MISSISSIPPI INSURANCE DEPARTMENT

MIKE CHANEY
Commissioner of Insurance
State Fire Marshal

MARK HAIRE
Deputy Commissioner of Insurance

501 N. WEST STREET, SUITE 1001
WOOLFOLK BUILDING
JACKSON, MISSISSIPPI 39201
www.mid.state.ms.us

MAILING ADDRESS
Post Office Box 79
Jackson, Mississippi 39205-0079
TELEPHONE: (601) 359-3569
FAX: (601) 359-2474

October 23, 2013

CERTIFIED MAIL
RETURN RECEIPT REQUESTED

Mr. Glen John Golemi, CEO & President
UnitedHealthcare of Mississippi, Inc.
795 Woodlands Parkway, Suite 301
Ridgeland, MS 39157

RE: Report of Examination as of December 31, 2011

Dear Mr. Golemi:

In accordance with Miss. Code Ann. §§ 83-5-201 et seq. and 83-41-337(1) (Rev. 2011), an examination of your Company has been completed. Enclosed herewith is the Order adopting the report and a copy of the final report as adopted.

Pursuant to Miss. Code Ann. § 83-5-209(6)(a) (Rev. 2011), the Mississippi Department of Insurance shall continue to hold the content of said report as private and confidential for a period of ten (10) days from the date of the Order. After the expiration of the aforementioned 10-day period, the Department of Insurance will open the report for public inspection.

If you have any questions or comments, please feel free to contact me.

Sincerely,

MIKE CHANEY
COMMISSIONER OF INSURANCE

BY _____
Christina J. Kelsey
Senior Attorney

MC/CJK/bs
Encls. Order w/exhibit

BEFORE THE COMMISSIONER OF INSURANCE
OF THE STATE OF MISSISSIPPI

RE: REPORT OF EXAMINATION OF
UNITEDHEALTHCARE OF MISSISSIPPI, INC. **CAUSE NO. 13-6706**

ORDER

THIS CAUSE came on for consideration before the Commissioner of Insurance of the State of Mississippi ("Commissioner"), or his designated appointee, in the Offices of the Commissioner, 1001 Woolfolk Building, 501 North West Street, 10th Floor, Jackson, Hinds County, Mississippi, pursuant to Miss. Code Ann. §§ 83-5-201 et seq. and 83-41-337(1) (Rev. 2011). The Commissioner, having fully considered and reviewed the Report of Examination together with any submissions or rebuttals and any relevant portions of the examiner's work papers, makes the following findings of fact and conclusions of law, to-wit:

JURISDICTION

I.

That the Commissioner has jurisdiction over this matter pursuant to the provisions of Miss. Code Ann. §§ 83-5-201 et seq. and 83-41-337(1) (Rev. 2011).

II.

That UnitedHealthcare of Mississippi, Inc. is a Mississippi-domiciled health maintenance organization ("HMO") which was initially certified as an HMO by the Mississippi State Department of Health on June 1, 1992, under the name Complete Health of Mississippi, Inc. ("CHM"). Effective May 1, 1996, the Articles of Incorporation of CHM resolved to change the name of the corporation to United Healthcare of Mississippi, Inc. Effective December 22, 2010, the Company changed its name to UnitedHealthcare of Mississippi, Inc.

FINDINGS OF FACT

III.

That the Commissioner, or his appointee, pursuant to Miss. Code Ann. §§ 83-5-201 et seq. and 83-41-337(1) (Rev. 2011), called for an examination of UnitedHealthcare of Mississippi, Inc. and appointed Darren L. Smith, Examiner-In-Charge, to conduct said examination.

IV.

That on or about September 19, 2013, the draft Report of Examination concerning UnitedHealthcare of Mississippi, Inc. for the period of January 1, 2009, through December 31, 2011, was submitted to the Mississippi Department of Insurance by Examiner-In-Charge, Darren L. Smith.

V.

That on or about September 30, 2013, pursuant to Miss. Code Ann. § 83-5-209(2) (Rev. 2011), the Department forwarded to the Company a copy of the draft report and allowed the Company a 15-day period to submit any rebuttal to said draft. The Company responded by letter on or about October 14, 2013, to the Department.

CONCLUSIONS OF LAW

VII.

The Commissioner, pursuant to Miss. Code Ann. § 83-5-209(3) (Rev. 2011), must consider and review the report along with any submissions or rebuttals and all relevant portions of examiner work papers and enter an Order: (1) adopting the Report of Examination as final or with modifications or corrections; (2) rejecting the Report of Examination with directions to reopen; or (3) calling for an investigatory hearing.

IT IS, THEREFORE, ORDERED, after reviewing the draft Report of Examination and all relevant examiner work papers, that the draft Report of Examination of UnitedHealthcare of Mississippi, Inc., attached hereto as Exhibit "A", should be and same is hereby adopted as final.

IT IS FURTHER ORDERED that a copy of the adopted Report of Examination, accompanied with this Order, shall be served upon the Company by certified mail, postage pre-paid, return receipt requested.

IT IS FURTHER ORDERED that the Mississippi Department of Insurance shall continue to hold the content of this report as private and confidential information for a period of ten (10) days from the date of this Order, pursuant to Miss. Code Ann. § 83-5-209(6)(a) (Rev. 2011).

IT IS FURTHER ORDERED, pursuant to Miss. Code Ann. § 83-5-209(4) (Rev. 2011), that within thirty (30) days of the issuance of the adopted report, UnitedHealthcare of Mississippi, Inc. shall file affidavits executed by each of its directors stating under oath that they have received a copy of the adopted report and related orders.

IT IS FURTHER ORDERED that UnitedHealthcare of Mississippi, Inc. take the necessary actions and implement the necessary procedures to ensure that all recommendations contained in the Report of Examination are properly and promptly complied with.

SO ORDERED, this the 23rd day of October 2013.

