

**REPORT OF EXAMINATION**

**OF**

**UNITED HEALTHCARE OF  
ALABAMA, INC.**

**AS OF**

**DECEMBER 31, 2007**

## TABLE OF CONTENTS

SCOPE OF EXAMINATION.....	2
ORGANIZATION AND HISTORY.....	2
MANAGEMENT AND CONTROL.....	4
<i>Stockholders</i> .....	4
<i>Officers</i> .....	5
<i>Conflict of Interest</i> .....	5
CORPORATE RECORDS.....	6
HOLDING COMPANY AND AFFILIATE MATTERS.....	6
<i>Holding Company Registration</i> .....	6
<i>Organizational Chart</i> .....	6
<i>Transactions and Agreements with Affiliates</i> .....	12
Management Agreement.....	12
Premium Allocation Agreement.....	13
Tax Sharing Agreement.....	14
Subordinated Revolving Credit Agreement.....	14
Agreement for the Provision of Services.....	15
Transplant Services Agreement.....	15
OPTUM Services Agreement.....	16
Vision Care Services Agreement.....	16
ACN Group, Inc. ....	17
Pharmacy Benefit Agreements.....	17
<i>Dividends to Stockholder</i> .....	18
FIDELITY BOND AND OTHER INSURANCE.....	18
EMPLOYEE AND AGENT'S WELFARE.....	18
SPECIAL DEPOSITS.....	18
FINANCIAL CONDITION/GROWTH OF THE COMPANY.....	19
MARKET CONDUCT ACTIVITIES.....	19
<i>Territory</i> .....	20
<i>Plan of Operation</i> .....	20
<i>Policy Forms and Underwriting Practices</i> .....	22
<i>Advertising and Marketing</i> .....	22
Compliance with Agents' Licensing Requirements.....	23
Terminated Agents.....	23
Rate Filings.....	23
REINSURANCE.....	23
ACCOUNTS AND RECORDS.....	25
COMPLIANCE WITH ALA. ADMIN. CODE 482-1-122.....	27
FINANCIAL STATEMENTS.....	28
NOTES TO FINANCIAL STATEMENTS.....	32

<b>CONTINGENT LIABILITIES AND PENDING LITIGATION .....</b>	<b>32</b>
<b>SUBSEQUENT EVENTS .....</b>	<b>32</b>
<b>COMPLIANCE WITH PREVIOUS RECOMMENDATIONS .....</b>	<b>32</b>
<b>COMMENTS AND RECOMMENDATIONS.....</b>	<b>33</b>
<b>CONCLUSION .....</b>	<b>35</b>

STATE OF MINNESOTA  
COUNTY OF HENNEPIN

Norlyn D. Baker, being first duly sworn, upon his oath deposes and says:

THAT he is an examiner appointed by the Commissioner of Insurance for the State of Alabama;

THAT an examination was made of the affairs and financial condition of UNITED HEALTHCARE OF ALABAMA, INC., for the period from January 1, 2005 through December 31, 2007;

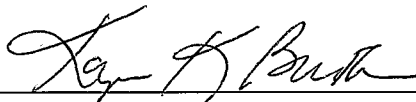
THAT the following 36 pages constitute the report to the Commissioner of Insurance of the State of Alabama; and

THAT the statements, exhibits and data therein contained are true and correct to the best of his knowledge and belief.



Norlyn D. Baker, CFE, CPA  
(Examiner-In-Charge)

Subscribed and sworn to before the undersigned authority this 24th day of March 2009.



(Signature of Notary Public)

KATHRYN K BARTH

\_\_\_\_\_, Notary Public  
(Print Name of Notary Public)





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GOVERNOR

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JIMMY W. GUNN

April 27, 2009

Honorable Jim R. Ridling  
Commissioner of Insurance  
State of Alabama, Department of Insurance  
201 Monroe Street, Suite 1700  
Montgomery, Alabama 36104

Dear Commissioner:

Pursuant to your instructions and in compliance with the statutory requirements of the State of Alabama and the resolutions of the National Association of Insurance Commissioners, an examination as of December 31, 2007 has been made of the affairs, financial condition, and market conduct of **United HealthCare of Alabama, Inc.** at its executive branch office located at 5901 Lincoln Drive, Edina, Minnesota 55436. The report of examination is submitted herewith.

Where the description "HMO" appears herein, without qualification, it will be understood to indicate United HealthCare of Alabama, Inc.

## **SCOPE OF EXAMINATION**

The HMO was last examined for the three-year period ended December 31, 2004. The current examination covers the three-year period from January 1, 2005 through December 31, 2007 and was conducted by examiners representing the State of Alabama, Department of Insurance. Where deemed appropriate, transactions subsequent to December 31, 2007 were reviewed.

The HMO was examined in accordance with the statutory requirements of the Alabama Insurance Code and the regulations and bulletins of the Alabama Department of Insurance; in accordance with the applicable guidelines and procedures promulgated by the National Association of Insurance Commissioners (NAIC); and in accordance with generally accepted examination standards.

The discussion of assets and liabilities contained in this report has been confined to those items which indicated a violation of the Alabama Insurance Code, the Insurance Department's rules and regulations, or which were deemed to require comments and/or recommendations.

A signed certificate of representation was obtained during the course of the examination. In this certificate, management attests to have valid title to all assets and to the nonexistence of unrecorded liabilities as of December 31, 2007. A signed letter of representation was also obtained at the conclusion of the examination whereby management represented that, through the date of this examination report, complete disclosure was made to the examiners regarding asset and liability valuation, financial position of the HMO, and contingent liabilities.

Due to the limitations imposed as a result of the Regulatory Settlement Agreement, the scope of the market conduct was limited to exclude the areas of review under that agreement. The market conduct portion of the examination consisted of a review of the HMO's territory, plan of operation, policy forms, rates and underwriting practices, advertising and marketing, treatment of policyholders, and compliance with agents' licensing requirements. See the Market Conduct Activities section for additional details.

## **ORGANIZATION AND HISTORY**

The information contained in this section of the examination report was excerpted from prior examination reports and updated as appropriate.

The HMO was founded in April 1985, as a joint venture between the Medical Advancement Foundation, an affiliate of the University of Alabama Health Sciences Foundation, and certain individual businessmen. Under the laws of the State of Alabama, the HMO was incorporated on July 16, 1985, as "Complete Health, Inc.," a for-profit health maintenance organization (HMO).

On November 15, 1989, with the approval of the Alabama Department of Insurance, the shareholders of the HMO transferred their stock to United HealthCare South, Inc. (formerly known as Complete Health Services, Inc.), thereby making the HMO a wholly-owned subsidiary of United HealthCare South, Inc. (UHC-South).

A change in the ultimate control of the HMO occurred in May of 1994, when UHC-South, the parent, merged with United HealthCare Corporation (UHC Corp). On April 30, 1996, United HealthCare Services, Inc. (UHS), an HMO management corporation and a wholly-owned subsidiary of UHC Corp, purchased UHC-South for its net book value from UHC Corp. UHS became the sole shareholder of UHC-South.

Effective May 1, 1996, the name of the HMO was changed from "Complete Health, Inc." to the current "United HealthCare of Alabama, Inc." Also on that date, the HMO's wholly-owned subsidiary, Complete Health of Alabama, Inc., changed its name to "United HealthCare of Alabama-FQ, Inc." (UHC AL-FQ).

On January 2, 1998, UHC-South merged into UHS, whereby UHS became the sole shareholder of the HMO.

On December 31, 1998, UHC AL-FQ merged into the HMO, with the HMO being the surviving entity. Since the HMO and UHC AL-FQ were under common control, the transaction was accounted for as a "pooling of interest.

As of June 30, 2000, UHS contributed its common stock of the HMO to UnitedHealthcare, Inc.

On May 9, 2005, the Alabama Insurance Commissioner granted approval to the HMO to have its executive and principal operations offices and its usual operations records in the State of Minnesota, so that general administration of the HMO's affairs may be combined with that of an affiliated insurer or insurers.

At December 31, 2007, the HMO's Annual Statement reflected issued capital stock totaling \$121,978, which consisted of 927,074 shares, outstanding 912,074 shares, of common stock of \$.11 par value and 2,000,000 shares of \$.01 par value preferred stock. In addition to the capital stock, the HMO reported \$17,561,870 of gross paid in and contributed surplus, \$65,820,021 of unassigned funds (surplus) and \$(56,250) of treasury stock.

