

**STATE OF OREGON**  
**DEPARTMENT OF**  
**CONSUMER & BUSINESS**  
**SERVICES**  
**DIVISION OF FINANCIAL**  
**REGULATION**



REPORT OF FINANCIAL EXAMINATION  
OF  
**UNITEDHEALTHCARE OF OREGON, INC.**  
**LAKE OSWEGO, OREGON**

AS OF

DEC. 31, 2024

STATE OF OREGON

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES

DIVISION OF FINANCIAL REGULATION

REPORT OF FINANCIAL EXAMINATION

OF

**UNITEDHEALTHCARE OF OREGON, INC.  
LAKE OSWEGO, OREGON**

**NAIC COMPANY CODE 95893**

AS OF

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**SALUTATION**

April 29, 2026

Honorable TK Keen, Oregon insurance commissioner  
Department of Consumer and Business Services  
Division of Financial Regulation  
State of Oregon  
350 Winter Street NE  
Salem, Oregon 97301-3883

Dear Commissioner Keen:

In accordance with your instructions and guidelines in the National Association of Insurance Commissioners (NAIC) Examiners Handbook, pursuant to ORS 731.300 and 731.302, respectively, we have examined the business affairs and financial condition of

**UNITEDHEALTHCARE OF OREGON, INC.  
Five Centerpointe Drive, Suite 600  
Lake Oswego, Oregon 97035**

**NAIC Company Code 95893**

hereinafter referred to as the “company or plan.” The following report is respectfully submitted.

## SCOPE OF EXAMINATION

We have performed our regular, single state, full-scope examination of UnitedHealthcare of Oregon, Inc. The examination was coordinated with the states of Colorado, Florida, Georgia, Illinois, Indiana, Louisiana, Missouri, North Carolina, New York, Ohio, Oklahoma, Texas, Washington, and Wisconsin for the multi-state examination of insurers under UnitedHealth Group. There are approximately 100 regulated legal entities in the UnitedHealth Group. The Connecticut Department of Insurance was designated as the lead state. The State of North Carolina was designated as the facilitating state and used Examination Resources, LLC to represent them on the exam. The last examination of this health care service contractor was completed as of Dec. 31, 2019. The current examination covers the period of Jan. 1, 2020, to Dec. 31, 2024.

We conducted our examination pursuant to ORS 731.300 and in accordance with ORS 731.302(1) which allows the examiners to consider the guidelines and procedures in the NAIC *Financial Condition Examiners Handbook*. The handbook requires that we plan and perform the examination to evaluate the financial condition, assess corporate governance, identify current and prospective risks of the company and evaluate system controls and procedures used to mitigate those risks. An examination also includes identifying and evaluating significant risks that could cause an insurer's surplus to be materially misstated both currently and prospectively.

All accounts and activities of the company were considered in accordance with the risk-focused examination process. This may include assessing significant estimates made by management and evaluating management's compliance with statutory accounting principles. The examination does not attest to the fair presentation of the financial statements included herein. If, during the course

of the examination an adjustment is identified, the impact of such adjustment will be documented separately following the company's financial statements.

This examination report includes significant findings of fact, as mentioned in ORS 731.302, and general information about the insurer and its financial condition. There may be other items identified during the examination that, due to their nature (e.g., subjective conclusions, proprietary information, etc.), are not included within the examination report, but separately communicated to other regulators and the company.

## **COMPANY HISTORY**

The plan is the successor of PacifiCare of Oregon, a nonprofit health maintenance organization incorporated under the laws of the State of Oregon on June 1, 1984. The current entity was incorporated on Aug. 28, 1985, as a for-profit stock corporation under the name PacifiCare of Oregon II. This entity received its certificate of authority on Jan. 30, 1987, to transact the business of accepting prepayment of health care services under the provisions of ORS Chapter 750. Effective Feb. 4, 1987, the entity purchased the assets of PacifiCare of Oregon, dissolving the nonprofit company and commencing business under the name PacifiCare of Oregon, Inc.

Effective Dec. 20, 2005, the plan was acquired as part of the acquisition of PacifiCare Health Systems, Inc., by UnitedHealth Group, Inc. The plan's current name was adopted Dec. 15, 2010, to be effective as of May 1, 2011.

Effective Jan. 1, 2022, the plan filed a Form D – Asset Transfer Agreement between the plan and Care Improvement Plus South-Central Insurance Company (CIPSC), which was approved on March 12, 2021, by the Division of Financial Regulation (DFR). The transaction was an

intercompany asset transfer of a Medicare Advantage Plan/Prescription Drug Business (MAPD-Plan) contract from the plan to CIPSC by means of a novation of the plan's U.S. Centers for Medicare & Medicaid Services (CMS) contract number H1281 to CIPSC to be effective Jan. 1, 2022. H1281 is a single county CMS contract in the state of Washington.

Effective Jan. 1, 2022, the plan filed a Form D – Asset Transfer Agreement between the plan and UnitedHealthcare Benefits of Texas (UHCBTX), which was approved on March 12, 2021 by the DFR. The transaction was an intercompany asset transfer of a MAPD-Plan contract from the plan to UHCBTX by means of a novation of the plan's CMS contract number H3805 to UHCBTX to be effective Jan. 1, 2022. H3805 is a multi-county CMS contract in the states of Oregon and Washington. The novations were for dates of service on or subsequent to Jan. 1, 2022.

### **Capitalization**

The plan's articles of incorporation authorize the issuance of 1 million shares of common stock, with a par value of \$1 per share. Of these shares, 500,000 shares were issued to PacifiCare Health Plan Administrators, Inc. Effective July 2012, this entity and PacifiCare, LLC, were merged with and into United HealthCare Services, Inc., now the direct parent.