J. Mark Haire

J. MARK HAIRE
DEPUTY COMMISSIONER OF INSURANCE

CERTIFICATE OF MAILING

I hereby certify that a true and correct copy of the above and foregoing Order and a copy of the final Report of Examination, as adopted by the Mississippi Department of Insurance, was sent by certified mail, postage pre-paid, return receipt requested, on this the 23rd day of October 2013, to:

Mr. Glen John Golemi, CEO & President
UnitedHealthcare of Mississippi, Inc.
795 Woodlands Parkway, Suite 301
Ridgeland, MS 39157

Christina J. Kelsey
Senior Attorney

Christina J. Kelsey
Senior Attorney
Counsel for the Mississippi Department of Insurance
Post Office Box 79
Jackson, MS 39205-0079
(601) 359-3577
Miss. Bar No. 9853

Mississippi Insurance Department

Report of Examination

of

UNITEDHEALTHCARE OF MISSISSIPPI, INC.

as of

December 31, 2011

TABLE OF CONTENTS

EXAMINER'S AFFIDAVIT AS TO STANDARDS AND PROCEDURES USED IN AN EXAMINATION

State of Mississippi,

County of Madison,

Darren L. Smith, being duly sworn, states as follows:

1. I have authority to represent Mississippi Insurance Department in the examination of UnitedHealthcare of Mississippi, Inc. as of December 31, 2011.

2. The Mississippi Insurance Department 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, and the examination of UnitedHealthcare of Mississippi, Inc. was performed in a manner consistent with the standards and procedures required by the National Association of Insurance Commissioners and the Mississippi Insurance Department.

The affiant says nothing further.

Darren L. Smith
Examiner-In-Charge

Subscribed and sworn before me by DARREN SMITH on this 15TH day of OCT., 20 13.

(SEAL)

NOTARY PUBLIC - State of Kansas
JEFFREY SOUDER
My Appt. Expires 2/11/2016

Notary Public

My commission expires 2/11/2016 [date].

MIKE CHANEY
Commissioner of Insurance
State Fire Marshal

MARK HAIRE
Deputy Commissioner of Insurance

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FAX: (601) 359-1951

May 31, 2013

Honorable Mike Chaney
Commissioner of Insurance
Mississippi Insurance Department
1001 Woolfolk State Office Building
501 North West Street
Jackson, Mississippi 39201

Dear Commissioner Chaney:

Pursuant to your instructions and authorization and in compliance with statutory provisions, an examination has been conducted, as of December 31, 2011, of the affairs and financial condition of:

UNITEDHEALTHCARE OF MISSISSIPPI, INC.
795 Woodlands Parkway, Suite 301
Ridgeland, MS 39157

License #	NAIC Group #	NAIC #	FEETS#	ETS#
9500034	0707	95716	95716-MS-2011-1	MS120-M15

This examination was commenced in accordance with Miss. Code Ann. § 83-5-201 *et seq*.

SCOPE OF EXAMINATION

We have performed our full-scope, single state examination of UnitedHealthcare of Mississippi, Inc. ("UHCMS" or "Company") as part of a coordinated examination on the part of the lead state of Connecticut and in conjunction with other jurisdictions of sub-group 6a (including Mississippi, Georgia, Arizona, Arkansas, Louisiana, Missouri, Utah and Florida). The last exam was completed as of December 31, 2004. The most recent examination was initially scheduled for December 31, 2008 and was cancelled by the Department for lack of business activity. This examination covers the period of January 1, 2009 through December 31, 2011.

We conducted our examination in accordance with the NAIC *Financial Condition Examiners Handbook*. The Handbook requires that we plan and perform the examination to evaluate the financial condition and identify prospective risks of the company by obtaining information about the company, including corporate governance, identifying and assessing inherent risks within the company, and evaluating system controls and procedures used to mitigate those risks. An examination also includes assessing the principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation, management's compliance with Statutory Accounting Principles and annual statement instructions, when applicable to domestic state regulations.

All accounts and activities of the company were considered in accordance with the risk-focused examination process.

COMMENTS AND RECOMMENDATIONS OF PREVIOUS EXAMINATION

The following is a summary of comments and recommendations contained in the prior examination report issued by the State of Mississippi as of December 31, 2004:

Recommendation:

It is recommended that the guaranty bond between UHC and Fidelity and Deposit Company of Maryland be effectuated in a timely manner, so not to allow for a possible lapse in coverage.

Resolution:

The Company resolved this issue.

Recommendation:

It is recommended that the Company review its current contracts and/other obligations to ensure that all contracts are effectuated timely and that the amounts are properly accrued and/or otherwise accounted for on the books and records of the Company.

Resolution:

The Company resolved this issue.

HISTORY OF THE COMPANY

Complete Health of Mississippi, Inc. (CHM) was incorporated on August 6, 1990, under the laws of the State of Mississippi. The Mississippi State Department of Health issued CHM a certificate of authority as an HMO effective June 1, 1993. The Articles of Incorporation authorized the issuance of two thousand (2,000) shares of common stock. At December 31, 1994, all shares were owned by Complete Health Services (CHS). CHS acquired this stock for $175.00 per share ($.01 par value) with capital allocated $20 to common stock and $349,980 as additional paid-in surplus. There have been no additional shares of stock issued or otherwise authorized. Effective July 1, 1995 the Mississippi Insurance Department (MID) issued a Privilege License and Certificate of Authority to CHM under authority of § 83-41-301 et. seq.

Effective May 1, 1996, CHM changed its name to UnitedHealthCare of Mississippi, Inc.. The Company was wholly-owned by United HealthCare Services, Inc. (UHC), which was wholly-owned by United HealthCare Corporation.

On June 21, 2000, the Company became a wholly-owned subsidiary of UnitedHealthcare Inc., which is a wholly-owned subsidiary of United HealthCare Services, Inc. (UHS), an HMO management corporation that provides services to the Company under the terms of a management agreement. UHS is a wholly-owned subsidiary of UnitedHealth Group, Incorporated ("UnitedHealth Group" or "UHG"), which changed its name from United HealthCare Corporation on March 6, 2000. Effective December 22, 2010, the Company's name was changed to UnitedHealthcare of Mississippi, Inc. (UHCMS).