## **MANAGEMENT AND CONTROL**

### ***Stockholders***

The HMO's Articles of Incorporation authorized the HMO to issue 927,074 shares of common stock at a par value of \$0.11 per share and 2,000,000 shares of preferred stock at a par value of \$0.01 per share. As of December 31, 2007, 927,074 shares of common stock and 2,000,000 shares of preferred stock were issued to the HMO's sole shareholder, United Healthcare, Inc.

### ***Board of Directors***

The By-Laws of the HMO provided that the business and affairs of the HMO shall be managed by the Board of Directors which number shall not be less than five nor more than seventeen.

On March 30, 2007, directors were elected in a written action in lieu of the annual meeting of the sole shareholder and were serving as of December 31, 2007. Director Ohman was elected by written action on July 20, 2007 after the resignation of Amy K. Knapp.

#### **Name/Residence**

Glen John Golemi  
Metairie, Louisiana

Thomas David Lewis  
Tampa, Florida

Forrest Gregory Burke  
Delano, Minnesota

Robert John Sheehy  
Edina, Minnesota

#### **Principal Affiliation**

Chief Executive Officer-Gulf States  
UnitedHealthcare, Inc.

Health Plan-CEO  
UnitedHealthcare, Inc.

Business Segment General Counsel  
UnitedHealth Group, Incorporated

Senior Vice President  
UnitedHealth Group, Incorporated

Daniel Laurence Ohman  
Edina, Minnesota

Regional CEO-Southeast Region  
UnitedHealthcare, Inc.

***Officers***

Officers elected by a written action in lieu of an annual meeting of the Board of Directors dated March 30, 2007 and serving at December 31, 2007, were as follows:

Officers

Title

Glen John Golemi

Chairman, President and  
Chief Executive Officer

Robert Worth Oberrender

Treasurer

Forrest Gregory Burke

Secretary

Timothy Gilbert Caron

Assistant Secretary

Juanita Bolland Luis

Assistant Secretary

Mary Lynn Stanislav

Assistant Secretary

John William Kelley

Vice President, Tax Services

Larry Brown Amacker, M.D.

Senior Medical Director

Donald Allan Powers

Vice President-Finance & Assistant  
Treasurer

***Committees***

As of December 31, 2007, the HMO's Board of Directors had not established any committees.

***Conflict of Interest***

The HMO has an established procedure for the disclosure of any outside interests, memberships, associations and/or affiliations an individual may have as a director, officer and/or key management personnel. The Conflict of Interest Policy was established in the By-Laws.

Annually completed questionnaires are reviewed and approved by the Board of Directors. A review of the statements signed during the examination period did not disclose any conflicts. It was noted that all of the directors and officers served as an officer and/or director of various entities affiliated with the HMO's parent, UnitedHealthcare, Inc.

## **CORPORATE RECORDS**

The HMO's Articles of Incorporation and By-Laws were inspected and found to provide for the operation of the HMO in accordance with usual corporate practices.

Records of the meetings and actions of the Stockholder, Board of Directors, since December 31, 2004 were reviewed.

There were no changes to the HMO's Articles of Incorporation or By-Laws during the three-year examination period.

## **HOLDING COMPANY AND AFFILIATE MATTERS**

### ***Holding Company Registration***

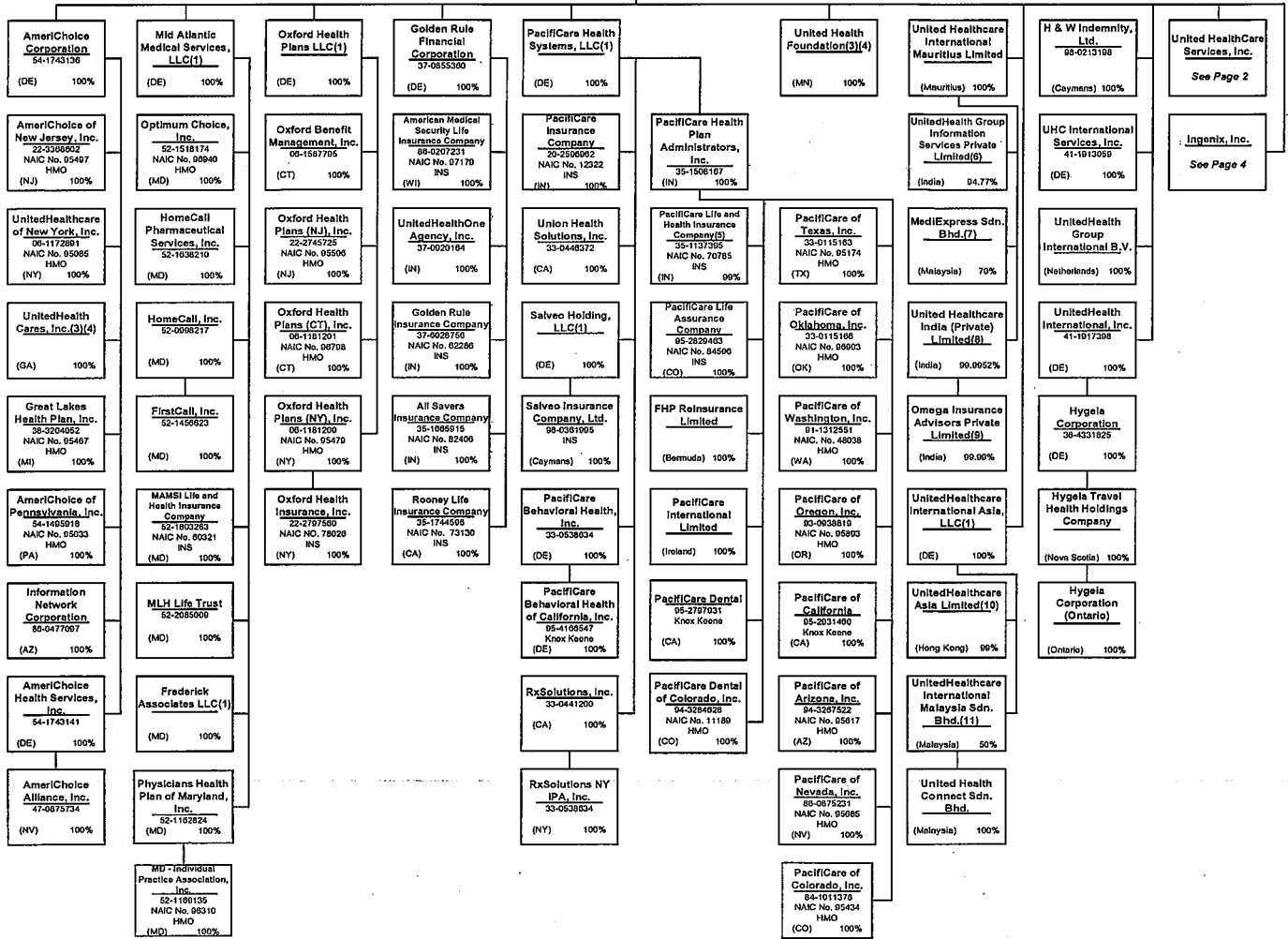
The HMO is not subject to the Alabama Insurance Holding Company Regulatory Act, as defined in ALA. CODE §27-29-1 (1975), except as expressly required by other statutes and regulations. Generally, health maintenance organizations are subject to regulation in regard to changes in control, but are not subject to the registration and continuing holding company reporting requirements that apply to insurance companies.

The HMO is a wholly owned subsidiary of UnitedHealthcare, Inc., a Delaware holding company. The HMO is also an indirect wholly owned subsidiary of UHS, a Minnesota healthcare management company that is wholly owned by UnitedHealth Group Incorporated, a publicly traded (NYSE: UNH) Minnesota holding company.

