a modified fee for service basis. Services related to mental health, substance abuse, and 24-hour medical advice call-in services are provided through affiliated intermediaries, which are compensated on a capitation basis.

A sample of contracts was reviewed, which indicates that provider agreements contain the hold harmless provision required by Colorado Regulation 4-7-1 (12)(B).

The last examination report noted that the Company had developed procedures to determine a provider's (intermediary's) ability to assume financial risk through capitation arrangements and to determine if the provider/intermediary understands these arrangements. However, these procedures did not fully comply with the requirements of Colorado Insurance Regulation 4-7-1(12)(E). Currently, with the exception of procedures to credential practitioners, the Company does not have comprehensive procedures to address the requirements of Colorado Insurance Regulation 4-7-1(12)(E). Although, these providers/intermediaries are affiliates, procedures should nevertheless exist and be implemented to help ensure that quality healthcare is provided. The procedures do not address the following requirements of Colorado Insurance Regulation 4-7-1(12)(E):

- Procedures relating to the financial review of intermediaries and providers accepting risk;
- Procedures relating to the review of the provider's subcontract specimen forms for compliance with applicable insurance laws and regulations, for the availability of services and for the evaluation of risk transfers;
- Procedures for the review of timely and accurate compensation of providers in accordance with underlying contracts;
- Procedures relating to the review of quality management, utilization review, credentialing and other health care management services, if being conducted by an intermediary, provider or subcontracting provider;
- In the event of the insolvency of a provider, procedures for assuring continuity of care to members and for making payments to subcontracting providers;
- Procedures for the annual reevaluation of providers; and
- Procedures for more frequent reevaluation of providers based on the results of previous reviews, complaints from members or providers, and other information which may impact the providers ability to pay subcontractors.

**RECOMMENDATION:**

No. 2

It is again recommended that the Company expand its review of intermediaries and providers to include all requirements set forth in Colorado Insurance Regulation 4-7-1(12)(E).

The Company offers a point-of-service product with its affiliate, United HealthCare Insurance Company, which combines the features of a conventional managed care delivery system with those of a traditional indemnity policy.

The Company stopped writing Medicare effective January 1, 1999, and stopped writing Medicaid effective November 1, 2002.

Enrollees receive a full range of prepaid health care services, including inpatient and outpatient hospital services, physician services, outpatient surgery, maternity care, emergency care, laboratory and x-ray services, skilled nursing services, pharmacy services, ambulance services, extended care services, hospice care, mental health services, home health services and vision care. Alcohol/drug detoxification services, as well as cardiac rehabilitation are provided. Some of the foregoing services are subject to deductibles and/or copayments.

The Company does not perform administrative functions for any self-insured groups.

GROWTH OF THE COMPANY

The growth of the Company for selected years is presented as follows:

<u>Year</u>	<u>Admitted Assets</u>	<u>Liabilities</u>	<u>Capital</u>	<u>Surplus Funds</u>
1999	\$34,557,726	\$17,624,828	\$100	\$16,932,798
2000	43,866,208	26,255,651	100	17,610,457
2001	54,936,993	29,251,753	100	25,685,140
2002	64,814,061	38,057,998	100	26,755,963
2003	57,307,778	27,668,336	100	29,639,342

A further summary of the Company's growth as reflected by revenues and expenses follows:

<u>Year</u>	<u>Membership Enrollment</u>	<u>Premium Revenues</u>	<u>Medical and Hospital Expenses</u>	<u>Loss Ratio (%)</u>	<u>Adm. Expenses</u>	<u>Adm. Exp. Ratio (%)</u>	<u>Combined Ratio (%)</u>
1999	85,727	\$118,463,003	\$103,676,645	87.5	\$19,231,788	16.2	103.7
2000	104,906	169,654,627	154,203,668	90.9	29,108,173	17.2	108.1
2001	102,148	214,317,338	203,646,407	95.0	20,723,830	9.7	104.7
2002	71,411	233,599,274	229,459,164	98.2	31,621,324	13.5	111.7
2003	48,899	173,676,539	149,864,433	86.3	22,171,176	12.8	99.1

Amounts reported in the above schedules were extracted from copies of filed annual statements with the exception of 2003, which were established or verified in connection with this financial examination.