CORPORATE RECORDS

The Articles of Incorporation, Bylaws and amendments thereto were reviewed and duly applied in other sections of this report where appropriate. Minutes of the meetings of the Shareholder, Board of Directors (Board), and various committees, as recorded during the period covered by this examination, were reviewed and appeared to be complete and in order with regard to actions brought up at the meetings for deliberation and appropriate action, which included the approval and support of the Company's transactions and events, as well as the review of the audit and examination report.

MANAGEMENT AND CONTROL

Board of Directors

The Articles of Incorporation and Bylaws vest the management and control of the Company's business affairs with the Board of Directors (Board). The members of the duly elected Board, along with their place of residence, number of years as director, and principal occupation at December 31, 2011 were as follows:

Name and Residence	Year Elected / Appointed	Principal Occupation
Glen John Golemi Covington, LA	2006	President & CEO United HealthCare Services, Inc.
Jocelyn Chisholm Carter Madison, MS	2011	Sr. Associate General Counsel United HealthCare Services, Inc.
Robert James Friedrichs Alpharetta, GA	2008	Southeast Region Chief Financial Officer United HealthCare Services, Inc.

Audit Committee

The Audit Committee, in coordination with UHG, is responsible for supervising audit work and reviewing the audit report prepared by the outside accounting firm. The committee also makes recommendations to the Board regarding the report and the selection of an outside accounting firm. The committee is also responsible for overseeing the Company's compliance with the Annual Financial Reporting Model Regulation and for ensuring management establishes, implements, and monitors a system of internal controls over financial reporting. The Audit Committee, consisting of three members, two of which are outside directors, meets quarterly and as needed.

Name	Relationship	Occupation
Daniel M. Cummings (Chair)	Independent	Audit Committee Chairman of several UHG legal entities, including UHC-MS.
Richard G. Dunlop	Independent	Vice President of Exchange Development Licensed CPA (OH).
Robert J. Friedrichs	Director	Southeast Region Chief Financial Officer United HealthCare Services, Inc.

Officers

Name	Year Elected / Appointed	Title
Glen John Golemi	2006	President and Chief Executive Officer
Bridget Leigh Galatas	2010	Chief Financial Officer
Robert Worth Oberrender	2003	Treasurer
Nyle Brent Cottington	2008	Assistant Treasurer
Christina Regina Palme-Krizak	2009	Secretary
Michelle Marie Huntley Dill	2009	Assistant Secretary

Name	Year Elected / Appointed	Title
Juanita Bolland Luis	2005	Assistant Secretary

Conflict of Interest

The Company has an established policy whereby each officer and director completes a conflict of interest questionnaire each year disclosing any potential or conceivable conflict with the director's or officer's responsibilities within or for the Company. The conflict of interest questionnaires were completed by all the directors and officers of the Company for the calendar years 2009, 2010 and 2011. A review of the disclosures made by the officers and directors did not reveal any material exceptions to the Company's established policies.

Corporate Governance

The risk-focused surveillance approach requires examiners to consider the insurer's corporate governance and established risk management processes. This evaluation includes assessing the "tone at the top", board of directors and management oversight and understanding and conveyance of the necessity of internal controls to employees. The Company shares common management and control with its ultimate parent company, UnitedHealthcare Group, (UHG). While the executive management of UHC-MS is in charge of the day to day operations of the business, UHG senior officers serve as a resource for the Company to study, analyze and recommend strategic courses of actions to be undertaken. The ultimate authority regarding the direction of the Company's business rests with UHG's senior management and the Board.

Upon review of the corporate governance structure, it was noted that the Company has an experienced board of directors and management team. The Company has appropriately and adequately bonded its directors and officers. At year-end, the Board of Directors, which per the Company Bylaws, are appointed by the shareholders (UHC) and hold a term of office until the next meeting of the shareholders, consisted of three non-independent members. All non-independent members are employees of the ultimate parent company, UHG. The Board is required to meet at least annually. In addition, the Board regularly conducts business via conference calls and written consents throughout the year. The Board had appointed an Audit Committee with insurance and financial expertise. The management records, such as Board and Audit Committee meeting minutes appeared to be in order. Information regarding the Board members, Audit Committee and other related information can be found in the "Management and Control" section of this report.

The appropriateness of the entity's organizational structure and its ability to provide the necessary information flow to manage its activities were considerations in obtaining our understanding of the organizational structure. Our consideration also encompassed understanding of the assignment of authority and responsibility. Our consideration of corporate governance encompassed the risk management function through discussions with senior management and members of the Board and through gaining an understanding of the risk

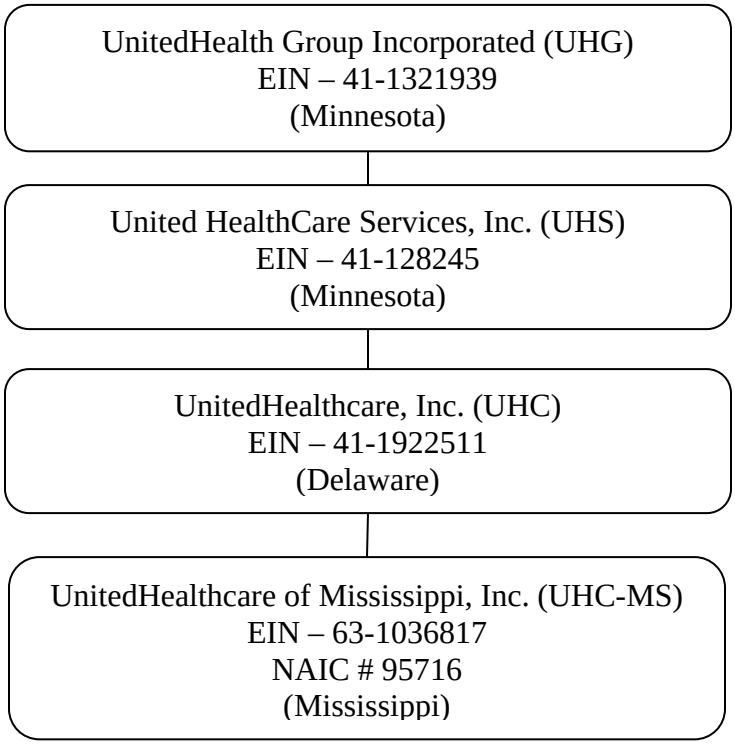
management function including inspection of relevant risk management documentation. Upon our review and consideration of these components and functions, there were no material concerns or exceptions noted.