### ***Organizational Chart***

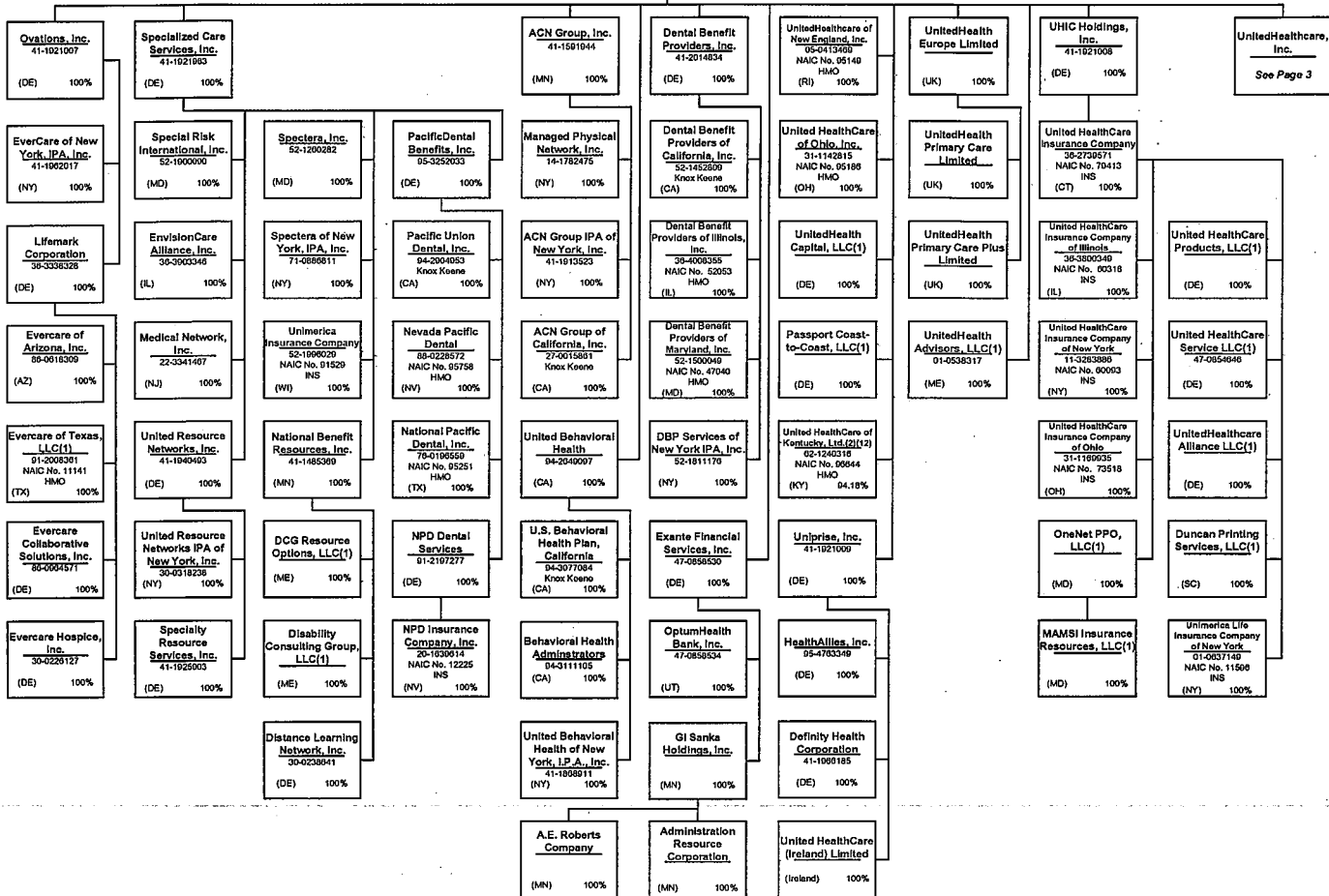
The following chart presents the identities of and inter-relationships among all affiliated persons within the Insurance Holding Company System at December 31, 2007.

