MIKE CHANEY
Commissioner of Insurance
State Fire Marshal

MARK HAIRE
Deputy Commissioner of Insurance

RICKY DAVIS
State Chief Deputy Fire Marshal

MISSISSIPPI INSURANCE DEPARTMENT

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

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

June 18, 2018

CERTIFIED MAIL
RETURN RECEIPT REQUESTED

Mr. Joseph Anthony Ochipinti, President and CEO
UnitedHealthcare of Mississippi, Inc.
795 Woodlands Parkway, Suite 301
Ridgeland, MS 39157

RE: Report of Examination as of December 31, 2016

Dear Mr. Ochipinti:

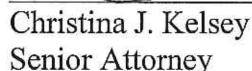
In accordance with Miss. Code Ann. §§ 83-5-201 et seq. and 83-41-337(1) (Rev. 2011), an examination of your Company has been completed. Enclosed herewith is the Order adopting the report and a copy of the final report as adopted.

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. 18-7298**

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 Andy L. Jennings, Examiner-In-Charge, to conduct said examination.

IV.

That on or about May 8, 2018, the draft Report of Examination concerning UnitedHealthcare of Mississippi, Inc. for the period of January 1, 2012, through December 31, 2016, was submitted to the Mississippi Department of Insurance by Examiner-In-Charge, Andy L. Jennings.

V.

That on or about May 25, 2018, 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 email on or about June 14, 2018, 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 prepaid, 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 18th day of June 2018.

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 18th day of June 2018, to:

Mr. Joseph Anthony Ochipinti, President and CEO
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, 2016

TABLE OF CONTENTS

EXAMINER'S AFFIDAVIT AS TO STANDARDS AND PROCEDURES USED IN AN EXAMINATION 1

SCOPE OF EXAMINATION....2

COMMENTS AND RECOMMENDATIONS OF PREVIOUS EXAMINATION 3

HISTORY OF THE COMPANY 4

CORPORATE RECORDS 4

MANAGEMENT AND CONTROL 4

STOCKHOLDERS....4
BOARD OF DIRECTORS....5
COMMITTEES 5
OFFICERS....6
CONFLICT OF INTEREST 6

HOLDING COMPANY STRUCTURE....6

ORGANIZATIONAL CHART 6
PARENT AND AFFILIATED COMPANIES 7
AFFILIATED AND RELATED PARTY TRANSACTIONS....8

FIDELITY BOND AND OTHER INSURANCE....17

PENSIONS, STOCK OWNERSHIP AND INSURANCE PLANS 18

TERRITORY AND PLAN OF OPERATION....18

GROWTH OF COMPANY....19

RESERVING AND UNPAID CLAIMS EXPERIENCE 19

REINSURANCE....19

ACCOUNTS AND RECORDS....20

STATUTORY DEPOSITS....20

FINANCIAL STATEMENTS 21

INTRODUCTION....21
STATEMENT OF ASSETS, LIABILITIES, CAPITAL AND SURPLUS 22
STATEMENT OF REVENUE AND EXPENSES....23
RECONCILIATION OF CAPITAL AND SURPLUS....24
RECONCILIATION OF EXAMINATION ADJUSTMENTS TO SURPLUS 25

MARKET CONDUCT ACTIVITIES....26

COMMITMENTS AND CONTINGENT LIABILITIES....33

SUBSEQUENT EVENTS 33

ACKNOWLEDGMENT....34

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

State of Texas,

County of Parker,

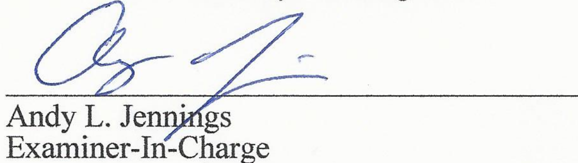
Andy L. Jennings, being duly sworn, states as follows:

1. I have authority to represent Mississippi Insurance Department in the examination of UnitedHealthcare of Mississippi, Inc. as of December 31, 2016.

2. The Mississippi Insurance Department is accredited under the National Association of Insurance Commissioners Financial Regulation Standards and Accreditation.

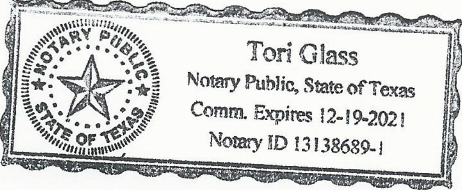
3. I have reviewed the examination work papers and examination report, and the examination of UnitedHealthcare of Mississippi, Inc. was performed in a manner consistent with the standards and procedures required by the National Association of Insurance Commissioners and the Mississippi Insurance Department.

The affiant says nothing further.

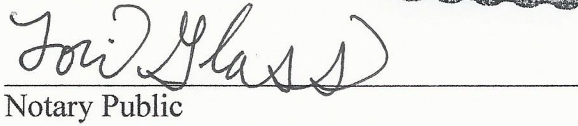


Andy L. Jennings
Examiner-In-Charge

Subscribed and sworn before me by Andy L. Jennings on this 23 day of May, 2018.



(SEAL)



Notary Public

My commission expires 12/19/2021 [date].