REINSURANCE

Commercial Business:

The Company has excess of loss protection through a reinsurance agreement with its affiliate, United HealthCare Insurance Company. The excess coverage applies to commercial risks and indemnifies the Company for 90% of a loss above a \$150,000 deductible per member. A lifetime limit of \$2,000,000 applies to each member. This contract results in the transfer of risk and complies with Section 10-3-118, C.R.S. and Colorado Insurance Regulation 3-3-2.

Medicaid Business:

During the examination period, the Company also acquired excess of loss protection for its Medicaid risks from United HealthCare Insurance Company. From July 1, 2001 through October 31, 2002, the Company was indemnified for 90% of a loss above a \$100,000 deductible per member (100% of the loss above \$100,000 was covered if the services were received in a facility credentialed by United Resource Network, an affiliated healthcare organization). A lifetime limit of \$2,000,000 applied to each member. When the Company stopped writing Medicaid business, this contract was no longer utilized. In 2005, the agreement was formally terminated, effective October 31, 2002.

The contract covering Medicaid business resulted in the transfer of risk. However, it did not fully comply with Section 10-3-118, C.R.S. and Colorado Insurance Regulation 3-3-2. A summary sheet describing the contract and its compliance with Section 10-3-118, C.R.S., and Colorado Insurance Regulation 3-3-2 was not filed within 30 days of its execution. The contract was executed on October 17, 2001, and the summary sheet was not filed with the Colorado Division of Insurance until April 2002. The insolvency clause did not state that payment would be made without diminution, due to the

Company's insolvency, as required by Section 10-3-118(3)(b), C.R.S., and the contract did not provide for a 90 day advance notice to the Commissioner of Insurance, in the event of termination for any reason, as required by Colorado Insurance Regulation 3-3-2(VII)(A)(4).

The last report of examination noted several of the same deficiencies in the commercial contract as are now noted in the Medicaid contract. The Company amended the commercial agreement during the course of the last examination to fully comply with the requirements of Section 10-3-118, C.R.S., and Colorado Insurance Regulation 3-3-2. In that the Company stopped writing Medicaid business in October 2002, the agreement was not amended, during the course of the this examination, to comply with Section 10-3-118, C.R.S., and Colorado Insurance Regulation 3-3-2. However, at year-end 2003, no reserve credits were taken under the Medicaid agreement.

**RECOMMENDATION:**

No. 3

It is recommended that the Company implement procedures to ensure that reinsurance agreements comply with the requirements of Section 10-3-118, C.R.S. and Colorado Insurance Regulation 3-3-2.

**STATUTORY AND SPECIAL DEPOSITS**

Held for the protection of all policyholders:

<u>Location</u>	<u>Type of Security</u>	<u>Par Value</u>	<u>Statement Value</u>	<u>Market Value</u>
Colorado	US Treasury Notes	\$ 1,000,000	\$1,002,996	\$1,005,940
Sub-total		<u>\$ 1,000,000</u>	<u>\$1,002,996</u>	<u>\$1,005,940</u>

The statutory deposit complies with the provisions of Sections 10-16-412, 10-3-206, 10-3-210, and 10-3-211, C.R.S., as well as Colorado Insurance Regulation 3-1-2.

The Company's statutory deposit is held under a custodial arrangement with a Denver bank. The custodial agreement complies with provisions of Colorado Insurance Regulation 3-1-6. The custodian is a member of the Federal Reserve System and satisfies the definition of custodian as set forth in Colorado Insurance Regulation 3-1-6(III).

**ACCOUNTS AND RECORDS**

The majority of the Company's accounting records and policy detail are maintained and generated through an in-house electronic data processing system. Various books and records are prepared daily, weekly or monthly from daily transaction input. A general ledger and supporting documents are prepared monthly. Other detailed supporting documents are prepared manually as necessary.

A trial balance was prepared from the general ledger for the year ended December 31, 2003, and all balances were traced to the appropriate asset, liability or income statement line and supporting schedules of the annual statement using work papers prepared by the Company. For the years 1999, 2000, 2001 and 2002, selected balances reported in the annual statement were traced to the corresponding general ledger balances.

A review of income, disbursements and postings to the general ledger was conducted for selected periods. Test checks of postings from original documents to the general ledger revealed no material differences.

The Company is audited annually by an independent certified public accounting firm. The 2003 work papers prepared by the firm were reviewed and used on a limited basis. As required by Colorado Insurance Regulation 3-1-4, the Company filed an audited financial report with the Colorado Division of Insurance for years 1999 through 2003. In addition, the Company filed actuarial opinions with the Colorado Division of Insurance for 1999 through 2003, in accordance with Colorado Insurance Regulation 3-1-3.