Management competence is a consideration in overall assessment of corporate governance. In our review of this area, we considered factors such as management's experience level and management turnover. There were no material concerns noted upon our consideration of this area. As indicated in the Management and Control section of this report, key management has significant experience with the Company and the officer/employee turnover ratio was low.

HOLDING COMPANY STRUCTURE

The Company is a member of an insurance holding company system as defined in Miss. Code Ann. §83-6-1. For the period covered by the examination, the Company filed holding company registration statements with the MID in compliance with Miss. Code Ann. §83-6-5 and §83-6-9.

Organizational Chart (Simplified)



UnitedHealth Group Incorporated (UHG) (ultimate parent) is a publicly-held company listed on the New York Stock Exchange under the ticker symbol UNH. At December 31, 2011, the UnitedHealth Group's consolidated assets were approximately $67.9 billion with a net worth of approximately $28.3 billion. The company offers a broad range of products through locally-

based health plans and specialty care management companies. The services include HMOs PPOs, health plan management, managed mental health and substance abuse services, utilization management, workers compensation/casualty services, specialized provider networks, employee assistance services, Medicare and managed care programs for the aged, healthcare evaluation services, information systems and administrative services.

United HealthCare Services, Inc. (UHS) is a wholly-owned HMO management corporation that provides consumer-oriented health benefit plans and services for individuals, families and companies. It offers health plans for medical, life insurance, vision, dental, disability, pharmacy; and Medicare plans. The company was founded in 1977 and is based in Edina, Minnesota. United HealthCare Services, Inc. operates as a subsidiary of UnitedHealth Group, Inc. (UHG) and provides services to the Company under the terms of a management services agreement.

UnitedHealthcare, Inc. (UHC) is a wholly-owned corporation that markets health benefits products through the following businesses: UnitedHealthcare Employer & Individual (E&I), UnitedHealthcare Medicare & Retirement (M&R) and UnitedHealthcare Community & State (C&S). These businesses share similar economic characteristics, products and services, types of customers, distribution methods, operational processes and regulatory environment. They also share significant common assets, including contracted networks of physicians, healthcare professionals, hospitals and other facilities, information technology infrastructure and other resources and provide services to the Company under the terms of a management services agreement.

Affiliated and Related Party Agreements & Transactions

The Company's transactions with related parties were reviewed and the following items were considered notable for purposes of this report:

- **Cash Contribution from Parent**
  The Company received a cash contribution of $15,000,000 on December 27, 2010, from UnitedHealthcare, Inc. (UHC) which was recorded as an increase to gross paid-in and contributed surplus. This infusion was in anticipation of launching the new Coordinated Access Network ("MississippiCAN") program through the Mississippi Division of Medicaid. The Company "repaid" this capital infusion through a $15,000,000 extraordinary dividend (to UHC) declared on October 29, 2012, approved by the Department on January 3, 2013 and paid on January 4, 2013.

- **Management Services Agreement**
  Effective January 1, 2011, the Company entered into a revised Management Services Agreement (MSA) with United HealthCare Services, Inc. (UHS). This agreement superseded and replaced the Amended and Restated MSA effective 12/31/1999. UHS provides administrative, claims administration, policy administration, member services and other services to the Company. The agreement also revised the fee structure from a percentage of net premium income and change in unearned premium reserves and reserve for rate credits, to a direct charge based on UHS's expenses for service or use of assets provided to the Company.

Mgmt. Services	2011	2010	2009
Management Fees	$5,504,000	$345,000	$0

- **Reinsurance Agreement (RSA-109)**
  Effective January 1, 2001, the Company entered into a reinsurance agreement with UnitedHealthcare Insurance Company (UHIC) for its commercial members. Under the agreement, UHIC reimburses 90% of eligible inpatient services in excess of $150,000 per member per contract year in exchange for a premium of $0.74 per member per month. The maximum reimbursement available is $2,000,000 per member annually. There is an additional 10% coinsurance waiver for use of designated network facilities, and a risk share plan whereby UHIC will return to the Company a portion of premiums paid in excess of recoveries.

Reinsurance	2011	2010	2009
Ceded Premiums	$3,310,000	$8,000	$0
Reins. Recoveries	$3,179,000	$7,000	$0

- **Combined Billing and Disbursement Operations Agreement**
  Effective January 9, 2004, the Company entered into the Agreement for Combined Billing and Disbursement Operations with UHIC and United HealthCare Services (UHS) in order to provide a common lockbox for premium collection and a zero balance disbursement account for the payment of certain bills.

Premiums	2011	2010	2009
Net Premium Income	$125,856,619	$2,869,286	$13,192

- **Tax Sharing Agreement**
  Effective December 20, 2005, the Company entered into the First Restated Tax Sharing Agreement with UnitedHealth Group, Inc., which provides for the formal allocation and payment of federal, state, and local income tax liabilities related to the consolidated federal tax return. Under this agreement, the determination of ordinary income or short or long-term capital gains or losses will be made on a separate company basis.