During the period under examination, the plan's parent did not make any capital contributions:

At Dec. 31, 2024, the plan reported gross paid in and contributed surplus of \$88,500,000.

### **Dividends to stockholders and other distributions**

During the period under examination, the plan declared and paid cash distributions to its parent as follows:

<u>Declared date</u>	<u>Paid date</u>	<u>Amount</u>	<u>Description</u>
05/18/2020	06/02/2020	\$ 59,000,000	Ordinary
08/26/2020	09/10/2020	\$ 43,500,000	Ordinary
05/18/2021	06/03/2021	\$ 65,000,000	Ordinary
11/23/2021	12/10/2021	\$ 54,500,000	Ordinary
08/18/2022	09/15/2022	\$ 48,000,000	Ordinary
11/18/2022	12/29/2022	\$ 20,000,000	Ordinary
12/04/2023	12/19/2023	\$ 5,500,000	Ordinary

The plan made the proper disclosure of the distributions to the administrator of DFR in accordance with the reporting requirements established by ORS 732.554 and 732.576.

## **CORPORATE RECORDS**

### **Board minutes**

In general, the review of the board meeting minutes of the plan indicated the minutes support the transactions of the plan and clearly describe the actions taken by its directors. A quorum, as defined by the plan’s bylaws, met at all of the meetings held during the period under review.

The bylaws authorize the plan to form one or more committees; however, no committees have been formed. Instead, the plan relies on appointed committees of the ultimate parent, UnitedHealth Group, Inc. (UHG). There are four committees authorized to assist in the management of UHG, as follows:

- Audit committee
- Corporate governance committee
- Nominating advisory committee
- Compensation and human resources committee
- Health and clinical practice policies committee

A review of the board minutes indicated the compensation and human resources committee of UHG approved the compensation of all its senior officers, which included the officers of the plan.

This process complies with the provisions of ORS 732.320(3).

**Articles of incorporation**

The plan last restated its Articles on Feb. 2, 2011. No changes were made during the period under examination. The articles of incorporation conform to the Oregon Insurance Code.

**Bylaws**

The bylaws were last amended and restated on May 1, 2011. No changes were made during the period under examination. The plan’s bylaws conform to Oregon statutes.

**MANAGEMENT AND CONTROL**

**Board of directors**

The bylaws, in Article 3, Section 1, state the business and affairs of the corporation shall be managed under the direction of the board. Article 3, Section 2 states the number of directors shall be three (3). The number of directors may be increased from time to time by amendment, but such number shall never be less than three. The bylaws were amended effective March 15, 2006 to increase the number of directors to four. As of Dec. 31, 2024, the plan was governed by a four-member board of directors as follows:

<b><u>Name and address</u></b>	<b><u>Principal affiliation</u></b>	<b><u>Representative</u></b>	<b><u>Member since</u></b>
Marc R. Briggs Draper, Utah	Chief executive officer Regional Health Plan for Medicare and Retirement	Company	2023
*Gary Gene Daniels West Linn, OR	Regional CEO Consumer Government Operations Medicare and Retirement Business	Company	2020
Chi Uyen Ho Placentia, CA	Chief Financial Officer UnitedHealthcare of Oregon, Inc.	Company	2024
Steven Louis Robino Brush Prairie, WA	Retired	Public	2021

\*Chairman

The directors as a group have experience in insurance, accounting and management, in accordance with the provisions of ORS 731.386. ORS 750.015(1) requires not less than one-third of the group of persons vested with the management of the affairs of a health care service contractor be representatives of the public who are not practicing doctors, employees, or trustees of a participant hospital. The company was not in compliance with this statute.

**I recommend the plan either replace one of the Board members with a public representative or add one additional public member to the Board to comply with ORS 750.015(1).**

**Officers**

Principal officers serving at Dec. 31, 2024, were as follows:

<b><u>Name</u></b>	<b><u>Title</u></b>
Marc R. Briggs	President and vice chair
Marilyn V. Hirsch	Treasurer
Bryn Searns	Secretary
Chi Uyen Ho	Chief financial officer
Nyle B. Cottingham	Vice president
Gary G. Daniels	Chair and president, commercial
Heather A. Lang	Assistant secretary

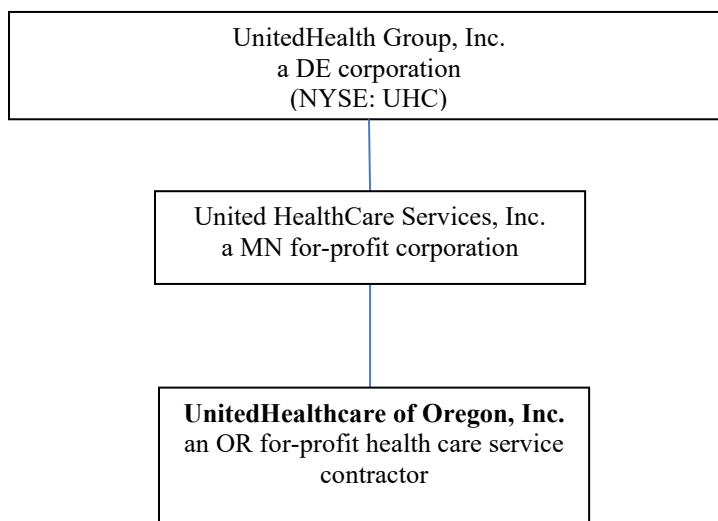
**Conflict of interest**

Officers and directors must complete annual conflicts of interest attestations and, if necessary, report any outside activities and relationships that may pose a potential conflict of interest. Upon disclosure, these outside activities are reviewed by compliance and ethics to determine whether they conflict with responsibilities to the company. If a conflict of interest is identified and cannot be mitigated, the employee is required to eliminate that conflict or resign his or her position with the company. From a review of the completed conflict of interest questionnaires, the company's

personnel performed due diligence in completing the conflict-of-interest statements. No material conflicts of interest were noted.