The Company's securities are held in safekeeping by a custodian, which is a member of the Federal Reserve System, and which satisfies the definition of "custodian" as set forth in Colorado Insurance Regulation 3-1-6(III). The custodial agreement complies with the requirements set forth in Colorado Insurance Regulation 3-1-6 governing such agreements.

#### Claims Handling System:

A sample of claim payments was tested for compliance with Section 10-16-106.5 (4)(a) and (4)(b), C.R.S. (prompt payment law). Based on the sampling performed, it was determined that the reports produced by the Company's computer system (UNET) do not always reflect the date the claim was originally received. As such, using reports produced by the UNET system the examination team could not determine whether or not claims payments comply with the provisions of Section 10-16-106.5 (4)(a) and (4)(b), C.R.S.

The Company automatically closes claims that are missing certain information. It forwards a letter to the provider and the patient requesting the missing information. Upon receipt of the missing information, the Company assigns the date the new information was received as the new received date for the claim. This new received date becomes the received date for reporting purposes. The Company's UNET system (UNET) retains the original received date, and uses it in the adjudication process, but the new received date is used in all reports generated by the UNET system. As such, the examination team was unable to test for compliance with Colorado's prompt pay laws using reports generated by the UNET system, on any claim for which additional information was requested.

While the Company's claims system does not automatically close all claims missing information, it does, however, close those claims missing some or all of the following information:

- Descriptive information relating to medical supplies;
- Information relating to the anesthesia code, modifier and/or minutes;
- Information relating to procedure codes;
- Detailed listing of information relating to services, supplies and charges rendered;
- Information relating to the coordination of benefits; and
- Information relating to persons who are students.

#### RECOMMENDATION:

No. 4

It is recommended that the Company modify its claims reporting system (UNET) so that the original received date can be included in all reports generated by the UNET system.

## FINANCIAL STATEMENTS

The following pages present a Statement of Assets, Liabilities, Capital and Surplus as of December 31, 2003, as determined by this examination. This statement is followed by supporting statements and reconciliations presented in the following order:

Statement of Assets, Liabilities, Capital and Surplus, December 31, 2003

Statement of Revenue and Expenses, for the Year 2003

Capital and Surplus Account, for the Year 2003

Reconciliation of Capital and Surplus, December 31, 1998 to December 31, 2003

Analysis of Examination Changes, December 31, 2003

Comparative Financial Statements, December 31, 1998 and December 31, 2003

**ASSETS, LIABILITIES, CAPITAL AND SURPLUS****DECEMBER 31, 2003****ASSETS**

	<u>Assets</u>	<u>Assets Not Admitted</u>	<u>Net Admitted Assets</u>
Bonds (Note – 1)	\$44,165,554		\$44,165,554
Cash	(378,668)		(378,668)
Short-term Investments	10,123,018		10,123,018
Receivable for Securities	3,855		3,855
Investment Income Due or Accrued	638,056		638,056
Uncollected Premiums (Note – 2)	1,840,707		1,840,707
Health Care Receivables and Other Amounts Receivable	1,160,295	\$245,039	915,256
Totals	<u>\$57,552,817</u>	<u>\$245,039</u>	<u>\$57,307,778</u>

**ASSETS, LIABILITIES, CAPITAL AND SURPLUS (continued)****DECEMBER 31, 2003****LIABILITIES, CAPITAL AND SURPLUS**Liabilities:

Claims Unpaid (Note – 3)	\$19,119,995
Aggregate Health Policy Reserves	2,619,907
Aggregate Health Claims Reserves	1,162,444
Premiums Received in Advance	911,654
General Expenses Due or Accrued	504,398
Federal Income Taxes Payable	1,292,784
Net Deferred Tax Liability	366,144
Amounts Withheld for the Account of Others	465
Amounts Due to Parents, Subsidiaries and Affiliates	53,042
Other Liabilities	1,029,397
Credit Balances Due Policyholders	608,106
Total Liabilities	<u>\$27,668,336</u>

Capital and Surplus:

Common Capital Stock	\$ 50
Preferred Capital Stock	50
Gross Paid in and Contributed Surplus (Note – 4)	62,339,301
Surplus Notes	10,000,000
Unassigned Funds	<u>(42,699,959)</u>
Total Capital and Surplus (Note – 5)	<u>\$ 29,639,442</u>