MIKE CHANEY
Commissioner of Insurance
State Fire Marshal

MARK HAIRE
Deputy Commissioner of Insurance

MISSISSIPPI INSURANCE DEPARTMENT

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

MAILING ADDRESS
Post Office Box 79
Jackson, MS 39205-0079
TELEPHONE: (601) 359-3569
FAX: (601) 576-2568

April 20, 2018

Honorable Mike Chaney
Commissioner of Insurance
Mississippi Insurance Department
1001 Woolfolk 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, 2016, of the affairs and financial condition of:

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

License #	NAIC Group #	NAIC #	FEETS#	MATS#
9500034	0707	95716	95716-MS-2016-2	MS-MS099-12

This examination was commenced in accordance with Miss. Code Ann. § 83-5-201 and § 83-41-337. The report of examination is herewith submitted.

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, including 17 states and 29 legal entities, conducted by the lead state of Connecticut and in conjunction with other jurisdictions of sub-group 5 (including Mississippi, Connecticut, Illinois, Texas). The last examination covered the period of January 1, 2009 through December 31, 2011. This examination covers the period of January 1, 2012 through December 31, 2016.

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, 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, in accordance with Miss. Code Ann. § 83-5-209 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/or the Company.

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, 2011:

Recommendation:

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

Resolution:

The Company resolved this issue. During the examination, it was noted that appointment approval effective dates were within 15 days of the requested effective date or date of policy writing.

Recommendation:

It is recommended that the Company pay claims in accordance with Miss. Code Ann. § 83-9-5 and maintain data necessary to confirm compliance.

Resolution:

The Company resolved this issue. During the examination, the effectiveness of selected internal controls for accuracy and completion of claim benefits and payments were tested and determined to be designed appropriately and operating effectively.

HISTORY OF THE COMPANY

The Company was incorporated on August 6, 1990 as Complete Health of Mississippi, Inc. ("CHM"), under the laws of the State of Mississippi. The Mississippi State Department of Health issued CHM a certificate of authority as a health maintenance organization (HMO) on June 1, 1992, and the Company commenced operations on January 1, 1993.

CHM became a member of the insurance holding company system of UnitedHealth Group, Incorporated ("UHG"), formerly known as United HealthCare Corporation, on May 31, 1994 with UHG's acquisition of United HealthCare South, Inc. ("UHC South"), formerly known as Complete Health Services, Inc., an Alabama corporation and sole shareholder of the Company. On April 30, 1996, UHG contributed the shares of UHC South to United HealthCare Services, Inc. ("UHS"), a Minnesota Corporation and wholly owned subsidiary of UHG, a Delaware corporation and publicly traded, diversified health company.

The Company changed its name to United HealthCare of Mississippi, Inc., effective May 1, 1996. Effective January 2, 1998, UHC South was merged into UHS, and the Company became a wholly owned subsidiary of UHS, who maintained control through its sole ownership of all issued and outstanding shares of the Company. On June 30, 2000, the Company's shares were transferred from UHS to UnitedHealthcare, Inc. ("UHC"), a Delaware corporation and wholly owned subsidiary of UHS. The Company changed the appearance of its name to UnitedHealthcare of Mississippi, Inc. on December 22, 2010 by filing Articles of Amendment to its Articles of Incorporation.

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

Stockholders

The Bylaws of the Company, as amended on December 22, 2010, to reflect the name change of the Company, provide that annual meetings of shareholders shall be held on the fourth Thursday in March, or at such other date and time as shall be designated from time to time by the Board and stated in the notice of meeting, at which they shall elect a Board by a plurality vote. A quorum is constituted as a majority of the votes entitled to be cast, represented in person or by proxy. The shareholder may also take action without a meeting if one or more consents in writing are signed by

all of the shareholders entitled to vote. All action taken by the sole shareholder during the period under examination was by unanimous written consent.

Board of Directors

The Articles of Incorporation and Bylaws vest the management and control of the Company's business affairs with the 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, 2016, were as follows:

Name and Residence	Year Elected / Appointed	Principal Occupation
Jocelyn C. Carter Madison, Mississippi	2011	Senior Associate General Counsel United HealthCare Services, Inc.
Joseph A. Ochipinti Orlando, Florida	2016	Market CEO, Employer & Individual United HealthCare Services, Inc.
Stephen L. Wilson, Jr. Franklin, Tennessee	2014	VP, Finance & Director of Network Management, Southeast Region Employer & Individual United HealthCare Services, Inc.

Committees

The Bylaws of the Company provide for the Board, by resolution adopted by a majority of the number of directors fixed by the bylaws or otherwise, may create one or more committees and appoint members of the Board to serve on them. Additionally, each committee must have two or more members, who serve at the pleasure of the Board. There were no committees established during the examination period, solely for the operations and activities of UHCMS.

As contemplated by the Charter of the UHS Audit Committee and pursuant to the Annual Financial Reporting Regulations promulgated by the NAIC and adopted by the relevant states (the Model Audit Rule), the Southeast Region UHS Audit Committee has been designated as the audit committee for UHCMS. 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 Model Audit Rule and for ensuring management establishes, implements, and monitors a system of internal controls over financial reporting. The Southeast Region Audit Committee provides coverage for multiple legal entities including UHCMS, consisting of three members, two of which are outside directors, and meets quarterly or as needed. The members of the committee, along with their relationship to the Company, and principal occupation at December 31, 2016, were as follows:

Name	Relationship	Occupation
James Yi-chen Huang	Independent	CFO, Southeast Region Community & State United HealthCare Services, Inc.
Salli J. Thompson (Chair)	Independent	Controller, OptumHealth Specialty Networks United HealthCare Services, Inc.
Stephen L. Wilson, Jr.	Director	VP, Finance and Director of Network Management, Southeast Region Employer & Individual United HealthCare Services, Inc.