**Insurance company holding system**

The company is a member of an insurance company holding system, in accordance with the provisions of ORS 732.552, ORS 732.554, and Oregon Administrative Rule (OAR) 836-027-0020(1). The following condensed organizational chart depicts the relationships of the company within the holding company system:



A description of each of the entities above is as follows:

UnitedHealth Group Inc. (UHC) is a Delaware for-profit stock holding company and a publicly held corporation trading on the New York Stock Exchange. As a holding company, it controls a highly diversified health care system, delivering insurance products, health care services, information, and technology.

United Healthcare Services, Inc. (UHS) owns a number of UnitedHealthcare and PacifiCare branded companies throughout the US. Through its insurance company subsidiaries, UHS provides

managed care and other health insurance products to groups, individuals, Medicare and Medicaid beneficiaries. UHS operates as a wholly owned subsidiary of United Health Group, Inc. and is the company's direct parent.

## **INTERCOMPANY AGREEMENTS**

The following agreements are in place between the company and members of the insurance holding company system.

### **Promissory note agreement**

Effective April 1, 2023, the company entered into a promissory note with UHS. Pursuant to the note, UHS agrees to lend the company an aggregate principal amount as named within the note for an arm's length interest charge. The note may be repaid at any time in whole or in part. Payment of principal and interest will be subordinated to the claims of nonaffiliated creditors. On Aug. 6, 2024, the company borrowed \$10 million from UHS and repaid the loan including interest in the amount of \$10,081,833 (rounded) on Sept. 24, 2024.

### **naviHealth, Inc. – Agreement for post-acute services**

Effective March 1, 2021, the plan entered into the post-acute care services agreement with naviHealth, Inc. (NHI). Under the agreement, NHI arranges for the delivery and provision of post-acute services, including without limitation, utilization management services, through an integrated care delivery system and provides SNF network infrastructure and maintenance services. Effective Jan. 1, 2025, the agreement was terminated.

### **Optum Washington Network, LLC – UnitedHealthcare Health services agreement**

Effective Jan. 1, 2021, the plan entered into the UnitedHealthcare Health services agreement with Optum Washington Network, LLC (OWN). Under the agreement, OWN and Optum participating

providers participate in UHC's health service delivery system by providing or arranging for covered services to Medicare Advantage members in coordination with the plan and other affiliates and participating providers under the terms specified in the agreement.

#### **Agreement for Combined Billing and Disbursement Operations**

Effective Jan. 1, 2007, the plan, UHIC, UHS, and PacifiCare Health Plan administrators entered into an agreement for combined billing and disbursement operations through a participating addendum. The agreement provides for a common lockbox for premium collection, and zero balance disbursements account for paying certain bills.

#### **AxelaCare Intermediate Holdings, LLC – Facility participation agreement**

Effective Feb. 1, 2016, the plan entered into the facility participation agreement with AxelaCare Intermediate Holdings, LLC. (AxelaCare). Under the terms of the agreement AxelaCare provides home infusion therapy services, including per diem nursing services and the cost of drugs. The Agreement is available to be used by all products, commercial, Medicare, and Medicaid that the plan may offer. Effective Jan. 1, 2019, the plan entered into the First Amendment to the agreement. AxelaCare shall be able to coordinate covered services in an ambulatory infusion suite (AIS) setting in addition to all other settings it presently provides covered services.

#### **Dental Benefit Providers, Inc. – Dental services agreement**

Effective Feb. 1, 2012, the plan entered into the dental services agreement with Dental Benefit Providers, Inc. (DBP). The agreement superseded and replaced the master services agreement with DBP, which the plan entered into through a participating addendum effective Jan. 1, 2009, including all subsequent amendments. Pursuant to the agreement, DBP is responsible for managing a network of dental providers, claims processing, and other administrative functions in order to

provide dental services for the plan's Medicare members. Subsequent amendments in 2013 through 2021 deleted and replaced Exhibit A Compensation for Services Addendum.

**Ear Professionals International Corporation – Ancillary provider participation agreement**

Effective Feb. 1, 2019, Ear Professionals International Corporation (EPIC) and UHIC entered into the amendment 11 to the ancillary provider participation agreement. The ancillary provider participation agreement between Epic Hearing Health Care, Inc. and UHIC was entered into, which was amended ten times. Epic Hearing Health Care, Inc. is a dba of EPIC, which was acquired by UHIC on March 30, 2018. The agreement and the subsequent amendments were entered prior to plan and EPIC becoming affiliates and therefore were not submitted to DFR. Under the terms of the agreement and subsequent amendments, EPIC is a provider of hearing aids for the plan's members. The plan participated in the agreement by signing a participating addendum effective Feb. 1, 2019. With amendment 11, all references to EPIC Hearing Healthcare, Inc. in the agreement and any prior amendments to the agreement are deemed to be references to EPIC, the correct legal name for provider.

Effective Dec. 23, 2024, Ear Professionals International, LLC. was no longer an affiliate within the plan's insurance holding company system.