Total Liabilities, Capital and Surplus \$ 57,307,778

**STATEMENT OF REVENUE AND EXPENSES****YEAR 2003**Revenues:

Net Premium Income	\$171,944,765
Change in Unearned Premium Reserves and Reserves for Rate Credits	7,056
Premiums Receivable for Other Health Care Related Revenues	1,724,718
Total Revenues	<u>\$173,676,539</u>

Expenses:

## Hospital and Medical:

Hospital and Medical Benefits	\$123,649,319
Other Professional Services	188,567
Prescription Drug	24,452,414
Other Medical Costs	167,787
Net Reinsurance Recoveries	(1,594,145)
Total Hospital and Medical Expenses	<u>\$146,863,942</u>

Claims Adjustment Expenses	6,130,136
General Administrative Expenses	22,171,176
Increase in Reserve for Accident and Health Contracts	(3,129,645)
Total Underwriting Deductions	<u>\$172,035,609</u>
Net Underwriting Gain	<u>\$1,640,930</u>
Net Investment Income Earned	2,416,326
Net Realized Capital Gains	119,848
Other Income	104
Net Income Before Federal Income Taxes	<u>\$4,177,208</u>
Federal Income Taxes Incurred	<u>(756,532)</u>
Net Income	<u>\$4,933,740</u>

**CAPITAL AND SURPLUS ACCOUNT****YEAR 2003**

Capital and Surplus Account, December 31, previous year		<u>\$26,756,063</u>
Net Income	\$4,933,740	
Change in Net Deferred Income Tax	(1,970,587)	
Change in Nonadmitted Assets	319,897	
Aggregate Write-in – Prior Period Adjustment	<u>(399,671)</u>	
Net Change in Capital and Surplus for the Year		<u>\$2,883,379</u>
Capital and Surplus December 31, 2003		<u><u>\$29,639,442</u></u>

**RECONCILIATION OF CAPITAL AND SURPLUS****December 31, 1998 through December 31, 2003**

	<u>1999</u>	<u>2000</u>	<u>2001</u>	<u>2002</u>	<u>2003</u>
Capital and Surplus, December 31, Previous Year	<u>\$4,100,756</u>	<u>\$16,932,898</u>	<u>\$17,610,557</u>	<u>\$25,685,239</u>	<u>\$26,756,063</u>
Net Income	(\$2,381,727)	(\$7,429,851)	(\$4,645,212)	(\$17,456,607)	\$4,933,740
Change in Net Deferred Income Tax				1,081,163	(1,970,587)
Change in Nonadmitted Assets	(786,131)	107,510	1,783,719	(553,732)	319,897
Increase in Paid In Surplus	11,000,000	8,000,000	12,000,000	18,000,000	
Increase in Surplus Notes	5,000,000				
Cumulative Effects of Changes in Accounting Principles Prior Period Adjustment			(1,063,825)		(399,671)
Change in Capital and Surplus for the Year	<u>\$12,832,142</u>	<u>\$677,659</u>	<u>\$8,074,682</u>	<u>\$1,070,824</u>	<u>\$2,883,379</u>
Capital and Surplus, December 31, Current Year	<u>\$16,932,898</u>	<u>\$17,610,557</u>	<u>\$25,685,239</u>	<u>\$26,756,063</u>	<u>\$29,639,442</u>

**ANALYSIS OF EXAMINATION CHANGES****December 31, 2003**

	<u>Per Company</u>	<u>Per Examination</u>	<u>Increase or (Decrease)</u>
<u>Assets:</u>			
Uncollected Premiums	\$1,232,601	\$1,840,707	\$608,106
<u>Liabilities:</u>			
Credit Balances Due Policyholders	\$0	\$608,106	<u>(\$608,106)</u>
Capital and Surplus per Annual Statement			\$29,639,442
Net Change Per Examination			<u>\$0</u>
Capital and Surplus Per Examination			<u>\$29,639,442</u>

**COMPARATIVE BALANCE SHEET****December 31, 1998 and December 31, 2003****ASSETS**

	<u>December 31,</u> <u>1998*</u>	<u>December 31,</u> <u>2003 *</u>
Bonds	\$ 12,344,930	\$44,165,554
Cash	(1,155,168)	(378,668)
Short-term Investments	562,345	10,123,018
Receivable for Securities		3,855
Investment Income Receivables	181,668	638,056
Uncollected Premiums	1,075,652	1,840,707
Amounts Recoverable From Reinsurers	451,167	
Amounts Due From Affiliates	9,853,044	
Health Care Receivables and Other Amounts Receivable	939,465	915,256
Aggregate Write-ins for Assets	<u>28,987</u>	
 Total Admitted Assets	 <u>\$ 24,282,090</u>	 <u>\$57,307,778</u>

\* The above amounts were determined by examination.