Officers

Name	Year Elected / Appointed	Title
Joseph A. Ochipinti	2016	President and Chief Executive Officer
Sharon S. Estess	2016	Chief Financial Officer
Robert W. Oberrender	2003	Treasurer
Christina R. Palme-Krizak	2009	Secretary
N. Brent Cottington	2015	Vice President
Heather A. Lang Jacobsen	2015	Assistant Secretary
Erin E. Weber	2016	Assistant Secretary

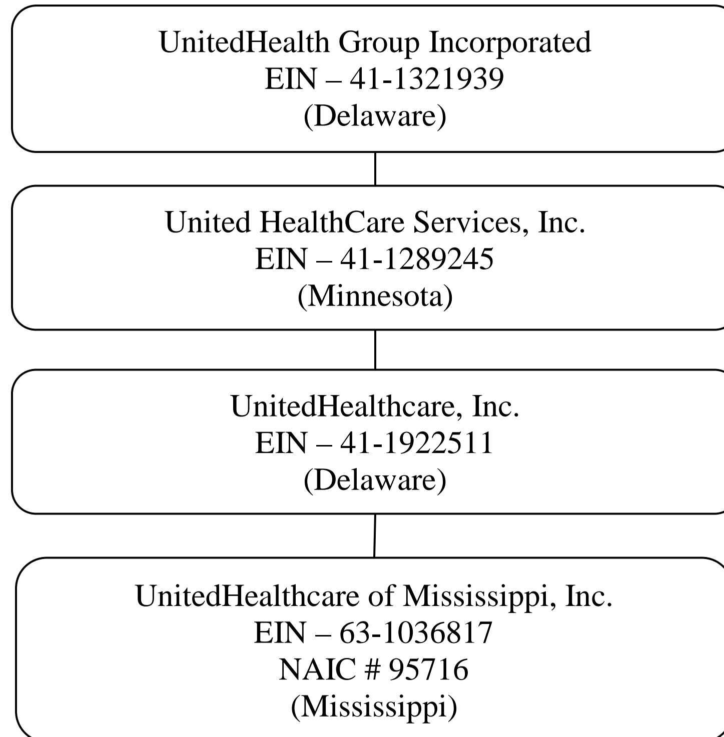
Conflict of Interest

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 each year of the examination period. A review of the disclosures made by the officers and directors did not reveal any material exceptions to the Company's established policies.

HOLDING COMPANY STRUCTURE

Organizational Chart

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, UHCMS filed holding company registration statements with the Mississippi Insurance Department ("MID" or "Department") in compliance with Miss. Code Ann. § 83-6-5 and § 83-6-9.



Parent and Affiliated Companies

UHG (ultimate parent) is a publicly-held company listed on the New York Stock Exchange under the ticker symbol UNH. At December 31, 2016, UHG's consolidated assets were approximately $122.8 billion with a net worth of approximately $38.2 billion. The corporation is a diversified health and well-being company that deploys core competencies in advanced, enabling technology, health care data, information and intelligence, and clinical care management and coordination to help meet the demands of the health system, through two distinct business platforms: health benefits operating under UnitedHealthcare and health services operating under Optum. There are four reportable segments across the two business platforms, which include: UnitedHealthcare (consists of UnitedHealthcare Employer & Individual ("E&I"), UnitedHealthcare Medicare & Retirement ("M&R"), UnitedHealthcare Community & State ("C&S"), and UnitedHealthcare Global); OptumHealth; OptumInsight; and OptumRx.

UHS is a wholly-owned HMO management corporation that provides health benefit programs for individuals and families, employers, military service members, retirees and their families, and Medicare and Medicaid beneficiaries. It offers Medicare plans, Medicaid plans, medical plans, consumer driven health plans, dental plans, vision plans, disability plans, life insurance plans, critical illness plans, and accident insurance plans. Plans are sold through brokers, consultants, Medicare agents and brokers, and online portals. Programs are offered through direct contracts with physicians and care professionals, hospitals, and other care facilities. The corporation was founded in 1977 and is based in Minnetonka, Minnesota. UHS operates as a subsidiary of UHG and provides services to the Company under the terms of a management services agreement.

UHC is a wholly-owned corporation that provides healthcare planning and management services through its subsidiaries. The corporation was incorporated in 1998, and operates as a subsidiary of UHS.

Affiliated and Related Party Transactions

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

- **Management Services Agreement**
  Effective January 1, 2011, UHCMS entered into a Management Services Agreement with UHS. Under the terms of the agreement, UHS provides management and operational support to the Company through a number of services, including but not limited to, banking, financial reporting, human resources, IT systems, audit, legal, compliance, regulatory affairs, facilities, taxes, insurance, treasury and investments, actuarial and underwriting, benefit design and administration, call centers and support activities, claims adjudication and payment systems, cost containment, data clearinghouse and warehouse systems, data management, disease management, financial administration systems, marketing, advertising, sales, public relations, medical management, payment integrity, pharmacy benefits management, provider networks and relations, quality oversight, specialty benefit management systems, third party administration, and wellness management. This agreement supersedes and replaces the Amended and Restated Management Agreement effective December 31, 1999. The agreement was submitted to MID for review on November 30, 2010, and was approved on December 21, 2010.