Taxes	2011	2010	2009
Federal & Foreign Income Taxes Incurred	$6,467,485	$200,833	$48,447

- **Revolving Credit Agreement**
  The Company also holds a $2,000,000 subordinated revolving credit agreement with United Healthcare Corporation at an interest rate of LIBOR plus 0.50%. This credit agreement is subordinated to the extent it does not conflict with any credit facility held by

either party. The aggregate principal; amount that may be outstanding at any time shall not exceed $2,000,000 and agreement is for one year term that automatically renews annually unless terminated by either party. The agreement was renewed effective December 31, 2011, and no amounts were outstanding under the line of credit as of December 31, 2011.

Revolving Credit	2011	2010	2009
Year end outstanding	$0	$0	$0

FIDELITY BOND AND OTHER INSURANCE

Pursuant to Miss. Code Ann. §83-41-311(2), a health maintenance organization is required to maintain a fidelity bond or fidelity insurance on employees, officers, directors and partners in an amount not less than $250,000 for each health maintenance organization or a maximum of $5,000,000 in aggregate maintained on behalf of health organizations owned by a common parent corporation. The Company is the named insured on a Blanket Crime Coverage Policy with a coverage limit of $25,000,000 issued by an authorized company. The amount of coverage exceeds the minimum requirements as suggested by the National Association of Insurance Commissioner's guidelines. The Company is also a named insured on policies issued by authorized companies for normal hazards incident to conducting ordinary business.

PENSIONS, STOCK OWNERSHIP AND INSURANCE PLANS

The Company has no employees. All employees are provided to the Company by United HealthCare Services, Inc. (UHS), an affiliated administrator, pursuant to a management services agreement; therefore, the Company does not provide any employee benefits and has no liability directly attributable to employee benefits other than amounts payable to UHS.

TERRITORY AND PLAN OF OPERATION

The Company is licensed to provide comprehensive medical and hospital products to its members, which are primarily employer groups or Medicaid recipients. The Company has two divisions of business: Commercial Products (Employer & Individual or E&I) and Community & State (also referred to as "Medicaid" or "C&S"). The E&I products side, which was approximately 8% of 2011 written premium, is primarily composed of group comprehensive hospital & medical plans for large national employers, public sector employees, mid-sized employers, small businesses and individuals. The C&S products side, approximately 92% of 2011 written premium, is composed primarily of the MississippiCAN Medicaid product under a contract with the Mississippi Division of Medicaid (DOM), and provides health care solutions to states that care for the economically disadvantaged, the medically underserved and those without

the benefit of employer funded coverage via health plans serving beneficiaries of Medicaid Plans, and other federal and state health care programs.

GROWTH OF COMPANY

The following table indicates key figures in evaluating the growth of the Company over the last three years:

	2011	2010	2009
Total admitted assets	$ 59,300,434	$ 20,685,818	$ 4,179,549
Total liabilities	$ 28,569,006	$ 15,378,838	$ 12,268
Total capital and surplus	$ 30,731,428	$ 5,306,980	$ 4,167,281
Direct premiums written	$ 129,166,768	$ 2,877,292	$ 13,192
Ceded premiums written	$ 3,310,149	$ 8,006	$ -
Net premium income	$ 125,856,619	$ 2,869,286	$ 13,192
Net underwriting gain (loss)	$ 32,032,785	$ (13,933,606)	$ 105,679
Net Income (loss)	$ 25,590,483	$ (14,107,934)	$ 91,957

RESERVING AND UNPAID CLAIMS EXPERIENCE

The Company's Chief Actuary, Mr. Allen Sorbo, FSA, MAAA, issued the actuarial opinions for the period under examination. Each actuarial opinion reported that the amounts carried in the balance sheet for reserves and related actuarial items were fairly stated and computed in accordance with reserving standards and actuarial principles, reasonably provided for all unpaid claims and claims adjustment expense obligations of the Company, and met the requirements of the insurance laws of the State of Mississippi.

The Company's unpaid claims and claims adjustment expense reserves as of December 31, 2011 were reviewed as part of the current examination. This review indicated no adjustment was required to the Company's unpaid claims and claims adjustment expense reserves for this examination report.

REINSURANCE

The Company was party to one reinsurance agreement during the exam period. Effective January 1, 2001, the Company entered into an agreement with United HealthCare Insurance Company (UHIC). Under the agreement, the deductible per member per agreement year is $150,000 for UHCMS. Claims in excess of the deductible are reimbursed at 90% of the excess

loss above $150,000 for inpatient services or 100% if services are received in a facility formally credentialed by certain entities. The maximum lifetime reinsurance indemnity payable for any one member is $2,000,000.

Additionally, since 2004, UHG had in place a $5MM guaranty bond filed on behalf of UHCMS and pledged to the MID in lieu of the Company obtaining the reinsurance through its affiliate, UHIC. Due to an oversight, the reinsurance agreement effective January 1, 2001 (above) was never non-renewed after the guaranty bond was put in place. When the Mississippi DOM awarded UHCMS the MississippiCAN (MSCAN) contract, it required reinsurance, so UHCMS filed Amendment No. 2 with the MID for the purpose of adding this reinsurance to the MSCAN Medicaid program. However protection for the MSCAN program is also included under the guaranty bond. For 2013, the Mississippi DOM has advised that the reinsurance is no longer required for the MSCAN program. Therefore, the Company terminated the January 1, 2001 agreement and Amendment No. 2 effective December 31, 2012 – see Subsequent Events.

ACCOUNTS AND RECORDS

The Company's books and records are fully automated. The accounting system produces a general ledger, subsidiary detail and other reports as required for the preparation of the financial statements and other regulatory reporting. Tests of the Company's accounts and records were determined based upon the examination procedures promulgated by the NAIC and applicable policies and directives issued by the Department. The Company's systems appear to furnish a reliable audit trail.

The Company's financial statements are subject to an annual audit conducted by independent certified public accountants. Deloitte & Touche, LLP performed the statutory audit for all years in the examination period. Unqualified opinions were issued for each year of the examination period.