**COMPARATIVE BALANCE SHEET**  
**(continued)**

**December 31, 1998 and December 31, 2003**

**LIABILITIES, CAPITAL AND SURPLUS**

	<u>December 31,</u> 1998 *	<u>December 31,</u> 2003 *
Claims Unpaid	\$23,487,859	\$19,119,995
Aggregate Health Policy Reserves		2,619,907
Aggregate Health Claims Reserves		1,162,444
Premiums Received in Advance	1,217,752	911,654
General Expenses Due or Accrued		504,398
Federal Income Taxes Payable		1,292,784
Net Deferred Tax Liability		366,144
Amounts Withheld for the Account of Others		465
Amounts Due to Parents, Subsidiaries and Affiliates	1,912,158	53,042
Other Liabilities	214,408	1,029,397
Credit Balances Due Policyholders		608,106
Total Liabilities	<u>\$26,832,177</u>	<u>\$27,668,336</u>
 <u>Capital and Surplus:</u>		
Common Capital Stock	\$ 50	\$ 50
Preferred Capital Stock	50	50
Gross Paid in and Contributed Surplus	13,339,301	62,339,301
Surplus Notes	5,000,000	10,000,000
Unassigned Funds	<u>(20,889,488)</u>	<u>(42,699,959)</u>
Total Capital and Surplus	<u>(\$ 2,550,087)</u>	<u>\$ 29,639,442</u>
 Total Liabilities, Capital and Surplus	 <u>\$24,282,090</u>	 <u>\$ 57,307,778</u>

\* The above amounts were determined by examination.

NOTES TO FINANCIAL STATEMENTSNote 1 – Bonds

As of December 31, 2003, the market value of bonds exceeded the respective statement value by \$1,866,103.

Note 2 - Uncollected Premiums

The Company offsets net credit balances due policyholders against the net uncollected premium balances. The credit balances represent retroactive adjustments to premiums for changes in rates and membership that are not typically known at the time the Company bills a policyholder. If a policyholder pays an invoice as billed, and later the premium is adjusted for a reduction in membership, a credit balance results, which the Company must refund to the policyholder or apply to future premiums. Debits and credits for an individual policyholder may be offset, and the net balance reported as an asset (uncollected premiums) or as a liability (credit balances due policyholders). The right of offset as defined in SSAP No. 64 does not exist for debit and credit balances attributed to unrelated policyholders. The net credit balances should be reported separately as a liability. As such, net credit balances in the amount of \$608,106 have been reclassified to Aggregate Write-ins for Credit Balances Due Policyholders.

**RECOMMENDATION:**

No. 5

It is recommended that the Company report net credit balances due policyholders as an Aggregate Write-in for Other Liabilities entitled "Credit Balances Due Policyholders."

Note 3 - Claims Unpaid

As part of the examination process, the examination team relied upon historical loss data provided by the Company for the evaluation of the claims unpaid reserve. The team requested four detail listings of claims paid, one for each of four cells selected from the Company's 2003 commercial claims paid lag. Each cell represented all commercial claims paid in a specific month that were incurred in a specific month. The four cells selected were:

<u>Listing</u>	<u>Amount Paid</u>	<u>Month Incurred</u>	<u>Paid Month</u>	<u>Lag</u>
#1	\$5,936,001	11/03	12/03	CO Commercial
#2	\$2,301,937	9/03	9/03	CO Commercial
#3	\$490,348	4/03	7/03	CO Commercial
#4	\$66,558	1/03	6/03	CO Commercial

One of the claims selected for review was included in listing #2, claims incurred and paid in September 2003. However, this particular claim was actually incurred in August 2003 and improperly included in the listing of claims incurred in September 2003. The Company represents that the system, in some instances, uses a field called "Date of Loss" in constructing its lags instead of the date the claim was actually incurred. The "Date of Loss" is the date the Company becomes at risk for the claim. For example, when certain products have annual deductibles, the Company is not at risk (not liable) for a claim until the deductible is met. This methodology has an effect on the construction of the Company's lags used in the determination of the claims unpaid reserve, and could impact the reserve established. While the claims unpaid reserve was evaluated for overall reasonableness, and the amount of the reserve has been accepted for purposes of this examination, the methodology used in constructing the Company's claim lags should be revised to ensure accuracy of the underlying data used to calculate the reserve.