  Effective January 1, 2015, UHCMS entered into the First Amendment to the Management Services Agreement with UHS. The amendment reflects modifications in the Third Party Administrator, Medicare Provisions and Medicaid Provisions, and the addition of an Exchange Regulatory Appendix Provision to comply with regulatory requirements. The first amendment was submitted to MID for review on November 7, 2014, and was approved on November 24, 2014. Fees under the agreement totaled the following during the examination period:

Management Services	2016	2015	2014	2013	2012
Management Fees	$83,950,024	$61,301,319	$16,351,945	$13,577,354	$7,606,000

- **UnitedHealthcare Insurance Company – Premium Allocation Agreement**
  Effective January 1, 1998, UnitedHealthcare Insurance Company ("UHIC") and UHS entered into a Premium Allocation Agreement acting on behalf of its affiliates including but not limited to UHCMS. UHCMS was added to the agreement as a participant through signing a Participating Addendum effective January 1, 1998. Under the terms of the agreement, UHIC provides health insurance coverage, which is marketed and issued in conjunction with products covered for members enrolled with the various managed care organizations under contract with UHS, including members enrolled with UHCMS. UHIC receives a percentage of consideration received for the policies and the HMO products.

Effective December 1, 2007, an amendment was added to comply with SSAP No. 96 on Accounting for and Disclosures about Transactions with Affiliates and Other Related Parties to be effective for reporting periods ending December 31, 2007 and thereafter.

- **Optum Biometrics, Inc. – Facility Provider Agreement**
  Effective October 1, 2010, UHCMS entered into a Facility Participation Agreement with Optum Biometrics, Inc. Under the terms of the agreement, the Company's Commercial members are provided influenza and pneumococcal vaccination services. The fees charged are per vaccination given and are the same for all customers. The agreement was submitted to MID for review on August 20, 2010, and was approved on September 9, 2010.

- **OptumInsight, Inc. f/k/a Ingenix, Inc. Services Agreement**
  Effective July 1, 2011, UHCMS entered into a Services Agreement with Ingenix, Inc. Under the terms of the agreement, the Company is provided with services involving the investigation, pursuit, and recovery of health care claim overpayments occurring due to fraudulent, abusive, or other inappropriate billing activity. The agreement was submitted to MID for review on May 11, 2011, and was approved on July 12, 2011.

  Effective January 1, 2013, UHCMS entered into the First Amendment to the agreement, which modified the agreement to the OptumInsight Services Agreement and amended the address for all notices and official communication for OptumInsight, Inc. ("OptumInsight"). In addition, Exhibit A-1, "Claim Analytics and Recovery Services", Exhibit A-2, "Retrospective Fraud, Waste & Abuse Services", and Exhibit A-3, "Subrogation Services", were amended by the pricing terms and the compensation for E&I Benefit Plans was amended for Claims Analytics and Recovery Services. The amendment was submitted to MID for review on November 12, 2012, and was approved on December 18, 2012.

  Effective September 1, 2013, UHCMS entered into the Second Amendment to the agreement, which amended certain compensation sections in Exhibit A-1, "Claim Analytics and Recovery Services", Exhibit A-2, "Retrospective Fraud, Waste & Abuse Services", and Exhibit A-3, "Subrogation Services", amended the description of "Legal Action" in Exhibits A-1 and A-2, and deleted 2(d) and 2(e) from Exhibit A-3. The amendment was submitted to MID for review on July 24, 2013, and was accepted on August 15, 2013.

  Effective May 1, 2014, UHCMS entered into the Third Amendment to the agreement, which amended certain compensation sections in Exhibit A-1, "Claim Analytics and Recovery Services", Exhibit A-2, "Retrospective Fraud, Waste & Abuse Services", and Exhibit A-3, "Subrogation Services", and added Exhibit A-4, "Premium Audit Services." The amendment was submitted to MID for review on March 24, 2014, and was approved on April 7, 2014.

  Effective December 31, 2014, UHCMS entered into the Fourth Amendment to the agreement, which deleted and replaced Exhibit A-1, "Claim Analytics and Recovery

Services", Exhibit A-2, "Retrospective Fraud, Waste & Abuse Services", Exhibit A-3, "Subrogation Services", and Exhibit A-4, "Premium Audit Services", and added Exhibit E, "Exchange Regulatory Appendix." The amendment was submitted to MID for review on November 7, 2014, and was approved on November 24, 2014.

Effective October 1, 2015, UHCMS entered into the Fifth Amendment to the agreement, which deleted and replaced Exhibit A-1, "Claim Analytics and Recovery Services", Exhibit A-2, "Retrospective Fraud, Waste & Abuse Services", Exhibit A-3, "Subrogation Services", and Exhibit A-4, "Premium Audit Services", deleted and replaced Exhibit C, "Mississippi Medicaid Program Regulatory Requirements Appendix", and added Exhibit C-1, "Mississippi Children's Health Insurance Program ("CHIP") Regulatory Requirements Appendix." The amendment was submitted to MID for review on August 27, 2015, and was accepted on September 15, 2015. Fees under the agreement totaled the following during the examination period:

OptumInsight Services	2016	2015	2014	2013	2012
Service Fees	$1,087,094	$1,018,183	$347,449	$844,448	$202,000

- **OptumRx, Inc. – Facility Participation Agreement**
  Effective January 1, 2012, UHCMS entered into a Facility Participation Agreement with OptumRx, Inc. ("OptumRx"). Under the terms of the agreement, OptumRx is a provider of Durable Medical Equipment Services and Hearing Aids for the Company's members. The agreement is made to be available to be used by all products, Commercial, Medicare and Medicaid that UHCMS may offer. The agreement was submitted to MID for review on November 17, 2011, and was approved on December 22, 2011.