STATUTORY DEPOSITS

The Company's statutory deposits with the state of Mississippi complied with Miss. Code Ann. §83-41-325(5). The following chart displays the Company's deposits at December 31, 2011.

Description	Par Value	Book Value	Fair Value
US Treasury Bond	$600,000	$737,318	$769,734

UNITEDHEALTHCARE OF MISSISSIPPI, INC.

FINANCIAL STATEMENTS
EXAMINATION AS OF DECEMBER 31, 2011

The following financial statements reflect the same amounts reported by the Company and consist of a Statement of Admitted Assets, Liabilities, Surplus and Other Funds – Statutory at December 31, 2011, a Statement of Income – Statutory for the year ended December 31, 2011, a Reconciliation of Capital and Surplus – Statutory for examination period ended December 31, 2011, and a Reconciliation of Examination Changes to Surplus – Statutory at December 31, 2011.

UNITEDHEALTHCARE OF MISSISSIPPI, INC.

STATEMENT OF ASSETS, LIABILITIES, SURPLUS AND OTHER FUNDS
DECEMBER 31, 2011

Assets		
Bonds	$	737,318
Cash and short-term investments		51,967,981
Cash and invested assets		52,705,299
Investment income due and accrued		6,612
Uncollected premiums and agents' balances		60,605
Amounts recoverable from reinsurers		1,810,316
amounts receivable relating to uninsured plans		210,810
Current Federal & Foreign income tax recoverable		3,480,503
Net deferred tax asset		441,597
Health Care and other amounts receivable		304,916
Aggregate write ins for other than invested assets		279,776
		-
Total Assets	**$**	**59,300,434**
Liabilities, Surplus and Other Funds		
Claims Unpaid	$	10,376,474
Unpaid claims adjustment expenses		281,011
Aggregate health policy reserves		7,036
Aggregate health claims reserves		50,033
Premiums received in advance		3,779,921
General expenses due and accrued		162,595
Ceded reinsurance premium payable		858,252
Amounts due parrent, subsidiaries and affiliates		828,796
Liability for amounts held under uninsured plans		2,606,940
Aggregate write ins for other liabilities		9,617,948
Total Liabilities		**28,569,006**
Common Capital Stock		20
Gross Paid in and Contributed Capital		32,827,293
Unassigned funds (surplus)		(2,095,885)
Total Capital and Surplus		**30,731,428**
Total Liabilities, capital and surplus	**$**	**59,300,434**

UNITEDHEALTHCARE OF MISSISSIPPI, INC.

SUMMARY OF OPERATIONS
FOR YEAR ENDED DECEMBER 31, 2011

Member Months	297,094
Revenue	
Net Premium Income	$ 125,856,619
Change in Unearned Premium Reserves	(2,881)
Total Revenues	$ 125,853,738
Underwriting Deductions	
Hospital/medical benefits	$ 64,480,823
Other professional services	4,134,565
Prescription Drugs	35,086,060
Net Reinsurance recoveries	(3,179,259)
Total Hospital and Medical	100,522,189
	-
Claims adjustment expense	3,236,592
General administrative expenses	4,522,172
Increase in reserve for life, A&H contracts	(14,460,000)
Total Underwriting Deductions	93,820,953
Net Underwriting Gain/Loss	32,032,785
	-
Net Investment income	25,183
Net Income before taxes	32,057,968
Federal & Foreign Income Taxes Incurred	6,467,485
Net Income	$ 25,590,483

UNITEDHEALTHCARE OF MISSISSIPPI, INC.

RECONCILIATION OF CAPITAL AND SURPLUS
FOR EXAMINATION PERIOD ENDED DECEMBER 31, 2011

	2011	2010	2009
Capital & Surplus, beginning of the year	$ 5,306,980	$ 4,167,281	$ 4,076,018
Net Income	25,590,483	(14,107,934)	91,957
Change in net deferred income tax	192,330	249,127	(694)
Change in non-admitted assets	(358,365)	(1,494)	-
Paid in	-	15,000,000	(9,600,000)
Aggregate write ins of gains/losses of surplus	-	-	9,600,000
Net change in Capital & Surplus	25,424,448	1,139,699	91,263
Capital & Surplus, end of the year	$ 30,731,428	$ 5,306,980	$ 4,167,281

UNITEDHEALTHCARE OF MISSISSIPPI, INC.

RECONCILIATION OF EXAMINATION ADJUSTMENTS TO NET WORTH
DECEMBER 31, 2011

There were no changes made to the assets, liabilities or net worth reported by the Company for the year ended December 31, 2011. The net worth, which totaled ($30,731,428) as of the examination date, was determined to be reasonably stated and in compliance with Miss. Code Ann. §83-41-325.

COMMENTS ON FINANCIAL STATEMENT ITEMS

Assets

There were no adjustments to assets during this examination.

Liabilities, Capital and Surplus

There were no adjustments to liabilities during this examination.

Capital and Surplus

The amount reported by the Company of $30,731,428 has been accepted for the purposes of this examination. Thus, there has been no change to the Company's Risk-Based Capital (RBC) ratio as of December 31, 2011.

The 2009 paid in capital reduction of $9,600,000 was an adjustment for a historical dividend reclassified from paid in capital. As noted previously, the Company received a cash contribution of $15,000,000 in 2010 from United Healthcare, Inc. (UHC) in anticipation of launching the new Coordinated Access Network (MississippiCAN) program through the Division of Medicaid. The Company "repaid" this capital infusion through a $15,000,000 extraordinary dividend (to UHC) declared on October 29, 2012, approved by the Department on January 3, 2013 and paid on January 4, 2013.

Risk-Based Capital

During the period under examination, the Company reported its Risk-Based Capital (RBC) ratio at a more than adequate level. The Company's RBC ratios, defined as total adjusted capital divided by authorized control level RBC, for the period under examination are as follows:

2009	494.8%
2010	2,755.6%
2011	719.1%

The significant changes were attributable to the cash contribution of $15,000,000 in late 2010 from United Healthcare, Inc. (UHC) in anticipation of launching the new Coordinated Access Network (MississippiCAN) effective January 1, 2011.