**Optum Biometrics f/k/a Wellness. Inc. – Facility provider agreement**

Effective Oct. 1, 2010, the plan participates in the facility participation agreement by and between Wellness, Inc. and UHIC. The purpose of this agreement is to provide influenza and pneumococcal vaccination services to plan's commercial and Medicare members. The fees are to be charged per vaccination given and are the same for all wellness customers.

### **OptumHealth Care Solutions, Inc. – Administrative services agreement**

Effective April 1, 2012, the plan entered into the administrative services agreement with OptumHealth Care Solutions, Inc. (OptumHealth). Pursuant to the agreement, OptumHealth is responsible for managing a network of therapy providers and other administrative functions in order to provide physical health solutions such as chiropractic and physical, occupation, and speech therapy for the plan’s commercial and Medicare members. The plan remains ultimately responsible for the delivery of therapy services to its members.

Effective Dec. 31, 2024, the agreement and subsequent amendments were terminated.

### **OptumInsight, Inc. f/k/a Ingenix, Inc. – Ingenix services agreement**

Effective Aug. 1, 2011, the plan entered into the Ingenix Services Agreement with Ingenix, Inc. (Ingenix). Pursuant to the agreement, Ingenix provides the plan with services related to claim analytics and recovery services, retrospective fraud, waste and abuse services, and subrogation services.

### **OptumRx, Inc. f/k/a RxSolutions, Inc. – Medicare Advantage durable medical equipment and supplies mail order network agreement**

On Jan. 1, 2009, the Medicare Advantage durable medical equipment and supplies mail order network agreement was entered into by and between RxSolutions, Inc. (RxSolutions) and United HealthCare Services, Inc. Effective March 1, 2009, the plan entered into a participating addendum to the agreement. Pursuant to the agreement and addendum, RxSolutions provides durable medical equipment and diabetic testing supplies to the plan’s Medicare Advantage members in connection with its Medicare Advantage operations. The durable medical equipment and supplies relate specifically to diabetic test strips, the reading instrument, and any equipment related to the testing

of the blood glucose level. The supplies covered are items such as the control solution, lancets, and batteries.

**OptumRx, Inc. – Participating addendum to the Prescription Drug Benefit Administration agreement – Commercial members**

On Jan. 1, 2013, OptumRx, Inc. (OptumRx) and UHS entered into a Prescription Drug Benefit Administration agreement. Pursuant to the agreement, OptumRx provides core prescription drug benefit services and mail order pharmacy services. Under the agreement, OptumRx established and maintains a network of pharmacies to service the benefit plans, provide claims processing services, benefits administration and support, marketing and sales support, account management services, rebate administration, clinical services, and finance and analytical support services including mail order network prescription services.

**OptumRx, Inc. - Facility participation agreement - Specialty pharmacy for medical benefit agreement**

Effective July 1, 2018, the plan entered into the facility participation agreement whereas OptumRx is acting as a specialty pharmacy for the medical benefits identified in the agreement.

**OptumRx, Inc. – Facility participation agreement for specialty pharmacy provider agreement, pharmacy benefit**

Effective July 1, 2018, the plan entered into the facility participation agreement. Pursuant to the agreement, OptumRx is acting as a specialty pharmacy provider. OptumRx is providing the specialty pharmacy medications identified in the payment appendix covered under the member's pharmacy benefits. Currently, this benefit is being offered to the plan's eligible members under the applicable participating commercial plan.

**Optum Women’s and Children’s Health, LLC f/k/a Alere Women’s and Children’s Health LLC – National ancillary provider participation agreement**

Effective Nov. 1, 2017, UHIC entered into the national ancillary provider participation agreement on behalf of itself and other affiliates with Optum Women’s and Children’s Health, LLC (OWCH). The plan participates in the agreement by entering into a participating addendum effective Nov. 1, 2017. Under the terms of the agreement, OWCH provides home infusion therapy to commercial, Medicare, and Medicaid pregnant women in need of certain hormonal and insulin therapy. The services provided include all pharmacy and clinical management/coordination, all infusion related supplies and equipment inclusive of IV poles and pumps (stationary, ambulatory, and disposable), delivery and associated mileage, hazardous waste disposal, patient education materials, medications, nursing services, diluents and solutions inclusive of flushes.

**Physician Care Network, LLC – Health services agreement**

Effective Jan. 1, 2020, the plan entered into an agreement with Physician Care Network, LLC (PCN). Under the terms of the Agreement, PCN is responsible for the health care needs and arranges for medical services through a network of providers for Medicare Advantage members for specific H plans in the state of Washington.

**Spectera, Inc. – Vision services agreement**

Effective Jan. 1, 2012, the plan entered into the Vision Services Agreement with Spectera, Inc. (Spectera). The agreement replaced the participating organization addendum to the Spectera master services agreement in effect since Jan. 1, 2009, including all subsequent amendments. Pursuant to the agreement, Spectera is responsible for managing a network of vision providers to provide vision services and or products (frames and contact lenses), claims processing, and other

administrative functions in order to provide vision services to the plan's commercial and Medicare members.

**United Behavioral Health – Behavioral health services agreement**

Effective March 1, 2012, the plan entered into the Behavioral Health Services Agreement with United Behavioral Health (UBH). Pursuant to the agreement, UBH is responsible for arranging for the provision of certain mental health and substance abuse treatment services to the plan's commercial and Medicare members.