  Effective January 1, 2013, UHCMS entered into the First Amendment to the agreement, which updated the rates to add additional hearing aids and deleted the durable medical equipment fee schedule. OptumRx continues to provide hearing aids to the Company's Commercial and Medicare members. The amendment was submitted to MID for review on November 20, 2012, and was approved on December 18, 2012.

- **Spectera, Inc. Vision Services Agreement**
  Effective January 1, 2012, UHCMS entered into a Vision Services Agreement with Spectera, Inc. ("Spectera"). Under the terms of the agreement, Spectera is responsible for developing, contracting, and managing a network of Vision Providers to provide Vision Services and/or products for the Company's Commercial members. The agreement was submitted to MID for review on November 28, 2011, and was approved on December 22, 2011.

  Effective January 1, 2014, UHCMS entered into the First Amendment to the agreement, which deleted and replaced Exhibit A, "Compensation for Services Addendum." The amendment was submitted to MID for review on October 29, 2013, and was accepted on November 7, 2013.

Effective April 1, 2014, UHCMS entered into the Second Amendment to the agreement, which added Specialty Benefits, LLC ("Specialty Benefits") as a party to the agreement. Specialty Benefits provides optometric materials, such as eye glasses and contact lenses prescribed by network providers for the Company's members. The amendment also deleted and replaced Exhibit A, "Compensation for Services Addendum", and Exhibit B, "Services Addendum." The amendment was submitted to MID for review on February 24, 2014, and was accepted on March 5, 2014.

Effective January 1, 2015, UHCMS entered into the Third Amendment to the agreement, which deleted and replaced Exhibit A, "Compensation for Services Addendum", and added Exhibit G, "Exchange Regulatory Appendix." The amendment was submitted to MID for review on October 15, 2014, and was approved on November 5, 2014.

Effective January 1, 2016, UHCMS entered into the Fourth Amendment to the agreement, which deleted and replaced Exhibit A, "Compensation for Services Addendum", and Exhibit F, "Delegated Credentialing Addendum", and added Exhibit H, "Third Party Administrator Appendix." The amendment was submitted to MID for review on November 30, 2015, and was approved on December 16, 2015. Fees under the agreement totaled the following during the examination period:

Vision Services	2016	2015	2014	2013	2012
Vision Fees	$13,675	$15,640	$12,432	$4,345	$0

- **Dental Benefit Providers, Inc. – Dental Services Agreement**
  Effective February 1, 2012, UHCMS entered into a Dental Services Agreement with Dental Benefit Providers, Inc. ("DBP"). Under the terms of the agreement, DBP is responsible for developing, contracting and managing a network of Dental Providers to provide dental services to the Company's Mississippi Coordinated Access Network ("Mississippi CAN") members. UHCMS remains ultimately responsible for the delivery of dental services to its members. The agreement was submitted to MID for review on December 28, 2011, and was approved on January 23, 2012.

  Effective November 1, 2013, UHCMS entered into the First Amendment to the agreement, which deleted and replaced Exhibit A, "Compensation for Services Addendum." The amendment was submitted to MID for review on September 9, 2013, and was accepted on September 30, 2013.

  Effective January 1, 2014, UHCMS entered into the Second Amendment to the agreement, which deleted and replaced Exhibit A, "Compensation for Services Addendum", Exhibit C, "Medicare Advantage Regulatory Requirements Appendix", and Exhibit E, "State Regulatory Requirements Appendix." The amendment was submitted to MID for review on November 14, 2013, and was accepted on November 26, 2013.

  Effective January 1, 2015, UHCMS entered into the Third Amendment to the agreement,

which deleted and replaced Exhibit A, "Compensation for Services Addendum" and Exhibit E, "State Regulatory Requirements Appendix" and added Exhibit G, "Exchange Regulatory Appendix." The amendment was submitted to MID for review on October 8, 2014, and was approved on October 23, 2014.

Effective July 1, 2015, UHCMS entered into the Fourth Amendment to the agreement, which added a rate for the Mississippi CHIP to Exhibit A, "Compensation for Services Addendum", added Exhibit E-1, "Mississippi CHIP Regulatory Requirements Appendix" and deleted and replaced Exhibit G, "Exchange Regulatory Appendix". The amendment was submitted to MID for review on June 1, 2015, and was approved on June 15, 2015. Fees under the agreement totaled the following during the examination period:

Dental Services	2016	2015	2014	2013	2012
Dental Fees	$641,838	$1,819,212	$714,549	$5,704,955	$2,566,000

- **United Behavioral Health – Behavioral Health Services Agreement**
  Effective April 1, 2012, UHCMS entered into a Behavioral Health Services Agreement with United Behavioral Health ("UBH"). Under the terms of the agreement, UBH is responsible for arranging for the provision of certain mental health and substance abuse treatment services to the Company's members. This agreement supersedes and replaces the Agreement for Provision of Services effective January 1, 1995, and all subsequent amendments. The agreement was submitted to MID for review on February 23, 2012, and was approved on April 16, 2012.

  Effective March 1, 2013, UHCMS entered into the First Amendment to the agreement, which deleted and replaced the rate chart in its entirety in Section 1 of Exhibit A, "Compensation for Services Addendum." Additionally, the amendment reflects the associated third-party administrative services and the Reinsurance Agreement between UHCMS and Unimerica Insurance Company ("Unimerica") that provides for the assumption of risk for a limited portion of benefits provided by the Company on a reinsurance basis. The amendment was submitted to MID for review on January 28, 2013, and was approved on February 20, 2013.