MARKET CONDUCT ACTIVITIES

A limited scope, market conduct examination was conducted in conjunction with the financial examination that included the following areas:

Operations Management
Producer Licensing and Appointment
Complaint and Grievance Handling
Claims Handling
Network Adequacy
Provider Credentials

The purpose of the limited scope market conduct examination was to review compliance by the Company with Mississippi Insurance Laws, Regulation, Bulletins and the NAIC Guidelines. NAIC Guidelines set the standard of conduct for a health insurer and promote a program of fair treatment of policyholders. Portions of the NAIC Market Regulation Handbook were used as a measure of compliance. Additionally, the examination reviewed certain areas as directed by the Chief Examiner at the MID.

A risk-focused approach was used to understand and assess the effectiveness of administrative and operating internal controls utilized by the Company to address selected market conduct requirements. Generally, examiners gained an understanding of controls and risk mitigation strategies and performed tests, as considered necessary, to assess the effectiveness of the controls and risk mitigation strategy. Additional substantive testing was performed to determine market conduct compliance with applicable rules and regulations based upon the results of these assessments and guidance from the MID.

Operations Management

The examination included a review of the Company's policies, practices and procedures regarding protection and disclosure of nonpublic personal information of customers, former customers and consumers who are not customers, to verify they comply with applicable state laws regarding privacy. In particular, to ensure appropriate privacy notices are provided to customers at, or prior to, the time the Company establishes a customer relationship and at least once in any period of twelve (12) consecutive months or once in each calendar year thereafter (annual notice) in accordance with Mississippi Regulation 2001-1 (*Privacy of Consumer Financial and Health Information Regulation*).

It was noted the Company provides active customers with notice of the privacy policy at least once a year. In the event of privacy policy changes, customers are sent an updated notice. Examiner reviews indicated a privacy statement was included within the packet of forms delivered to new insured's. The privacy policy is also posted on the Company web site. The Company had a privacy policy in place for the protection of policy holders and non-insured customers. No issues were noted related to the Company's policies, practices and procedures

regarding privacy protection and compliance with applicable regulatory requirements.

Producer Licensing and Appointment

For the period under examination, the Company relied upon producers who were licensed and appointed with the MID for commercial healthcare enrollments. Enrollment in the MississippiCAN program is administered solely by the Mississippi Division of Medicare (DOM) and does not require the use of producers/agents, and therefore, was out of scope for this market conduct assessment. The Company provided a listing of all commercial producers licensed and appointed (whether receiving commissions or not) from January 1, 2011 through December 31, 2011 and examiners compared the list to the MID's producer database using computer aided audit techniques to reconcile the company listing of commercial producers to information provided to MID. Discrepancies noted in this reconciliation were as follows:

- For fourteen (14) policies, the policy effective date was more than 15 days prior to the producer appointment date rendering the Company out of compliance with MS. Code Ann 83-17-75 (2).

It is recommended that the Company ensure that each producer is appointed, pursuant to MS. Code Ann 83-17-75 (2), prior to accepting written policies.

Complaints & Grievances Handling

The Company's policies and practices for handling complaints and grievances were reviewed as part of the Market Conduct examination. The Company maintains a complaint log that was found to record data categories as recommended by the NAIC. It was noted that the Company did not start tracking informal (oral) complaints for the new (effective January 1, 2011) "MississippiCAN" Medicaid program until January 2012. In August of 2011, the Mississippi DOM requested that the Company begin to report this information, and the Company implemented reporting in January 2012. Examiners judgmentally selected and reviewed the January, February and March 2012 Grievance/Complaint monitoring reports containing 150 informal grievances (complaints) and 5 formal grievances. Informal complaints were generally related to access to services/providers, benefit denial/limitation and administrative issues. The five formal grievances were all related to benefit denial or limitation issues. No issues were noted related to the Company's policies, practices and procedures regarding complaints and grievances and compliance with applicable regulatory requirements.

Claims Handling

The Company's policies and practices for ensuring that claims are properly handled were reviewed as part of the Market Conduct examination based upon a download of all claims paid, pended or denied during the quarter ending December 31, 2011. This work focused on compliance with Miss Ann Code 83-9-5 which requires prompt payment of claims. Results were noted as follows:

Combined Out of Compliance (OOC) Results						
	Claim Count			Final Disposition Amount		
	OOC Count	Total Population	OOC%	OOC Paid	Total Paid	OOC%
Total	17,051	416,153	4.10%	$938,738	$25,193,075	3.73%

In addition, testing performed to confirm the accuracy of data provided for the analysis above indicated that examination standards for data quality were not met. Discrepancies were noted in the dates claims were paid/denied for Commercial claims and MSCAN claims as described below.

- For the Commercial sample of 109 claims, 43 final disposition dates did not match supporting documentation. The dates differed by up to six days.

Additionally, the systemically calculated interest amount associated with MSCAN claims was incorrect. The system was automatically accruing 1.5% interest per year, rather than 1.5% per month as required under MS 83-9-5 (1)(h)(3).

Network Adequacy

The Company's policies and practices for ensuring appropriate healthcare access to enrollees were reviewed as part of the Market Conduct examination. Examiners reviewed the 2011 Availability of Practitioners & 2012 Accessibility Analyses for the Southeast Region E&I business provided by the Company. The Company achieved all performance standards except for geographical availability of Urgent Care Centers as measured by the geo-access reports. The Company had appropriately identified actions to improve performance. Examiners conclude the Company had developed appropriate accessibility metrics and monitors performance against defined standards at least annually.