**UnitedHealth Group Incorporated**  
MN 41-1321030



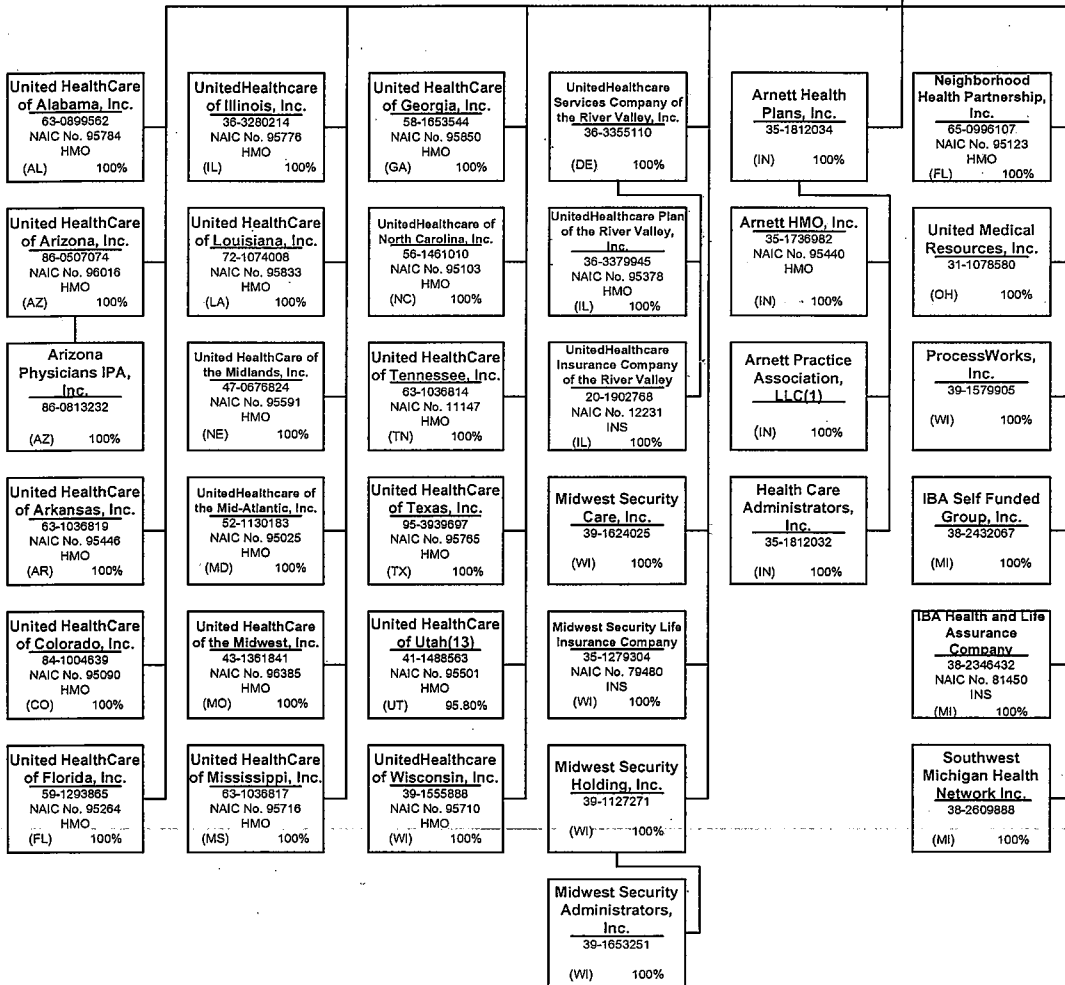
**United HealthCare Services, Inc.**

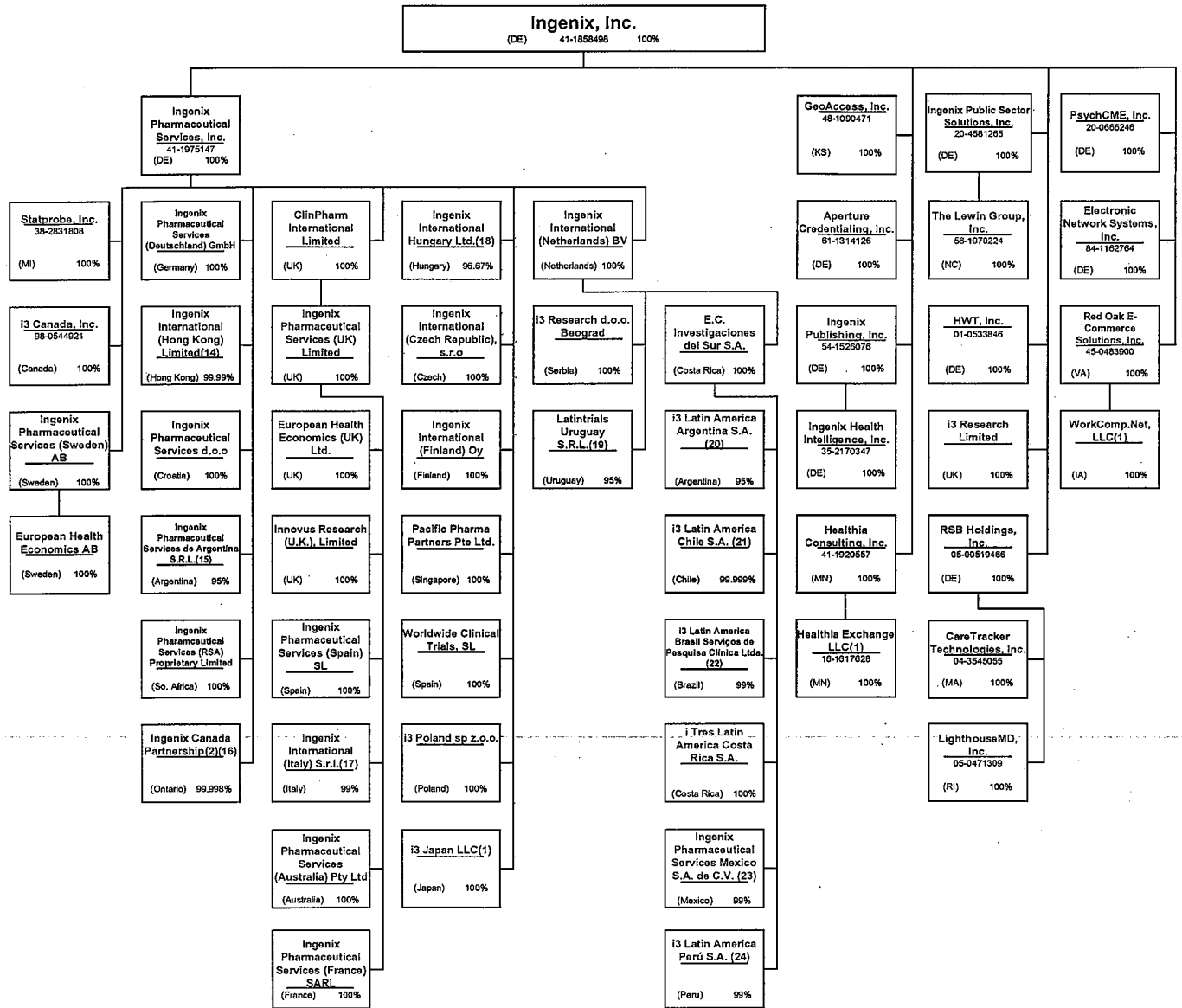
(MN) 41-1280245 100%



**UnitedHealthcare, Inc.**

(DE) 41-1922511 100%





## Notes

All legal entities on the Organization Chart are Corporations unless otherwise indicated.

- (1) Entity is a Limited Liability Company
- (2) Entity is a Partnership
- (3) Entity is a Non-Profit Corporation
- (4) Control of the Foundation is based on sole membership, not the ownership of voting securities
- (5) PacifiCare Life and Health Insurance Company is 99% owned by PacifiCare Health Plan Administrators, Inc. and 1% owned by PacifiCare Health Systems, LLC
- (6) UnitedHealth Group Information Services Private Limited is 94.77% owned by United Healthcare International Mauritius Limited and 5.15% owned by United HealthCare Services, Inc.. The remaining 0.09% is owned by UnitedHealth International, Inc.
- (7) MediExpress Sdn. Bhd. is 70% owned United Healthcare International Mauritius Limited and 30% owned by individual nominee shareholders from whom United has powers of attorney
- (8) United Healthcare India (Private) Limited is 99.9952% owned by United Healthcare International Mauritius Limited and 0.0048% owned by UnitedHealth International, Inc.
- (9) Omega Insurance Advisors Private Limited is 99.99% owned by United Healthcare India (Private) Limited and 0.01% owned by Sudesh S. Shetty
- (10) UnitedHealthcare Asia Limited is 99% owned by UnitedHealthcare International Asia, LLC and 1% owned by UnitedHealth International, Inc.
- (11) UnitedHealthcare International Malaysia Sdn. Bhd. is 50% owned by UnitedHealthcare International Asia, LLC and 50% owned by UnitedHealthcare Asia Limited
- (12) General partnership interests are held by United HealthCare Services, Inc. (89.77%) and by UnitedHealthcare, Inc. (10.23%). United HealthCare Services, Inc. also holds 100% of the limited partnership interests. When combining general and limited partner interests, United HealthCare Services, Inc. owns 94.18% and UnitedHealthcare, Inc. owns 5.83%
- (13) United HealthCare of Utah is 95.80% owned by UnitedHealthcare, Inc. and 4.20% owned by 34 physicians / physician groups
- (14) Ingenix International (Hong Kong) Limited is 99.99% owned by Ingenix Pharmaceutical Services, Inc. and 0.01% owned by Ingenix, Inc.
- (15) Ingenix Pharmaceutical Services de Argentina S.R.L. is 95% owned by Ingenix Pharmaceutical Services, Inc. and 5% owned by Ingenix, Inc.
- (16) Ingenix Canada Partnership is 99.998% owned by Ingenix Pharmaceutical Services, Inc. and 0.002% owned by Ingenix, Inc.
- (17) Ingenix International (Italy) S.r.l. is 99% owned by Ingenix Pharmaceutical Services (UK) Limited and 1% owned by ClinPharm International Limited
- (18) Ingenix International Hungary Ltd. is 96.67% owned by Ingenix Pharmaceutical Services, Inc. and 3.33% owned by Ingenix, Inc.
- (19) LatIntrials Uruguay S.R.L. is 95% owned by Ingenix International (Netherlands) BV and 5% owned by Ingenix Pharmaceutical Services, Inc.
- (20) i3 Latin America Argentina S.A. is 95% owned by E.C. Investigaciones del Sur S.A. and 5% owned by i Tres Latin America Costa Rica S.A.

(21) i3 Latin America Chile S.A. is 99.999% owned by E.C. Investigaciones del Sur S.A. and 0.001% owned by i Tres Latin America Costa Rica S.A.

(22) i3 Latin America Brasil Serviços de Pesquisa Clínica Ltda. is 99% owned by E.C. Investigaciones del Sur S.A. and 1% owned by i Tres Latin America Costa Rica S.A.

(23) Ingenix Pharmaceutical Services Mexico S.A. de C.V. is 99% owned by E.C. Investigaciones del Sur S.A. and 1% owned by i3 Latin America Argentina S.A.

(24) i3 Latin America Perú S.A. is 99% owned by E.C. Investigaciones del Sur S.A. and 1% owned by i3 Latin America Argentina S.A.

## *Transactions and Agreements with Affiliates*

### Management Agreement

The HMO had no employees during the period under examination. The amended and restated management agreement was entered into as of December 31, 1999 by and between the HMO and UHS, a Minnesota corporation. Under the terms of the agreement, UHS will provide management, financial and administrative services as necessary for the day to day operations of the HMO. The services included, but were not limited to:

- computerized management information systems;
- development and implementation of standardized contracts concerning the HMO's subscribers and providers;
- preparation and filing of required applications and records;
- general and administrative and financial services;
- placement and maintenance of insurance with respect to HMO's operations;
- underwriting services;
- internal audit services;
- marketing, sales, and provider relations;
- recruitment, compensation and supervision of all on-site personnel;
- retention of adequate office space, furniture and equipment;
- maintenance of appropriate books and records with respect to its activities, whereby all documentation is available for review by HMO representatives and the Alabama Insurance Department; and
- the establishment of a payment process.

The HMO was responsible for the costs associated with:

- payment of all debts and obligations of the HMO;
- retention and compensation of independent auditors;
- payment of all fees and costs directly and indirectly related to the delivery of health care services and supplies to enrollees;
- establishment and maintenance of appropriate financial reserves, capital requirements and payments relating to deposits, annual fees and licensing fees;
- payments relating to premium, income, sales, or any other form of taxes;

- payments made to independent broker, consultant or agent in regard to sales of the HMO's products, programs or to other independent consultant or advisors;
- premium for policies of insurance with respect to the HMO's operations;
- bad debt expenses; and
- activities and expenses related to the Board of Directors and Committees of the HMO.