  Effective November 1, 2013, UHCMS entered into the Second Amendment to the agreement, which deleted and replaced the rate chart in its entirety in Section 1 of Exhibit A, "Compensation for Services Addendum", and added rates for the Mississippi Medicaid Program. The amendment was submitted to MID for review on September 18, 2013, and was approved on September 25, 2013.

  Effective February 1, 2014, UHCMS entered into the Third Amendment to the agreement, which deleted and replaced Exhibit A, "Compensation for Services Addendum." The amendment was submitted to MID for review on December 30, 2013, and was accepted on January 21, 2014.

  Effective August 1, 2015, UHCMS entered into the Fourth Amendment to the agreement,

which deleted and replaced Exhibit A, “Compensation for Services Addendum”, and Exhibit E, “Mississippi Medicaid Program Regulatory Requirements Appendix”, and added Exhibit E-1, “Mississippi CHIP Regulatory Requirements Appendix”, and Exhibit G, “Exchange Regulatory Appendix.” The amendment was submitted to MID for review on June 30, 2015, and was accepted on July 22, 2015.

Effective September 1, 2016, UHCMS entered into the Fifth Amendment to the agreement, which deleted and replaced Exhibit A, “Compensation for Services Addendum”, Exhibit E, “Mississippi Medicaid Program Regulatory Requirements Appendix”, and Exhibit F, “Delegated Credentialing Addendum”, and added Exhibit H, “Third Party Administrator Appendix.” The amendment was submitted to MID for review on July 25, 2016, and was approved on August 18, 2016. Fees under the agreement totaled the following during the examination period:

Behavioral Health Services	2016	2015	2014	2013	2012
Behavioral Health Fees	$9,940,679	$6,514,270	$2,906,089	$563,954	$111,000

- **OptumRx, Inc. – Prescription Drug Benefit Administration Agreement for Commercial Members**

  Effective January 1, 2013, OptumRx and UHS entered into a Prescription Drug Benefit Administration Agreement. UHCMS was added to the agreement as a participant through signing a Participating Addendum effective January 1, 2013. The agreement covers the Company’s commercial members only. Under the terms of the agreement, OptumRx is providing UHCMS with Core Prescription Drug Benefit Services and Mail Order Pharmacy Services. Under the Core Prescription Drug Benefit Services, OptumRx established and maintain 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. Under the Mail Order Pharmacy Services, OptumRx provides the Company with mail order network prescription services. UHCMS remains ultimately responsible for the pharmacy benefit administration services provided to its members. The agreement was submitted to MID for review on September 21, 2012, and was approved on October 5, 2012.

  Effective September 1, 2015, UHCMS entered into a Participating Plan Addendum to participate in the First and Second Amendments to the agreement. The First amendment added Exhibit D, “Exchange Regulatory Appendix” and Exhibit E, “Third Party Administrator and Other Services,” and the Second amendment updated rates and other definitions. The agreement continues to cover the Company’s commercial members only. The amendments were submitted to MID for review on July 30, 2015, and was accepted on August 17, 2015.

- **OptumHealth Care Solutions, Inc. – Administrative Services Agreement**
  Effective March 1, 2013, UHCMS entered into an Administrative Services Agreement with OptumHealth Care Solutions, LLC ("OptumHealth"). Under the terms of 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 Company's Commercial and Medicaid members. UHCMS remains ultimately responsible for the delivery of therapy services to its members. The agreement was submitted to MID for review on January 28, 2013, and was approved on February 20, 2013.

  Effective January 1, 2015, UHCMS entered into the First Amendment to the agreement, which deleted and replaced Exhibit A, "Compensation for Services Addendum", Exhibit C, "Medicare Advantage Regulatory Requirements Appendix", and Exhibit E, "Mississippi Medicaid Regulatory Requirements Appendix", and added Exhibit G, "Exchange Regulatory Appendix". The amendment was submitted to MID for review on November 17, 2014, and was approved on December 2, 2014.

  Effective September 1, 2016, UHCMS entered into the Second Amendment to the agreement, which deleted and replaced Exhibit A, "Compensation for Services Addendum", Exhibit E, "Mississippi Medicaid Program Regulatory Requirements Appendix", and Exhibit F, "Delegated Credentialing Addendum", and added Exhibit E-1, "Mississippi CHIP Regulatory Requirements Appendix" and Exhibit H, "Third Party Administrator Appendix". The amendment was submitted to MID for review on July 25, 2016, and was accepted on August 18, 2016. Fees under the agreement totaled the following during the examination period:

OptumHealth Services	2016	2015	2014	2013	2012
Service Fees	$448,531	$387,222	$117,915	$111,358	$49,000

- **OptumRx, Inc. – Facility Participation Agreement – Specialty Pharmacy for the Medical Benefit**
  Effective December 1, 2015, UHCMS entered into a Facility Participation Agreement with OptumRx. Under the terms of the agreement, OptumRx is acting as a specialty pharmacy provider. OptumRx is providing the specialty pharmacy medications covered under the member's medical benefits. In addition to dispensing and delivering the specialty pharmacy medications, OptumRx is providing information, including side effect management, storage of the medication, missed dose management, and disease state information, to the Company's members or their caregivers. OptumRx is also providing access to customer service representatives and pharmacists to provide support and guidance to UHCMS's members and family members. The agreement was submitted to MID for review on October 28, 2015, and was accepted on November 17, 2015.