RECOMMENDATION:

No. 6

It is recommended that the Company modify its procedures used in developing the claims lags used to determine the claims unpaid reserve, so that the date the claim was incurred is consistently used in constructing the lags instead of the date of loss.

Note 4 - Gross Paid In and Contributed Surplus

On August 9, 2001, the Company's parent, "United HealthCare Services, Inc.," contributed additional capital in the amount of \$3,000,000. Management fees were forgiven in lieu of a cash contribution. The Company reported this contribution as a reduction in management fee expense instead of a capital contribution. Thus, the benefit of this contribution was incorrectly realized through operations instead of a direct credit to surplus. SSAP No. 72(7) requires that the forgiveness of obligations to a parent must be treated as contributed surplus. Therefore, \$3,000,000 has been reclassified from Unassigned Funds to Gross Paid in and Contributed Surplus.

RECOMMENDATION:

No. 7

It is recommended that the Company implement procedures to ensure that capital contributions made through the forgiveness of debt be reported in accordance with SSAP No. 72(7).

Note 5 - Capital and Surplus

Pursuant to Section 10-16-411, C.R.S., the Company is required to maintain a minimum surplus level of at least \$1,000,000, or an amount equivalent to the risk-based capital (RBC) requirements set forth in "Colorado Insurance Regulation 3-1-11. As of December 31, 2003, the Company's adjusted capital of \$29,639,442 exceeded the "Company Action Level" RBC by \$15,069,694.

SUMMARY

The results of this examination determined that as of December 31, 2003, the Company had admitted assets of \$57,307,778, liabilities of \$27,668,336 and surplus of \$29,639,442. As a result of this examination, surplus was not changed.

RECOMMENDATIONS

Recommendations made as a result of this examination are listed below:

Issue	Rec. No.	Page No.	Recommendation
<u>Plan of Operation</u>  It is noted that the company does not always have written agreements with its producers. For some markets it publishes and pays in accordance with a commission schedule, and for other markets the commission is negotiated, without a formal written agreement	1	14	It recommended that the Company implement procedures to ensure that it executes written agreements with all producers.
The last examination report noted that the Company had developed procedures to determine a provider's (intermediary's) ability to assume financial risk through capitation arrangements and to determine if the provider/intermediary understands these arrangements. However, these procedures did not fully comply with the requirements of Colorado Insurance Regulation 4-7-1(12)(E). Currently, with the exception of procedures to credential practitioners, the Company does not have comprehensive procedures to address the requirements of Colorado Insurance Regulation 4-7-1(12)(E). Although, these providers/intermediaries are affiliates, procedures should nevertheless exist and be implemented to help ensure that quality healthcare is provided.	2	15	It is again recommended that the Company expand its review of intermediaries and providers to include all requirements set forth in Colorado Insurance Regulation 4-7-1(12)(E).

Issue	Rec. No.	Page No.	Recommendation
<p><u>Reinsurance</u></p> <p>The contract covering Medicaid business resulted in the transfer of risk. However, it did not fully comply with Section 10-3-118, C.R.S. and Colorado Insurance Regulation 3-3-2. A summary sheet describing the contract and its compliance with Section 10-3-118, C.R.S., and Colorado Insurance Regulation 3-3-2 was not filed within 30 days of its execution. The contract was executed on October 17, 2001, and the summary sheet was not filed with the Colorado Division of Insurance until April 2002. The insolvency clause did not state that payment would be made without diminution, due to the Company's insolvency, as required by Section 10-3-118(3)(b), C.R.S., and the contract did not provide for a 90 day advance notice to the Commissioner of Insurance, in the event of termination for any reason, as required by Colorado Insurance Regulation 3-3-2(VII)(A)(4).</p>	3	17	It is recommended that the Company implement procedures to ensure that reinsurance agreements comply with the requirements of Section 10-3-118, C.R.S. and Colorado Insurance Regulation 3-3-2.
<p><u>Accounts and Records</u></p> <p>The Company automatically closes claims that are missing certain information. It forwards a letter to the provider and the patient requesting the missing information. Upon receipt of the missing information, the Company assigns the date the new information was received as the new received date for the claim. This new received date becomes the received date for reporting purposes. The Company's UNET system (UNET) retains the original received date, and uses it in the adjudication process, but the new received date is used in all reports generated by the UNET system. As such, the examination team was unable to test for compliance with Colorado's prompt pay laws using reports generated by the UNET system, on any claim for which additional information was requested.</p>	4	18	It is recommended that the Company modify its claims reporting system (UNET) so that the original received date can be included in all reports generated by the UNET system.