As compensation for these services, the HMO is to pay a monthly management fee based on:

1. a specific dollar amount multiplied by the number of persons covered by the HMO's commercial managed care programs for that month, including individuals and their dependents whose employers or groups offered a self funded health care coverage program utilizing the HMO's provider network, and
2. a specific dollar amount multiplied by the number of persons covered by the HMO's Medicare managed programs for that month.

For these services, the HMO paid \$29,729,000 for 2006 and \$28,721,000 for 2007.

The termination of this agreement may be made by any party upon 180 days written notice and prior notification to the Alabama Insurance Commissioner, as required by ALA. CODE §27-21A-4 (1975) and Section 13 of the Alabama Department of Insurance Regulation Number 79.

This agreement and amendments were approved by the Alabama Insurance Commissioner. An amendment, approved on April 6, 2006, increased the price of HMO's Medicare managed programs.

#### Premium Allocation Agreement

Effective January 1, 1998, UHS on behalf of itself and its HMO subsidiaries, entered into a premium allocation agreement with United HealthCare Insurance Company (UHIC). Under the terms of this agreement UHIC may receive premiums for insurance coverage marketed and issued in conjunction with products marketed and issued by the HMOs. The consideration was to be 1) fair and reasonable; 2) determined according to annual actuarial reviews; 3) allocated in conformity with customary insurance accounting practices

consistently applied. In 2001, the HMO filed this contract with the Alabama Insurance Commissioner who replied that as the HMO was not a direct contractor under this contract, no specific approval was required.

For the years 2007, and 2006, the HMO paid UHIC \$29,000 and \$35,000, respectively.

#### Tax Sharing Agreement

On June 28, 1994 and effective June 1, 1994 and as amended October 1, 1996, the HMO, under its previous corporate name of Complete Health Inc., entered into a tax sharing agreement with United HealthCare Corporation (UHC), the HMO's ultimate parent. Under the terms of the agreement, a consolidated federal income tax return shall be filed by UHC for each taxable year. The agreement provides that the consolidated tax liability of the affiliated companies for any taxable year, if any, shall be allocated by applying the effective rate of the consolidated return to each company's income not to exceed the stand alone tax liability of the subsidiary.

The approval of this agreement was not required because a July 6, 2001 letter from the Commissioner of Insurance stated in part that: "...The following agreements are not directly between United HealthCare of Alabama, Inc. and its affiliates. Therefore, my approval is not required..."

#### Subordinated Revolving Credit Agreement

Effective December 1, 1999, the HMO entered into a subordinated revolving credit agreement with United Healthcare Corporation (now known as UnitedHealth Group Incorporated). Under the terms of the agreement, the HMO is able to borrow money on a short term basis and establish a revolving line of credit. The HMO is able to borrow up to \$10 million. Interest shall be at the LIBOR rate in effect on the last business day of the calendar month prior to the calendar month for which the interest is calculated plus fifty basis points.

The terms of the agreement were to December 31, 2002, with automatic annual renewals for additional one year terms. Termination may be made by either party giving sixty days prior written notice.

No amounts were outstanding at December 31, 2007 and 2006. The HMO paid interest of approximately \$11,000 and \$23,000 in 2007 and 2006,

respectively.

The Agreement was approved by the Alabama Insurance Commissioner on May 18, 2004.

#### Agreement for the Provision of Services

The HMO, then known as Complete Health, Inc. entered into a contract with United Behavioral Health, Inc., (UBH) effective January 1, 1996. Under the terms of the agreement, UBH was to provide and/or arrange for the provision of certain mental health and substance abuse services to members of the HMO. The contract was for three years and renews automatically for additional one year terms, unless terminated by either party providing written notice 60 days prior to the termination.

The agreement is an exclusive agreement regarding the rights, responsibilities, and other conditions for the provision and payment of Mental Health and/or Substance Abuse (MHSA) Services and/or Utilization Management (UM) Services. The responsibilities of UBH shall be limited as defined by the terms of this agreement.

- UBH is responsible for arranging for a Provider network to provide mental services to covered persons.
- UBH shall assure that 90% of all covered persons who reside within the service area are within 30 miles or 30 minutes of a Provider.
- UBH shall provide to all covered persons a 24-hour toll-free telephone number for referral for required services, crisis intervention, and responding to inquiries regarding available services.

Fees under this agreement are calculated on a per member per month basis.

During 2007 and 2006, the HMO paid approximately \$2,863,000 and \$2,767,000 respectively.

The agreement and all amendments were approved by the Alabama Insurance Commissioner. Two amendments to the agreement were made in the examination period changing the rates for services provided.

#### Transplant Services Agreement

Effective May 14, 1998, the HMO and UHS, on behalf of its division, United

Resources Networks (URN), entered into a transplant agreement whereby UHS would arrange for access to Participating Providers for the provision of certain transplant services. The agreement stipulated that UHS provide certain other services to the HMO for a stated fee paid on a per member per month basis. The contract may be terminated after three years from the effective date by either party with 90 days written notice.

During the years 2007 and 2006, the HMO paid approximately \$38,000 and \$41,000 respectively.

The Alabama Insurance Commissioner approved the agreement and amendments thereto.

#### OPTUM Services Agreement

This agreement, effective November 1, 1999, was between OPTUM, a division of UHS, and United Healthcare, Inc., on behalf of the Plans that are affiliated with United Healthcare. Under the terms of the agreement OPTUM provides call-in services known as Care24, an immediate access to employee assistance program; Health and WellBeing; and NurseLine Services, a nurse line general health information service for enrollees. Fees are calculated on a per member per month basis.

An amendment effective January 1, 2005, added the HMO's commercial enrollees to the agreement.

The agreement can be terminated with ninety days written notice and automatically renews for additional one-year terms.

For the years 2007 and 2006, the HMO paid approximately \$196,000 and \$214,000, respectively.

#### Vision Care Services Agreement

UHS, on behalf of health plans that are owned and/or managed by UHS and its affiliates had a vision care services agreement with Spectera, Inc. (Spectera), then known as Coordinated Vision Care, Inc., a vision benefit management company. Under the terms of the agreement, Spectera is to manage and arrange participating providers to render vision care services and claims processing for enrollees. The HMO became a participating plan effective October 1, 2001. The terms of the agreement provide for automatic renewals

for one year terms unless terminated by either party upon 120 days prior written notice.

During 2007 and 2006, the HMO paid approximately \$2,000 and \$3,000 respectively.

The approval of this agreement was not required because a July 6, 2001 letter from the Commissioner of Insurance stated in part that: "...The following agreements are not directly between United HealthCare of Alabama, Inc. and its affiliates. Therefore, my approval is not required..."

#### ACN Group, Inc.

Effective September 1, 2002, the HMO became a participant in an agreement with ACN for chiropractic network access services and Complementary and Alternative Medicine network access services.

Termination provisions provide for automatic renewals for one year terms unless terminated by either party giving 180 days prior written notice.

Fees are calculated on a per member per month basis. For the years 2007 and 2006, the HMO paid approximately \$21,000 and \$28,000 respectively.

The approval of this agreement was not required because a July 6, 2001 letter from the Commissioner of Insurance stated in part that: "...The following agreements are not directly between United HealthCare of Alabama, Inc. and its affiliates. Therefore, my approval is not required..."

#### Pharmacy Benefit Agreements

Effective January 1, 2007, UHS and RxSolutions, Inc., d/b/a Prescription Solutions, entered into a pharmacy benefits management agreement for Medicare Part D plans. The agreement terminates December 31, 2008 and automatically renews for 12 month periods every January 1 or until mutually agreed upon in writing.

Fees are calculated on a per member per month basis plus a per Prescription Claim services fee and a per Prescription Claim for Medication Therapy services fee. Other administrative fees are due for other individual services on a per consultation or case basis. Additionally, UHS is due rebates for certain prescription drugs as specified in the agreement.

In 2007, the HMO paid \$468,000 for these services and received \$9,023,000 in rebates.

### ***Dividends to Stockholder***

The HMO paid the following dividends:

2005	\$28,300,000
2006	13,000,000
2007	<u>29,000,000</u>
Total	<u>\$70,300,000</u>

### **FIDELITY BOND AND OTHER INSURANCE**

The HMO was a named insured on a blanket crime policy issued by National Union Fire Insurance Company of Pittsburgh, Pennsylvania, to its ultimate parent, which met the minimum requirement of the National Association of Insurance Commissioners Financial Examiners Handbook. This bond covered the following: employee dishonesty, loss inside the premises, loss outside the premises, money orders and counterfeit paper currency, and depositors' forgery coverage.