- **OptumRx, Inc. – Facility Participation Agreement – Specialty Pharmacy for the Pharmacy Benefit**
  Effective December 1, 2015, UHCMS entered into a Facility Participation Agreement with OptumRx. Under the terms of the agreement, OptumRx is acting as a specialty pharmacy provider. OptumRx is providing the specialty pharmacy medications covered under the member's pharmacy benefits. In addition to dispensing and delivering the specialty pharmacy medications, OptumRx is providing information, including side effect management, storage of the medication, missed dose management, and disease state information, to the Company's members or their caregivers. OptumRx is also providing access to customer service representatives and pharmacists to provide support and guidance to UHCMS's members and family members. The agreement was submitted to MID for review on October 28, 2015, and was accepted on November 17, 2015.

- **AxelaCare Intermediate Holdings, LLC – Facility Participation Agreement**
  Effective February 1, 2016, UHCMS entered into a 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 was submitted to MID for review on December 30, 2015, and was accepted on February 1, 2016.

- **OptumRx, Inc. – Third Amended and Restated Prescription Drug Benefit Administration Agreement**
  Effective November 1, 2016, OptumRx and UHS entered into a Third Amended and Restated Prescription Drug Benefit Administration Agreement acting on behalf of its affiliates, including but not limited to UHCMS. Under the terms of the agreement, OptumRx is responsible for establishing and maintaining a network of participating pharmacies, prescription drug claims processing services, and general administrative support as to the prescription drug benefit covered for members enrolled with the various managed care organizations under contract with UHS, including members enrolled with UHCMS. The agreement applies to the Company's Medicaid members. UHCMS remains ultimately responsible for assuring coverage of all prescription drug benefit services to its members. This Agreement replaces the Amended and Restated Prescription Drug Benefit Administration Agreement, effective January 1, 2010, and the Second Amended and Restated Prescription Drug Benefit Administration Agreement, effective January 1, 2013, and all subsequent amendments. The agreement was submitted to MID for review on September 28, 2016, and was accepted on October 31, 2016. Fees under the agreement totaled the following during the examination period:

Prescription Drug Benefit	2016	2015	2014	2013	2012
Administration Fees	$4,454,826	$3,732,959	$1,956,750	$1,616,833	$412,000

- **Combined Billing and Disbursement Operations Agreement**
  Effective June 9, 2004, UHCMS entered into a Combined Billing and Disbursement

Operations Agreement with UHIC and UHS. Under the terms of the agreement, UHS has consolidated its computer platforms in order to bring greater efficiency in the delivery of products and services from its affiliates. Additionally, customers are provided a combined bill and a common bank lockbox held in the name of UHIC to direct single premium payments to. All incoming receipts are identified and sorted according to proper affiliate company, and promptly transferred to the appropriate health plan or insurer owned account. The agreement does not provide for pooling of assets for investment or investment-related purposes. The agreement was submitted to MID for review on March 18, 2004, and was approved on June 9, 2004. Premium income subject to the agreement totaled the following during the examination period:

Premiums	2016	2015	2014	2013	2012
Net Premium Income	$1,235,122,925	$897,063,751	$400,158,419	$360,651,176	$126,379,537

- **First Restated Tax Sharing Agreement**
  Effective December 20, 2005, UHCMS was added as participant to a First Restated Tax Sharing Agreement with UHG and all subsidiaries. The agreement establishes a formal method for the allocation and payment of federal, state and local income tax liabilities related to the consolidated federal tax returns filed each year. Taxes under the agreement totaled the following during the examination period:

Taxes	2016	2015	2014	2013	2012
Federal & Foreign Income Taxes Incurred	$160,874	$7,628,646	$7,277,200	$535,986	$2,148,701

- **Amended and Restated Subordinated Revolving Credit Agreement**
  Effective October 1, 2012, UHCMS entered into an Amended and Restated Revolving Credit Agreement with UHG. Under the terms of the agreement, UHG provides a short-term borrowing facility for the Company where UHCMS may borrow funds upon demand from UHG up to a maximum of $15,000,000, at an interest rate equal to London InterBank Offered Rate (LIBOR) plus 50 basis points. No advances were made under the agreement in 2016, and no amounts were outstanding under the line of credit at year end during the examination period. The agreement was submitted to MID for review on August 15, 2012, and was accepted on October 5, 2012.

- **Unimerica Insurance Company – Reinsurance Agreement**
  Effective March 1, 2013, UHCMS entered into a Reinsurance Agreement with Unimerica. Under the terms of the agreement, the Company cedes to Unimerica and Unimerica accepts in exchange for the specified reinsurance premium 100% of the covered obligations as of the effective date. Unimerica remains liable as reinsurer on all liability reinsured under the agreement until such time as UHCMS no longer has liability with respect to the covered obligations. The agreement covers only the following obligations of the Company's specialty health coverages: human organ and bone marrow transplants and related services,

infertility treatment and services, mental health and substance abuse treatments and services, and chiropractic, physical and occupational therapy treatments and services for musculoskeletal conditions that occur on or after the effective date of the agreement. The agreement was submitted to MID for review on January 28, 2013, and was approved on February 20, 2013.

Effective February 1, 2014, UHCMS entered into the First Amendment to the agreement, which deleted and replaced the covered obligations set forth in Schedules 2.1 (a)(i) – 2.1 (a)(iv), and deleted and replaced Section 3.2 (b), "Reimbursement." The amendment was submitted to MID for review on December 23, 2013, and was approved on January 16, 2014.