For the MississippiCAN (C&S) program, examiners judgmentally selected and reviewed the third and fourth quarter 2011 "Managed Care Accessibility Analysis". The Company measures geographic accessibility based on member location against performance standards (by county) for rural and urban areas for various provider groups and types. Examiners also judgmentally selected three months of the monthly "Management Reports" used in monthly discussions with the MS DOM, and reviewed the reasonableness and adequacy of metrics. Additionally,

examiners judgmentally selected and reviewed the National Quality Oversight Committee meeting minutes and the National Service Operations Committee Meeting Minutes for evidence of review and oversight of metrics to ensure an effective network of providers. The Company had developed and effectively implemented adequate network measurements and reporting procedures.

Provider Credentials

The Company's policies and practices for ensuring appropriate healthcare access to enrollees were reviewed as part of the Market Conduct examination. The UHG National Credentialing Center has a Credentialing Plan and associated policies and procedures developed to maintain compliance with state, federal and accrediting agency regulations and requirements, including written policies and procedures for credentialing and re-credentialing verification of all health care professionals with whom the Company contracts. This is a shared process in which the regulated entity (UHC-MS) benefits. Examiners noted that the Connecticut (CT) examination team (coordinated exam lead state) tested the effectiveness of the credentialing process and also reviewed the 2011 audit report prepared by the UHG internal audit organization. Examiners noted that the CT examination team assessed the credentialing internal controls as strong, and therefore, will rely on the judgment, test work, results and conclusions of the CT examiners in accordance with NAIC guidelines. The Company had developed and effectively implemented adequate provider and credentialing procedures.

COMMITMENTS AND CONTINGENT LIABILITIES

During and subsequent to the examination period, the Company was not involved in litigation outside the normal course of business.

SUBSEQUENT EVENTS

Subsequent year end, UHCMS received communication from the state regarding the amount owed for the Inpatient Savings Program. Based on an analysis performed by state-hired third party consultant, Milliman, UHCMS owed the state $730,000 more than was reported as a liability ($2.61MM) for 2011. The independent CPA, Deloitte & Touche LLP (D&T) determined that this was because of a "look back" assessment which analyzed claims experience and compared this to the expected cost. D&T concluded this was not an error as the company used the information they had available at the time to record the liability, and the additional information was not available until after year end. UHG concluded that was a Type 2 subsequent event as the information was not available to UHCMS prior to year end. D&T concurred and noted the subsequent event was properly disclosed in the subsequent event footnote in the annual statement. The Inpatient Savings Program ended effective December 31, 2012 for existing MississippiCAN membership and was not in effect for the members who came into the plan during the expansion effective December 1, 2012. Liability balances attributed to the Inpatient Savings Program for 2011 will be settled during 2013, with 2012 balance expected

to be settled in 2014.

The Reinsurance Agreement (RSA-109) with UHIC effective January 1, 2001 was terminated effective December 31. 2012, as it was no longer a requirement of the Mississippi Division of Medicaid. The MID did not object to this termination provided the $5MM guaranty bond remained in place.

COMMENTS AND RECOMMENDATIONS

In addition to the Comments on Financial Statements noted in the previous section of this report, the following comments and recommendations were noted during the examination as of December 31, 2011:

Market Conduct

- Producer Licensing

  For the period under examination, the Company relied upon producers who were licensed and appointed with the MID for commercial healthcare enrollments. Enrollment in the MississippiCAN program is administered solely by the Mississippi Division of Medicare (DOM) and does not require the use of producers/agents, and therefore, was out of scope for this market conduct assessment. The Company provided a listing of all commercial producers licensed and appointed (whether receiving commissions or not) from January 1, 2011 through December 31, 2011 and examiners compared the list to the MID's producer database using computer aided audit techniques to reconcile the company listing of commercial producers to information provided to MID. Discrepancies noted in this reconciliation were as follows:

  - For fourteen (14) policies, the policy effective date was more than 15 days prior to the producer appointment date rendering the Company out of compliance with MS. Code Ann 83-17-75 (2).

  It is recommended that the Company ensure that each producer is appointed, pursuant to MS. Code Ann 83-17-75 (2), prior to accepting written policies.

- Claims

  The Company's policies and practices for ensuring claims are properly handled were reviewed as part of the Market Conduct examination based upon a download of all claims paid, pended or denied during the quarter ending December 31, 2011.

This work focused on compliance with Miss Ann Code 83-9-5 which required prompt payment of claims. Results were noted as follows:

Combined Out of Compliance (OOC) Results						
	Claim Count			Final Disposition Amount		
	OOC Count	Total Population	OOC%	OOC Paid	Total Paid	OOC%
Total	17,051	416,153	4.10%	$938,738	$25,193,075	3.73%

In addition, testing performed to confirm the accuracy of data provided indicated that examination standards for data quality were not met. During claims accuracy testing issues were identified with the claims paid/denied dates for both Commercial claims and MSCAN claims.

- For the Commercial sample of 109 claims, 43 final disposition dates did not match supporting documentation. The dates differed by up to six days.

Additionally, the systemically calculated interest amount associated with MSCAN claims was incorrect. The system was automatically accruing 1.5% interest per year, rather than 1.5% per month as required under MS 83-9-5 (1)(h)(3).

We recommend the Company pay claims in accordance with Miss Ann Code 83-9-5 and maintain data necessary to confirm compliance.

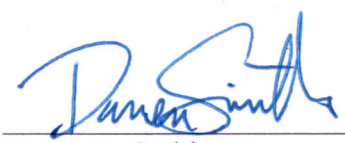
ACKNOWLEDGMENT

The examiners representing the Mississippi Insurance Department and participating in this examination were:

Examiner-In-Charge:	Darren L. Smith
Examiners:	Trina Barton, CPA, AMCM Elizabeth J. Forney, CPA Kristina Gaddis, CFE, CISA Joanne Smith
Supervising Examiner:	John B. Humphries, ASA, MAAA, CFE, AES, MCM, CISA
Actuary:	Michael Presley, FSA, MAAA

The courteous cooperation of the officers and employees responsible for assisting in the examination is hereby acknowledged and appreciated.

Respectfully submitted,



Darren L. Smith
Examiner-In-Charge
AGI Services