Issue	Rec. No.	Page No.	Recommendation
<p><u>Note 2 - Uncollected Premiums</u></p> <p>The Company offsets net credit balances due policyholders against the net uncollected premium balances. The credit balances represent retroactive adjustments to premiums for changes in rates and membership that are not typically known at the time the Company bills a policyholder. If a policyholder pays an invoice as billed, and later the premium is adjusted for a reduction in membership, a credit balance results, which the Company must refund to the policyholder or apply to future premiums. Debits and credits for an individual policyholder may be offset, and the net balance reported as an asset (uncollected premiums) or as a liability (credit balances due policyholders). The right of offset as defined in SSAP No. 64 does not exist for debit and credit balances attributed to unrelated policyholders. The net credit balances should be reported separately as a liability. As such, net credit balances in the amount of \$608,106 have been reclassified to Aggregate Write-ins for Credit Balances Due Policyholders.</p>	<p>5</p>	<p>28</p>	<p>It is recommended that the Company report net credit balances due policyholders as an Aggregate Write-in for Other Liabilities entitled "Credit Balances Due Policyholders."</p>

Issue	Rec. No.	Page No.	Recommendation
<p><u>Note 3 - Claims Unpaid</u></p> <p>One of the claims selected for review was reported as incurred and paid in September 2003. However, this particular claim was actually incurred in August 2003 and improperly included in the listing of claims incurred in September 2003. The Company represents that the system, in some instances, uses a field called "Date of Loss" in constructing its lags instead of the date the claim was actually incurred. The "Date of Loss" is the date the Company becomes at risk for the claim. For example, when certain products have annual deductibles, the Company is not at risk (not liable) for a claim until the deductible is met. This methodology has an effect on the construction of the Company's lags used in the determination of the claims unpaid reserve, and could impact the reserve established. While the claims unpaid reserve was evaluated for overall reasonableness, and the amount of the reserve has been accepted for purposes of this examination, the methodology used in constructing the Company's claim lags should be revised to ensure accuracy of the underlying data used to calculate the reserve.</p>	<p>6</p>	<p>28</p>	<p>It is recommended that the Company modify its procedures used in developing the claims lags used to determine the claims unpaid reserve, so that the date the claim was incurred is consistently used in constructing the lags instead of the date of loss.</p>

Issue	Rec. No.	Page No.	Recommendation
<p><u>Note 4 - Gross Paid In and Contributed Surplus</u></p> <p>On August 9, 2001, the Company’s parent, “United HealthCare Services, Inc.,” contributed additional capital in the amount of \$3,000,000. Management fees were forgiven in lieu of a cash contribution. The Company reported this contribution as a reduction in management fee expense instead of a capital contribution. Thus, the benefit of this contribution was incorrectly realized through operations instead of a direct credit to surplus. SSAP No. 72(7) requires that the forgiveness of obligations to a parent must be treated as contributed surplus. Therefore, \$3,000,000 has been reclassified from Unassigned Funds to Gross Paid in and Contributed Surplus.</p>	7	29	<p>It is recommended that the Company implement procedures to ensure that capital contributions made through the forgiveness of debt be reported in accordance with SSAP No. 72(7).</p>

CONCLUSION

The courtesy, assistance and cooperation extended by the officers and employees of the Company during the course of this examination are hereby acknowledged.

David P. Rudine, Actuary for the Colorado Division of Insurance, conducted the actuarial phase of the examination. Philip Gates, EDP Auditor, conducted the electronic data processing phase of the examination.

In addition to the undersigned, Julie A. Hansen, Examiner for the Colorado Division of Insurance, participated in the examination.

Respectfully submitted,

---

Douglas Befort  
Examiner In Charge  
Division of Insurance  
State of Colorado