In addition to the aforementioned fidelity bond, the HMO is also a named insured on coverages protecting the HMO's various interests against hazards to which it may be exposed.

### **EMPLOYEE AND AGENT'S WELFARE**

The HMO had no employee pension, retirement or insurance plans as it had no employees. All personnel are employees of UHS which provides services to the HMO under the terms of a management agreement.

### **SPECIAL DEPOSITS**

The State of Alabama held, as a statutory deposit, a \$100,000 par value, 6.750% interest rate, U.S. Treasury Note, with a maturity date of May 15, 2008. At December 31, 2007, this bond had a statement value of \$101,697 and a fair value of \$100,805.

## **FINANCIAL CONDITION/GROWTH OF THE COMPANY**

The following table shows admitted assets, liabilities, capital and surplus, and net premium income for the period under review taken from copies of filed annual statements.

	<u>2005</u>	<u>2006</u>	<u>2007</u>
Net Admitted Assets	\$81,135,078	\$159,724,456	\$148,455,088
Total Liabilities	45,563,310	106,550,495	65,007,469
Total Capital and Surplus	35,571,768	53,173,961	83,447,619
Net Premium Income	312,013,596	356,672,613	379,281,410

## **MARKET CONDUCT ACTIVITIES**

For most aspects of consumer relations, the HMO is regulated by the Alabama Department of Public Health (ADPH). During the examination period, ADPH did not conduct a claims audit on the HMO.

The HMO is a party to the UNITED HEALTHCARE, ET AL. REGULATORY SETTLEMENT AGREEMENT, effective August 27, 2007, between United Healthcare Insurance Company and 25 related parties (affiliated companies) and the commissioners and superintendent of the five lead states consisting of the Arkansas Department of Insurance, Connecticut Insurance Department, Florida Office of Insurance Regulation, Iowa Insurance Division and New York State Insurance Department and approximately 35 signatory state departments of insurance including the Alabama Department of Insurance. The term of the agreement is from the effective date to December 31, 2010.

Under the terms of the agreement, the affiliated companies are to implement a Process Improvement Plan for areas of review and retain an independent examiner to conduct compliance reviews and provide written reports on the results of the reviews to the lead states.

The multi-state areas of review include Claims, Coordination of Benefits, Appeals/Grievances/Complaints, Explanation of Benefits, Contracted Entities, Utilization Review, Operations/Management and Provider Network. The signatory regulators, according to the terms of the agreement, "will not engage in any investigation or examination of the UHC companies relating to the

issues subject to this Agreement.”

Accordingly, the areas of review under the agreement were not reviewed in this examination.

***Territory***

As of December 31, 2007, the HMO was licensed to transact business only in the State of Alabama. The certificate of authority was inspected and found to be in order.

The Alabama Department of Insurance and the Alabama Department of Public Health authorized the HMO to market products in the following Alabama counties:

Autauga	Conecuh	Henry	Monroe
Baldwin	Coosa	Houston	Perry
Barbour	Covington	Lauderdale	Pickens
Bibb	Crenshaw	Jackson	Pike
Blount	Cullman	Jefferson	Randolph
Bullock	Dale	Lawrence	Russell
Butler	Dallas	Lee	Shelby
Calhoun	Dekalb	Limestone	St. Clair
Chambers	Elmore	Lowndes	Talladega
Cherokee	Escambia	Macon	Tallapoosa
Chilton	Etowah	Madison	Tuscaloosa
Choctaw	Fayette	Marengo	Washington
Clarke	Franklin	Marshall	Wilcox
Cleburne	Geneva	Montgomery	Walker
Coffee	Greene	Morgan	Winston
Colbert	Hale	Mobile	

***Plan of Operation***

The HMO, a for-profit health maintenance organization (HMO), offered a variety of managed care programs and products through contractual arrangements with health care providers. The products offered included fully insured point-of-sale (POS) and basic health care services through an organized system which combines the delivery and financing of health care (HMO)

products. The HMO products included a closed access network of providers as well as an open access plan. The HMO's POS, or "plus", products featured closed access and open access models with out-of-network benefits. In addition, the HMO also offered a Medicare HMP product called "Medicare Complete" to seniors.

As of December 31, 2007, the HMO used various independent agents to market and sell its products. A listing of agents was obtained from the HMO and a comparison was made to the Alabama Department of Insurances agent's listing of all agents that were licensed by the Alabama Department of Insurance. The total number of agents the HMO employed or licensed at December 31, 2007 was 1,386. The agents were paid commissions as a percentage of premium on the policies they wrote.

The delivery of all professional services was rendered by providers that were under contract with the HMO and indirectly through administrative service providers. Members were generally required to use these providers in order for the HMO to pay the full benefit for claims submitted by the providers. However, the HMO also paid out-of-plan provider claims under certain circumstances, such as emergency care and for health care services from physicians and other providers outside the HMO's network under the point-of-service options.

The HMO's primary products were:

- Comprehensive (hospital and medical)
- Medicare Supplement
- Title XVIII – Medicare
- Medicare Part D offered under Medicare Advantage products

In order to provide the most comprehensive health care to its members, the HMO relied on a variety of delivery systems. Those delivery systems were designed to meet the customers' needs for preventive care and comprehensive health care. The total delivery system included:

- Hospitals
- Skilled nursing facilities
- Rehabilitation facilities
- Home health care
- Mental Health/Substance Abuse
- Pharmacy services

- Other ancillary services
- Primary care physicians
- Specialty physicians

### ***Policy Forms and Underwriting Practices***

The United HealthCare of Alabama, Inc., Underwriting Department was responsible for the development and implementation of underwriting and pricing policies. The underwriting manual outlined the different products available and the sales process for the different group sizes and products.

The HMO bases underwriting for a plan on various factors including the following:

- Any significant changes in enrollment in the plan
- The turnover rate of enrolled subscribers
- The age of each employee, or alternatively, aggregate age information categories of not more than five-year increments
- The gender of each employee. This may be compiled as aggregate information by category.
- The number of dependents, if available.
- Whether the employee is eligible for single or family coverage, and if three-tier, the number of dual coverage.
- Whether the employee elects single or family coverage, and if three-tier, the number of dual coverage.
- Rating considerations included health characteristics, size of group, location of group, age/gender, and family composition.

There have been no new small business HMO plans added since the beginning of 2002, and key 50+ accounts have added new HMO benefit plans which are mainly plan design modifications.

### ***Advertising and Marketing***

Marketing is done through brochures, and email letters. United Healthcare also markets its products to consumers through the use of brochures and flyers at enrollment meetings. In addition, United Healthcare uses broad consumer advertising mediums, such as print, radio and TV ads for brand recognition advertising. This advertising rarely includes specific product information and does not include specific local references to any United Healthcare plan.

### Compliance with Agents' Licensing Requirements

The examiners reviewed HMO practices on agent licensing to determine whether the agents, who sold the HMO policies, were properly licensed. A sample of producers, paid by the HMO during the years 2005, 2006 and 2007, was traced to the Alabama Department of Insurance Agents Licensing Division register of appointed agents without significant exceptions. All exceptions were adequately explained by the HMO.

In addition, a sample of producer files and commission payments were reviewed in conjunction with issued policies to ensure the selling agent was properly appointed prior to writing the business and to ascertain that the HMO only pays commissions to properly licensed and appointed agents and agencies. Based upon this review, there were no exceptions noted.

### Terminated Agents

The examiner requested from the HMO a listing of terminated agents for the years under review. A sample was selected and traced to supporting documentation with no exceptions noted. None of the files reviewed indicated the agent was terminated for cause.

A review of the HMO's policies and procedures indicated the HMO has a procedure in place for reporting to the Alabama Department of Insurance in those instances when an agent is terminated for cause.

### Rate Filings

The HMO's rates were filed with and approved by the Alabama Department of Insurance in accordance with ALA. ADMIN. CODE 482-1-079-.05(1987).

## **REINSURANCE**

The HMO did not assume or cede any reinsurance during the examination period.