**UnitedHealthcare Insurance Company and eAlliance General Agency – eAlliance General Agency agreement**

Effective July 1, 2018, UHIC and eAlliance General Agency entered into the UnitedHealthcare Insurance Company eAlliance General Agency agreement, acting on behalf of its affiliates, including but not limited to the plan. The plan participates in the agreement by entering into a Participating Addendum effective Sept. 1, 2018. Under the terms of the Agreement, the plan pays eAlliance General Agent commissions for the sale of Medicare products made by licensed agents. eAlliance General Agency is a licensed insurance agency that markets multi-carrier Medicare Advantage, Medicare Supplement, and prescription drug plan options to Medicare enrollees via a call center. The charges covered under this agreement are covered under the management services agreement between the plan and UHS.

**UnitedHealthcare Insurance Company and Real Appeal, Inc. – National Ancillary Provider Participation Agreement: Obesity and diabetes prevention services**

Effective Jan. 1, 2019, Real Appeal, Inc. (facility) and UHIC entered into the National Ancillary Provider Participation Agreement, acting on its behalf, including but not limited to the plan. The plan desires to participate in the agreement by entering into a participating addendum effective

Jan. 1, 2019. Under the terms of the agreement, facility will provide obesity and diabetes prevention services focusing on weight loss to commercial members. The services include a customizable program delivered to eligible participants with the goal of preventing diabetes and other obesity-related diseases. The program uses a 52-week approach with online technology and live audio/video capabilities.

#### **United HealthCare Services, Inc. – Management services agreement**

Effective Jan. 1, 2011, the plan entered into the management services agreement with UHS. Pursuant to the management services agreement, UHS provides management and operational support to the plan. This management services agreement includes additional services as compared to the previous management and administrative services agreement, such as disease management, health care decision support, and wellness management.

Effective March 1, 2017, the plan entered into the second amendment to the agreement (second amendment). The primary purpose of the second amendment was to implement an updated methodology for calculating management fees. Specifically, the updated language implemented a current year true-up, which yielded more accurate results and ensured that adjustments apply in the current year.

#### **UnitedHealth Group Incorporated – Second amended and restated tax sharing agreement**

Effective March 1, 2019, the plan entered into the second amended and restated tax sharing agreement with UnitedHealth Group Incorporated, the ultimate controlling person. The agreement establishes a formal method for allocating and payment of federal, state, and local income tax liabilities related to the consolidated federal tax returns filed each year. The terms of the agreement are consistent with the terms set forth in similar agreements signed between United and other

regulated affiliates in its insurance holding company system filed with the state department of insurance offices during calendar years 2015 to 2017.

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

The examination of insurance coverages involved a review of the adequacy of limits and retentions and the solvency of the insurers providing the coverages. The plan's insurance coverages are provided through insurance policies from an unaffiliated carrier, and coverage protected UHC and all its majority owned subsidiary companies as a named insured. The group as a whole is insured up to \$25,000,000 in aggregate liability, with \$500,000 retention, against losses from acts of dishonesty and fraud by its employees and agents. Fidelity bond coverage was found to meet the coverage limits recommended by the NAIC.

Other insurance coverages in force at Dec. 31, 2024, were found to be adequate and included:

Commercial general liability	Commercial property
Umbrella liability	
Managed care professional liability	

### **TERRITORY AND PLAN OF OPERATION**

The plan is authorized to conduct business as a health care service contractor in Oregon and Washington. It offers comprehensive commercial products to individuals. The company also served as a plan sponsor offering Medicare Parts A & B, along with Medicare Advantage and Medicare Part D prescription drug insurance coverage (Medicare Part D program) under a contract with CMS. Effective Jan. 1, 2022, the company novated its CMS contracts to affiliates UnitedHealthcare Benefits of Texas and Care Improvement Plus South-Central Insurance Company at a \$0 book value for dates of service on or subsequent to Jan. 1, 2022. The company

operates through holding company agreements to provide multiple and varied services, including an administrative services agreement. Many of these affiliated arrangements are with Optum non-insurance entities.

During the last five years, the plan reported total enrolled members as follows:

<b>Line of business</b>	<b>2024</b>	<b>2023</b>	<b>2022</b>	<b>2021</b>	<b>2020</b>
Individual hospital & medical	6,746	5,007	3,835	1,928	0
Group hospital & medical	0	1	271	292	301
FEHBP	0	0	0	0	0
Medicare	0	0	0	193,920	178,076
Medicaid	0	0	0	0	0
Other	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>
Total enrollment	<u>6,746</u>	<u>5,008</u>	<u>4,106</u>	<u>196,140</u>	<u>178,377</u>

At year-end 2024, the plan reported direct business, as follows:

<b>State</b>	<b>Direct premiums written</b>
Oregon	\$ (64,936)
Washington	<u>45,819,391</u>
Total	<u>\$ 45,754,455</u>

### **GROWTH OF THE PLAN**

Growth of the plan over the past five years is reflected in the following schedule. Amounts were derived from plan's filed annual statements, except in those years when a report of examination was published by the Oregon Division of Financial Regulation.

<b><u>Year</u></b>	<b><u>Assets</u></b>	<b><u>Liabilities</u></b>	<b><u>Capital and surplus</u></b>	<b><u>Net income (loss)</u></b>
2020	\$ 628,253,269	351,258,361	\$ 276,994,908	\$ 119,778,821
2021	605,872,968	344,984,549	260,888,419	102,740,276
2022	273,237,849	52,265,593	220,972,256	26,161,838
2023	255,789,746	35,019,034	220,770,712	6,366,252
2024 *	242,156,328	19,099,812	223,056,516	809,691

\*Per examination

## LOSS EXPERIENCE

The following exhibit reflects the annual underwriting results of the plan over the past five years. The amounts were obtained from copies of the plan’s filed annual statements and, where indicated, from the previous examination reports.