Effective January 1, 2005, the HMO entered into an Insolvency Reinsurance Agreement with United Healthcare Insurance Company (reinsurer). Under the terms of this agreement, in the event of the HMO's insolvency, the reinsurer will provide payments directly to the HMO's liquidator, receiver or statutory

successor on the basis of liability under the policies of the HMO without diminution for the insolvency or failure to pay by the liquidator, receiver or statutory successor. Reinsurer will accept the HMO's obligations with respect to losses paid or payable for health care services rendered on or prior to insolvency of the HMO by providers that were not under contract to the HMO. In addition, members shall have their coverage continued for this period for which their premiums have been paid and benefits will be continued to members confined in an inpatient facility on the date of insolvency until their discharge or coverage under a health benefit plan by another carrier. The reinsurer will not be responsible for claims if notice of claim has not been received in writing within two years of the insolvency date.

The contract was approved by the Alabama Insurance Commissioner December 17, 2004.

Premiums paid under this agreement for 2007 and 2006 were approximately \$384,000 and \$350,000, respectively.

## ACCOUNTS AND RECORDS

The HMO's general accounting records consisted of an automated general ledger and various subsidiary ledgers. The record keeping functions are performed in Edina, Minnesota by UHS, the indirect parent of the HMO. Our review did not disclose any significant deficiencies in these records.

All systems, programs and data processing equipment are owned by United Healthcare Services, Inc. However, under the First Amendment to the Management Agreement, it states "that all data relating to the Plan...is owned by the Plan."

The HMO is required to provide examiners detailed records supporting the amounts and disclosures in the filed Annual Statements within ten business days in accordance with the ALA. ADMIN. CODE 482-1-118-.06(1999). During this examination, the HMO was asked to provide information supporting the amounts and disclosures in the filed Annual Statements through 75 formal requests. The required ten business day response time to provide the requested information was exceeded on 39 of the formal requests. Accordingly, the HMO is not in compliance with ALA. ADMIN. CODE 482-1-118-.06(1999). The following table demonstrates requests by category and time to respond.

<u>Examination Category</u>	Total	# Not Timely	Days to Respond
Financial	20	15	12 to 34
Information Technology	25	7	12 to 101
Market Conduct	7	5	12 to 36
Planning	9	6	13 to 98
Risk Assessment	6	1	39
Statutory Compliance	8	5	16 to 64
Total	75	39	

It should be noted that partial responses were received timely for some of the 39 items cited above and, in one instance, that of supplying the data file for

paid claims, an extension was granted to accommodate the HMO's request for additional time.

The HMO responses to risk assessment and remediation information for use in planning the examination weren't fully received for three months. As this information is a part of the planning process for determination of the procedures to be performed in the examination, the delay caused planning to be completed before the information was received resulting in additional procedures in the examination. Additionally, the information is considered proprietary and confidential by the HMO and certain documentation provided had to be reviewed and noted by examiners and the documents returned. This caused the examination process to take longer than had copies been provided. AL ADMIN. CODE 482-1-118.06(1999) states "The insurer shall provide, within ten (10) working days, any record or response requested in writing by any duly appointed, assistant employee or examiner of the Commissioner." In addition, Alabama Attorney General's Opinion 1980-198 requires copies of examination documentation to be provided upon request.

The HMO was requested to provide an interview with the Chair of the Audit Committee of UNH, the HMO's ultimate parent, for examination planning purposes as the HMO Board of Directors did not designate an Audit Committee. The HMO did not arrange access to the Audit Committee Chair on a timely basis. With no indication from the HMO that the interview would be scheduled after 90 days, the examination team, with appropriate authorization, had direct communication with the Chair and scheduled a date and time for an interview.

The HMO was notified of the direct contact and the scheduled interview.

Additionally, it should be noted that requests for data files for premiums to support the amounts shown in the HMO's annual statement were not provided timely and completely which required additional requests for supporting data and the claims data file, although the HMO was granted additional time to provide data by the examination, took longer than the usual amount of time to provide such data for an examination.

In addition, it was noted that the Service Provider Listing received from the HMO does not reflect the current services provided within the Description of Vendor Services Provided by the EDI Clearing Houses.

The HMO did not provide timely access to subject matter experts to explain the claims process, location of the claims processing centers and the testing of controls over claims in the SAS 70 audit of claims processing.

In Exhibit of Net Investment Income of the 2007 Annual Statement, derivative instrument income of \$1,871,773 was reported. However, the amount should have been reported on line 6 as interest income from cash, cash equivalents and short term investments.

### **COMPLIANCE WITH ALA. ADMIN. CODE 482-1-122**

Per the legal department at the Alabama Department of Insurance, health maintenance organizations are not required to comply with ALA. ADMIN. CODE 482-1-122(2002). They are, however, required to be in compliance with the federal privacy law.

The HMO did not share customers' personal information with any nonaffiliated third parties. Any information the HMO disclosed to any third parties was for the purpose of conducting day-to-day business functions such as the payment of claims.

Instructions were in place for employees to provide guidelines for the handling of personal information the HMO employees or affiliated parties might have to access.

The HMO did provide notices to its customers that indicated the types of information it collected, the way it was used and the manner of collection. The notices also informed the customers that the HMO did not disclose any information to any nonaffiliated third parties unless permitted to do so by law.

The HMO's disclosure of any health information was made only after authorization from its customers unless the disclosures were made under Code of ALA. ADMIN. CODE 482-1-122 (2001).

## **FINANCIAL STATEMENTS**

The financial statements included in this report were prepared on the basis of the HMO's records, and the valuations and determinations made during the examination for the year 2007. Amounts shown in the comparative statements for the years 2005 and 2006 were compiled from HMO copies of filed Annual Statements.

	Page
Statement of Assets, Liabilities, Surplus and Other Funds	30
Summary of Operations	31
Capital and Surplus Account	32

**THE NOTES TO THE FINANCIAL STATEMENTS ARE AN INTEGRAL PART THEREOF.**

**UNITED HEALTHCARE OF ALABAMA, INC.**  
**STATEMENT OF ASSETS, LIABILITIES, SURPLUS AND OTHER FUNDS**  
**FOR THE YEAR ENDED DECEMBER 31, 2007**

<b>ASSETS</b>	<u>Assets</u>	<b>Non-Admitted</b> <u>Assets</u>	<b>Net Admitted</b> <u>Assets</u>
Bonds	\$67,319,748		\$67,319,748
Cash and short-term investments	69,462,982		69,462,982
Receivable for securities	64,270		64,270
Investment income due and accrued	923,357		923,357
Uncollected premiums and agents' balances in course of collection	2,459,742		2,459,742
Current federal income tax recoverable	5,360,116		5,360,116
Net deferred tax asset	386,799		386,799
Health care and other amounts receivable	2,787,885	309,811	2,478,074
Prepaid expenses	<u>519,375</u>	<u>\$519,375</u>	<u>0</u>
Total assets	<u>\$149,284,274</u>	<u>\$829,186</u>	<u>\$148,455,088</u>
<b>LIABILITIES</b>	<u>Covered</u>	<u>Uncovered</u>	<u>Total</u>
Claims unpaid	\$45,001,354		\$45,001,354
Accrued medical incentive pool and bonus amounts	66,000		66,000
Unpaid claim adjustment expenses	927,508		927,508
Aggregate health policy reserves	2,717,908		2,717,908
Aggregate health claim reserves	1,546,790		1,546,790
Premiums received in advance	514,113		514,113
General expenses due and accrued	1,229,429		1,229,429
Amounts withheld or retained for the account of others	19,836		19,836
Amounts due to parents, subsidiaries and affiliates	5,535,627		5,535,627
Liabilities for amounts under uninsured plans	7,448,904		<u>7,448,904</u>
Total liabilities			<u>65,007,469</u>
<b>SURPLUS</b>			
Common capital stock	XXX	XXX	101,978
Preferred stock	XXX	XXX	20,000
Gross paid in and contributed surplus	XXX	XXX	17,561,870
Unassigned funds (surplus) (Note 1)	XXX	XXX	65,820,021
Less 15,000 shares treasury stock at cost	XXX	XXX	<u>56,250</u>
Surplus as regards policyholders	XXX	XXX	<u>83,447,619</u>
Total liabilities and surplus			<u>\$148,455,088</u>

THE NOTES TO THE FINANCIAL STATEMENTS ARE AN INTEGRAL PART THEREOF.