<u>Year</u>	(1) <u>Total revenues</u>	(2) <u>Total hospital and medical</u>	(2)/(1) <u>Medical loss ratio</u>	(3) <u>Claim adjustment and administrative expenses</u>	(2)+(3)/(1) <u>Combined loss ratio</u>
2020	\$ 2,042,338,566	\$ 1,605,939,223	78.6%	\$ 282,407,169	92.4%
2021	2,206,980,382	1,847,627,544	83.7%	240,979,762	94.6%
2022	57,274,475	23,715,830	41.4%	8,204,856	55.7%
2023	34,434,288	26,338,362	76.5%	5,822,302	93.4%
2024 *	46,123,827	45,287,344	98.2%	4,714,721	108.4%

\* Per examination

A combined ratio of more than 100 percent would indicate an underwriting loss. The plan reported underwriting losses in one of the last five years.

## REINSURANCE

The plan’s management concluded it does not need the protection or expense of reinsurance coverage because the upstream parent has developed sophisticated forecasting and capital planning disciplines which give it the ability to accurately forecast statutory net worth quarterly against RBC levels and other solvency requirements. Furthermore, the plan’s greater predictability based on its experience and control, in conjunction with the liquidity of its investment portfolio, makes it possible to cover its own risks without conventional reinsurance. UHG regularly performs a thorough review of the reinsurance programs, catastrophic claims experience, and capital planning process of its subsidiaries and has determined that the plan does not need reinsurance, asserting there are no additional risks to the plan’s clients or providers.

## ACCOUNTS AND RECORDS

In general, the plan's records and source documentation supported the amounts presented in the plan's Dec. 31, 2024, annual statement and were maintained in a manner by which the financial condition was readily verifiable pursuant to the provisions of ORS 733.170.

## STATUTORY DEPOSIT

The plan maintained a surety bond in the amount of \$250,000 on deposit at DFR, which meets the requirements of ORS 750.045(2). Bond #6120713 was placed on Sept. 5, 2001, to be effective Oct. 15, 2001, through Safeco Insurance Company of America and is still in place as of the date of examination.

The plan is also licensed in the state of Washington. The Office of the Insurance Commissioner requires the plan to maintain a minimum regulatory deposit of \$600,000. The plan holds a surety bond for \$600,000 to satisfy this requirement.

## COMPLIANCE WITH PRIOR EXAMINATION RECOMMENDATIONS

The prior examination report included one recommendation as follows:

**I recommend the plan either replace one of the board members with a public representation or add two additional public members to the board to comply with ORS 750.015.**

The plan was still in violation with ORS 750.015 at YE 2024 as it had a four-member board, but only one public representative who was not a practicing doctor, employee, or trustees of a participant hospital.

## **SUBSEQUENT EVENTS**

Marc R. Briggs, former president and vice-chair left United Health Group, Inc. effective June 6, 2025. Gary Gene Daniels, former board chair, was removed from his role and left United Health Group, Inc. effective April 9, 2025. Meghan J. Meridith became the new board chair effective Oct. 13, 2025.

## **FINANCIAL STATEMENTS**

The following financial statements are based on the statutory financial statements filed by the plan with DFR and present the financial condition of the plan for the period ending Dec. 31, 2024. The financial statements are prepared by management and therefore, the responsibility of management. The accompanying comments on financial statements reflect any examination adjustments to the amounts reported in the annual statement and should be considered an integral part of the financial statements. These statements include:

- Statement of assets
- Statement of liabilities, capital and surplus
- Statement of revenue and expenses
- Reconciliation of surplus since the last examination

**UNITEDHEALTHCARE OF OREGON, INC.**  
**ASSETS**  
**As of Dec. 31, 2024**

<b>Assets</b>	<b>Net admitted assets</b>	<b>Notes</b>
Bonds	\$ 203,922,613	1
Cash, cash equivalents and short-term investments	8,206,313	1
Other invested assets (Schedule BA)	<u>13,063,010</u>	1
Subtotal, cash and invested assets	<u>225,191,936</u>	
Investment income due and accrued	1,099,810	
Premiums and considerations		
Uncollected premiums and agents' balances in course of collection	858,353	
Accrued retrospective premiums and contracts subject to redetermination	1,867,587	
Amounts receivable relating to uninsured plans	538,937	
Current federal and foreign income tax recoverable	-	
Net deferred tax asset	267,481	
Receivables from parent, subsidiaries and affiliates	10,109,582	
Health care receivable	1,845,746	
Aggregate write-ins for other than invested assets	<u>376,896</u>	
Total assets	<u>\$ 242,156,328</u>	

**UNITEDHEALTHCARE OF OREGON, INC.**  
**LIABILITIES, CAPITAL AND SURPLUS**  
**As of Dec. 31, 2024**

	<b>Current year total</b>	<b>Notes</b>
Claims unpaid	\$ 7,329,111	2
Accrued medical incentive pool and bonus amounts	1,030,484	2
Unpaid claims adjustment expense	63,975	2
Aggregate health policy reserves	9,045,071	2
Aggregate health claim reserves	67,492	
Premiums received in advance	342,711	
General expenses due or accrued	323,804	
Current federal and foreign income tax payable	133,926	
Remittances and items not allocated	563,010	
Amounts due to parent, subsidiaries and affiliates	-	
Liability for amounts held under uninsured plans	19,686	
Aggregate write-ins for liabilities	<u>180,542</u>	
Total Liabilities	<u>19,099,812</u>	
Common capital stock	\$ 500,000	
Gross paid-in and contributed capital	88,500,000	
Unassigned funds (surplus)	<u>134,056,516</u>	
Surplus as regards policyholders	<u>\$ 223,056,516</u>	
Total liabilities, surplus and other funds	<u>\$ 242,156,328</u>	