**UNITED HEALTHCARE OF ALABAMA, INC.**

**STATEMENT OF REVENUE AND EXPENSES**

**For the Year Ended December 31, 2007**

**REVENUES**

Net premium income	\$379,281,410
Change in unearned premium reserves and reserve for rate credits	3,924,236
Aggregate write-ins for other health care related revenues	<u>1,345,680</u>
Total revenues	<u>384,551,326</u>

**HOSPITAL AND MEDICAL**

Hospital/medical benefits	245,635,891
Other professional services	857,023
Prescription drugs	26,082,429
Incentive pool, withhold adjustments and bonus amounts	<u>128,198</u>
Total hospital and medical	<u>272,703,541</u>
Claims adjustment expenses	4,802,348
General administrative expenses	28,294,289
Increase in reserves for health contracts	<u>(50,000)</u>
Total underwriting deductions	<u>305,750,178</u>
Net underwriting gain or (loss)	<u>78,801,148</u>
Net investment income earned	9,553,042
Net realized capital gains or (losses)	<u>9,944</u>
Net investment gains or (losses)	9,562,986
Aggregate write-ins for other income or expenses	<u>4,600</u>
Net income or (loss) before federal income taxes	88,368,734
Federal and foreign income taxes incurred	<u>30,379,000</u>
Net income (loss)	<u>\$57,989,734</u>

THE NOTES TO THE FINANCIAL STATEMENTS ARE AN INTEGRAL PART THEREOF.

**UNITED HEALTHCARE OF ALABAMA, INC.**  
**STATEMENT OF NET WORTH**  
**FOR THE YEARS ENDED DECEMBER 31, 2005, 2006 and 2007**

	<u>2005</u>	<u>2006</u>	<u>2007</u>
Capital and surplus, beginning of reporting period	<u>\$45,502,348</u>	<u>\$35,571,768</u>	<u>\$53,173,961</u>
Net income	20,067,752	31,444,748	57,989,734
Change in net deferred income tax	(1,128,642)	903,193	(1,035,506)
Change in non-admitted assets	(569,690)	(1,745,748)	2,319,430
Dividends to stockholders	<u>(28,300,000)</u>	<u>(13,000,000)</u>	<u>(29,000,000)</u>
Net change in capital and surplus for the year	<u>(9,930,580)</u>	<u>17,602,193</u>	<u>30,273,658</u>
Capital and surplus, end of reporting period	<u>\$35,571,768</u>	<u>\$53,173,961</u>	<u>\$83,447,619</u>

THE NOTES TO THE FINANCIAL STATEMENTS ARE AN INTEGRAL PART THEREOF.

## **NOTES TO FINANCIAL STATEMENTS**

There were no notes to financial statements that indicated a violation of the Alabama Insurance Code, the Insurance Department's rules and regulations, or which were deemed to require comments and/or recommendations.

Note 1 – Unassigned Funds (Surplus) \$65,820,021  
Unassigned Funds (Surplus) was \$65,820,021 in the December 31, 2007 Annual Statement and this examination made no adjustments to that amount.

## **CONTINGENT LIABILITIES AND PENDING LITIGATION**

The review of contingent liabilities and pending litigation included an assessment of representations made by HMO management; a review of a summary of pending litigation made by the HMO's legal counsel and a general review, during the examination, of the HMO's records and files, including claim files.

This review did not disclose any items that would have a material impact on the HMO's financial condition in the event of an adverse outcome.

## **SUBSEQUENT EVENTS**

### ***Dividends:***

On April 24, 2008, in a written consent action, the Board of the HMO declared an ordinary dividend to its parent of \$28,935,000 and made payment to the parent on May 30, 2008.

### ***Changes in administration:***

In the first quarter of 2008, Patricia A. Bowen was elected to serve as Secretary of the HMO. Directors elected to the Board in the first quarter included Patricia A. Bowen, Robert J. Fredrichs and Catherine M. Palmier, MD, replacing Thomas D. Lewis, Forrest G. Burke and Robert J. Sheehy.

## **COMPLIANCE WITH PREVIOUS RECOMMENDATIONS**

The examination included a review to determine the current status of the eleven exception conditions commented upon in the preceding Report of

Examination, dated June 6, 2006, which covered the period from January 1, 2002 through December 31, 2004. This review indicated that the HMO had not satisfactorily complied with the prior recommendations as listed below:

**It is recommended** that the HMO maintain detailed records supporting the filed Annual Statements that can be readily available to examiners within ten business days in accordance with the ALA. ADMIN. CODE 482-1-118-.06(1999), which states “The insurer shall provide, within ten (10) working days, any record or response requested in writing by any duly appointed, assistant employee or examiner of the Commissioner. When the requested record or response is not produced or cannot be produced by the insurer within ten working days, the non-production shall be deemed a violation of this rule, unless the Commissioner or duly appointed person making the request grants an extension in writing or the insurer can demonstrate to the satisfaction of the Commissioner that there is a reasonable justification for the delay.”

## **COMMENTS AND RECOMMENDATIONS**

The following summary presents the comments and recommendations that are made in the current *Report of Examination*.

### **Accounts and Records**

**As mentioned in the previous examination, it is recommended** that the HMO take such measures as to be readily able to provide examiners detailed records supporting the amounts and disclosures in the filed Annual Statements within ten business days in accordance with the ALA. ADMIN. CODE 482-1-118-.06(1999), which states “The insurer shall provide, within ten (10) working days, any record or response requested in writing by any duly appointed, assistant employee or examiner of the Commissioner. When the requested record or response is not produced or cannot be produced by the insurer within ten working days, the non-production shall be deemed a violation of this rule; unless the Commissioner or duly appointed person making the request grants an extension in writing or the insurer can demonstrate to the satisfaction of the Commissioner that there is a reasonable justification for the delay.” This examination has experienced numerous instances in which insufficient, incomplete and/or untimely responses to information requests were received resulting in additional requests for information being made.

**It is recommended** that the HMO assign an officer with sufficient authority to require compliance with ALA. ADMIN. CODE 482-1-118-.06(1999), to

require full and complete responses to information requests in compliance with the Alabama Attorney General's Opinion 1980-198 and to be the HMO administrator for examination coordination, responses and relations.

**It is recommended** that the HMO provide the requested information regarding CMS proposals and rating in accordance with AL ADMIN. CODE 482-1-118.06 (1999), "The insurer shall provide, within ten (10) working days, any record or response requested in writing by any duly appointed, assistant employee or examiner of the Commissioner."

**It is recommended** that the HMO provide copies of Enterprise Risk Management processes and testing that evaluates the risks in its business and administration and the remediation thereof to comply with AL ADMIN. CODE 482-1-118.06(1999) requiring responses to examination requests to be provided within ten working days and to be in compliance with Alabama Attorney General's Opinion 1980-198 requiring copies of examination documentation be provided to examiners.

**It is recommended** that the HMO respond to requests for interviews with Board members and officers in accordance with the Alabama Administrative Code. The HMO's action contravenes ALA. ADMIN. CODE 482-1-118.06 which states, "The insurer shall provide, within ten (10) working days, any record or response requested in writing by any duly appointed deputy, assistant, employee or examiner of the Commissioner."

**It is recommended** that the HMO comply with ALA ADMIN. CODE 482-1-118-.06(1999) requiring responses to requests be provided within ten working days in the completion of the Attachment B-Service Provider Questionnaire to the NAIC Exhibit C, Controls Over Information Systems Questionnaire, and in providing data files to support the amounts shown in the annual statement.

**It is recommended** that the HMO periodically update their Service Provider Listing including the Description of Vendor Services Provided to accurately reflect those services stated in the contract.

**It is recommended** that the HMO provide timely access to subject matter experts in accordance with AL ADMIN. CODE 482-1-118.06(1999).

## CONCLUSION

The customary insurance examination procedures as recommended by the National Association of Insurance Commissioners have been followed to the extent appropriate and possible in connection with the verification and evaluation of assets and determination of liabilities set forth in this report.

In addition to the undersigned, Lisa M. Peterson, CFE, CISA, AES, IS Specialist, Ryan J. Havick, CFE, Emilie S. Brady, AFE, and Heide Moss, as representatives of the consulting firm Eide Bailly, LLP and Harland A. Dyer, ASA, MAAA, Consulting Actuarial Examiner, all representing the Alabama Department of Insurance, participated in this examination of United HealthCare of Alabama, Inc.

Respectfully submitted,



Norlyn D. Baker, CFE, CPA

Examiner-In-Charge

Representing the State of Alabama Department of Insurance

March 24, 2009