**UNITEDHEALTHCARE OF OREGON, INC.**  
**STATEMENT OF REVENUE AND EXPENSES**  
**For the Year Ended Dec. 31, 2024**

	Current year total	Notes
<b>Revenue</b>		
Net premium income	\$ 45,754,455	
Change in unearned premium reserves and reserve for rate credits	369,372	
Aggregate write-ins for health care related revenues	<u>-</u>	
Total revenues	<u>46,123,827</u>	
Hospital and Medical:		
Hospital/medical benefits	35,448,219	
Other professional services	19,179	
Outside referrals	-	
Emergency room and out-of-area	-	
Prescription drugs	8,928,020	
Aggregate write-ins for other hospital and medical	-	
Incentive pool, withhold adjustments and bonus amounts	<u>891,926</u>	
Subtotal	45,287,344	
Less:		
Net reinsurance recoveries	<u>-</u>	
Total medical and hospital	45,287,344	
Non-health claims	-	
Claim adjustment expenses	1,428,739	
General administrative expenses	3,285,982	
Increase in reserves for life and accident and health contracts	<u>-</u>	
Total underwriting deductions	<u>50,002,065</u>	
Net underwriting gain or (loss)	<u>(3,878,238)</u>	
Net investment income earned	3,641,678	
Net realized capital gains (losses)	<u>(269,534)</u>	
Net investment gains (losses)	3,372,144	
Net gain or (loss) from agents' or premium balances charged off	95,691	
Aggregate write-ins for other income or expense	20,669	
Federal income taxes incurred	<u>(1,199,425)</u>	
Net income	<u>\$ 809,691</u>	

**UNITEDHEALTHCARE OF OREGON, INC.**  
**RECONCILIATION OF SURPLUS SINCE THE LAST EXAMINATION**  
**For the Year Ended Dec. 31,**

	2024	2023	2022	2021	2020
Surplus as regards policyholders, Dec. 31, previous year	<u>\$220,770,712</u>	<u>\$220,972,256</u>	<u>\$260,888,419</u>	<u>\$276,994,908</u>	<u>\$261,674,189</u>
Net income (loss)	809,691	6,366,252	26,161,838	102,740,276	119,778,821
Change in net unrealized capital gains or (losses)	-	-	(521,718)	192,079	72,179
Change in net deferred income tax	147,942	(178,826)	(1,478,820)	(263,059)	822,550
Change in non-admitted assets	1,328,171	(888,970)	3,922,537	724,215	(2,852,831)
Change in provision for reinsurance	-	-	-	-	-
Change in surplus notes	-	-	-	-	-
Cumulative effects of changes in accounting principles	-	-	-	-	-
Capital changes:					
Paid in	-	-	-	-	-
Transferred from surplus (stock dividend)	-	-	-	-	-
Transferred to surplus	-	-	-	-	-
Surplus adjustments:					
Paid in	-	-	-	-	42,000,000
Transferred to capital (stock dividend)	-	-	-	-	-
Transferred from capital	-	-	-	-	-
Dividends to stockholders	-	(5,500,000)	(68,000,000)	(119,500,000)	(102,500,000)
Change in treasury stock	-	-	-	-	-
Examination adjustment	-	-	-	-	-
Aggregate write-ins for gains and losses in surplus	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>
Net change in capital and surplus	<u>2,285,804</u>	<u>(201,544)</u>	<u>(39,916,163)</u>	<u>(16,106,489)</u>	<u>15,320,719</u>
Capital and surplus end of reporting year	<u>\$223,056,516</u>	<u>\$220,770,712</u>	<u>\$220,972,256</u>	<u>\$107,393,621</u>	<u>\$276,994,908</u>

**NOTES TO FINANCIAL STATEMENTS**

**Note 1 – Invested assets**

At year-end 2024, the plan’s long-term bond investments were diversified in U.S. government securities, including residential and commercial mortgage-backed securities, U.S. states, territories and possessions, U.S. political subdivisions, and U.S. special revenue bonds. The plan also had a significant investment in U.S. corporate issues. The entire portfolio of long and short-term bonds was rated as filing exempt or Class 1 or 2 by the Security Valuation Office of the NAIC. The plan also reported one other long-term invested asset classified as an unaffiliated non-guaranteed Federal low-income housing tax credit. Cash equivalents were comprised of four exempt money market mutual funds and one qualified cash pool under SSAP No.2R. The company did not hold any preferred or common stocks, nor any short-term investments.

The company had a small exposure to mortgage-backed securities. All MBS issues were investment rated, with a carrying book value of \$55.1 million, which comprised 27 percent of the total long-term bond portfolio and 24.5 percent of all invested assets.

A comparison of the major investments over the past five years shows the following:

<b><u>Year</u></b>	<b><u>A</u></b> <b><u>Bonds</u></b>	<b><u>B</u></b> <b><u>Cash and</u></b> <b><u>short-term</u></b>	<b><u>Ratio</u></b> <b><u>A/</u></b> <b><u>Total assets</u></b>	<b><u>Ratio</u></b> <b><u>B/</u></b> <b><u>Total assets</u></b>
2020	\$ 305,409,235	\$ 131,037,803	48.6%	20.9%
2021	323,164,121	124,251,453	53.3%	20.5%
2022	260,368,154	3,229,029	95.3%	01.2%
2023	236,924,615	11,053,665	92.6%	04.3%
2024	203,922,613	8,206,313	84.2%	03.4%

As of Dec. 31, 2024, sufficient invested assets were invested in amply secured obligations of the United States, the State of Oregon, or in FDIC insured cash deposits, and the company was in compliance with ORS 733.580. The board of directors approved all investment transactions in each of the years under review, and the company was in compliance with ORS 733.730.

Effective May 1, 2011, the plan entered into a custodial agreement with The Northern Trust Company. The agreement contained all of the relevant protections described in OAR 836-027-0200(4)(a) through (n).

**Note 2 – Actuarial reserves**

Gary Iannone, ASA, MAAA, vice president, corporate actuarial services of UnitedHealthcare Services, Inc., of which UnitedHealthcare of Oregon, Inc. is an affiliate, prepared the statement of actuarial opinion on behalf of the plan.

Nan Nguyen, ASA, MAAA, actuarial manager from Risk & Regulatory Consulting (RRC) reviewed the actuarial liabilities for the group examination, including the company. The actuarial liabilities were also reviewed by Tricia Matson, FSA, MAAA, partner at RRC, Veronika Cooper, FSA, MAAA, actuarial consultant at RRC, Lisa Parker, ASA, MAAA, actuarial supervisor at RRC, Andrew Larocque, ASA, MAAA, actuarial supervisor at RRC and Janet Romanelli, ASA, MAAA, supervising health actuary at RRC. They relied on information provided by the company, its consulting actuaries, and its auditors in performing their review. Based on their analysis of IBNR reserves and other health policy reserves, including the MLR rebate reserve, they concluded that the methodologies, assumptions, and calculations appear reasonable and appropriate.

	<u>Annual statement</u>
Claims unpaid	\$ 7,329,111
Accrued medical incentive pool and bonus amounts	1,030,484
Unpaid claims adjustment expenses (CAE)	63,975
Aggregate health policy reserves	9,045,071
Aggregate health claim reserves	67,492
Reserve for claim interest	<u>12,361</u>
Total actuarial liabilities	\$ 17,548,494

The plan’s appointed actuary opined that the reserves for the above actuarial liabilities carried by the plan as of Dec. 31, 2024, were in accordance with accepted actuarial standards consistently applied and were fairly stated in accordance with sound actuarial principles. The examination health actuaries concurred that based on their review of the external auditors (Deloitte & Touche) work and conclusions as well as their own analysis, they concluded the IBNR methodology, assumptions, and resulting booked reserves to be reasonable.

### **ANALYSIS OF CHANGES IN FINANCIAL STATEMENTS**

There were no adjustments to capital and surplus resulting from this examination.

### **SUMMARY OF COMMENTS AND RECOMMENDATIONS**

The following is a summary of the recommendations made as a result of this examination.

Page:

- 9 I recommend the plan either replace one of the board members with a public representative or add one additional public member to the board to comply with ORS 750.015(1).

## CONCLUSION

During the five-year period covered by this examination, the surplus of the plan has decreased from \$261,674,189 as presented in the Dec. 31, 2019, report of examination to \$223,056,516 as shown in this report. The comparative assets and liabilities are:

	<u>2024</u>	<b>Dec. 31,</b> <u>2019</u>	<u>Change</u>
Assets	\$ 242,156,328	\$ 479,062,497	\$(236,906,169)
Liabilities	<u>19,099,812</u>	<u>217,388,308</u>	<u>(198,288,496)</u>
Surplus	<u>\$ 223,056,516</u>	<u>\$ 261,674,189</u>	<u>\$ ( 38,617,673)</u>

## **ACKNOWLEDGMENT**

The cooperation and assistance extended by the officers and employees of the plan during the examination process are gratefully acknowledged.

In addition to the undersigned, Jordan Mills, CFE, David Lorenz, CIE, AFE, and Danielle Marsh, APIR, insurance examiners for the State of Oregon, Department of Consumer and Business Services, Division of Financial Regulation, participated in this examination.

We would also like to thank examiners representing the States of Colorado, Florida, Georgia, Illinois, Indiana, Louisiana, Missouri, North Carolina, New York, Ohio, Oklahoma, Texas, Washington, and Wisconsin for their participation in the examination.

Respectfully submitted,

/s/ Mark A. Giffin  
\_\_\_\_\_  
Mark A. Giffin, CFE  
Senior insurance examiner  
Division of Financial Regulation  
Department of Consumer and Business Services  
State of Oregon

**AFFIDAVIT**

STATE OF OREGON)

County of Marion)

Mark A. Giffin, CFE, being duly sworn, states as follows:

1. I have authority to represent the state of Oregon in the examination of UnitedHealthcare of Oregon, Inc., Lake Oswego, Oregon.
2. The Division of Financial Regulation of the Department of Consumer and Business Services of the State of Oregon is accredited under the National Association of Insurance Commissioners Financial Regulation Standards and Accreditation.
3. I have reviewed the examination work papers and examination report. The examination of UnitedHealthcare of Oregon, Inc. was performed in a manner consistent with the standards and procedures required by the Oregon Insurance Code.

The affiant says nothing further.

/s/ Mark A. Giffin  
Mark A. Giffin, CFE  
Senior insurance examiner  
Division of Financial Regulation  
Department of Consumer and Business Services  
State of Oregon

Subscribed and sworn to before me this 29th day of June, 2026.

/s/ Alicia Terrera Jennings  
Notary Public in and for the State of Oregon

My commission expires: November 5, 2027