Effective January 1, 2016, UHCMS entered into the Second Amendment to the agreement, which deleted and replaced the covered obligations set forth in Schedules 2.1 (a)(i) – 2.1 (a)(iv), and deleted and replaced the language in several sections of the agreement. The amendment was submitted to MID for review on June 30, 2015, and was approved on July 22, 2015.

Effective September 1, 2016, UHCMS entered into the Third Amendment to the agreement, which deleted and replaced the covered obligations set forth in Schedules 2.1 (a)(i) – 2.1 (a)(iv), and deleted and replaced the language in several sections of the agreement. The amendment was submitted to MID for review on July 25, 2016, and was approved on August 18, 2016. Premiums and recoveries under the agreement totaled the following during the examination period:

Reinsurance	2016	2015	2014	2013	2012
Ceded Premiums	$64,904,258	$46,300,307	$27,049,249	$429,447	$0
Reins. Recoveries	$65,281,923	$48,223,299	$24,080,047	$116,678	$0

- **Cash Contribution from Parent**
  The Company received multiple cash contributions from UHC during the examination period as an increase to gross paid-in and contributed surplus. Contributions totaled the following during the examination period:

Contributions	2016	2015	2014	2013	2012
Cash Infusions	$30,000,000	$24,500,000	$0	$28,000,000	$0

FIDELITY BOND AND OTHER INSURANCE

Pursuant to Miss. Code Ann. § 83-41-311(2), a HMO shall maintain in force a fidelity bond or fidelity insurance on employees and officers, directors and partners in an amount not less than $250,000 for each HMO or a maximum of $5,000,000 in aggregate maintained on behalf of HMOs owned by a common parent corporation, or such sum as may be prescribed by the commissioner. The Company is a named insured on UHG's Blanket Crime Policy with a coverage limit of

$25,000,000 issued by an authorized company. The amount of coverage exceeds the minimum requirements in accordance with Miss. Code Ann. § 83-41-311(2). 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 personnel are employees of UHS, pursuant to the management services agreement. Therefore, UHCMS does not provide any defined benefit or contribution plans, multiemployer plans, or postretirement plans.

TERRITORY AND PLAN OF OPERATION

The Company is licensed as a HMO to offer a variety of managed care programs and products to its enrollees in all Mississippi counties, consisting primarily of employer groups and Medicaid eligible beneficiaries. UHCMS operates under two of UHG's functional lines: Medicaid (C&S) and Commercial Products (E&I). C&S products made up approximately 92% of the Company's 2016 written premium, provided to high-risk Medicaid beneficiaries through the Mississippi CAN and eligible beneficiaries through CHIP. These health care services were provided under the Company's contracts with the Mississippi Division of Medicaid (DOM), effective through June 30, 2017, and subject to annual renewal provisions thereafter. E&I products made up approximately 8% of the Company's 2016 written premium, primarily consisting of group comprehensive hospital & medical plans for employers and individuals. Through the examination date, the Company also offered individual exchange business in Mississippi.

GROWTH OF COMPANY

The following table indicates key figures in evaluating the growth of the Company during the examination period:

	2016	2015	2014	2013	2012
Total admitted assets	$ 223,416,110	$ 220,645,637	$ 113,853,461	$ 106,768,748	$ 73,263,423
Total liabilities	126,645,221	153,854,564	59,179,152	61,806,719	54,465,664
Total capital and surplus	96,770,889	66,791,073	54,674,309	44,962,029	18,797,759
Direct premiums written	1,300,365,864	944,083,622	427,207,667	361,080,623	129,838,243
Ceded premiums written	65,242,939	47,019,871	27,049,249	429,447	3,458,706
Net premium income	1,235,122,925	897,063,751	400,158,418	360,651,176	126,379,537
Net underwriting gain (loss)	8,591,699	(18,208,214)	20,164,175	(2,172,386)	5,210,128
Net income or (loss)	8,892,775	(25,162,927)	13,383,520	(2,611,362)	3,109,411

RESERVING AND UNPAID CLAIMS EXPERIENCE

The Company's opining actuary, Mr. Gary Iannone, ASA, MAAA, issued the actuarial opinion for the period ended December 31, 2016. The Company's prior opining actuary, Mr. Allen Sorbo, FSA, MAAA, issued the actuarial opinions for the period covering January 1, 2012 through December 31, 2015. The actuarial opinions reported that the amounts carried in the balance sheets 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 were reviewed as part of the current examination. Per the review, no adjustments were required to the Company's unpaid claims and claims adjustment expense reserves, as of December 31, 2016.

REINSURANCE

During the examination period, the Company ceded 100% of covered obligations to Unimerica

relating to specialty health coverages, including mental health and substance abuse treatments and services and chiropractic and physical therapy treatments and services. In consideration of the reinsurance provided, UHCMS pays a reinsurance premium to Unimerica. Reinsurance premiums ceded, calculated on a PMPM basis, of $64,904,258 as of December 31, 2016, were netted against net premium income. Unimerica reimburses the Company for the ceded percentage of claims incurred in connection with the covered obligations, in addition to an expense allowance to compensate UHCMS for administrative services provided. As of December 31, 2016, reinsurance recoveries totaled $65,281,923, and amounts recoverable from reinsurers totaled $6,056,068. See (Unimerica Insurance Company - Reinsurance Agreement) under "Affiliated and Related Party Transactions" for more details.

The Company did not assume any reinsurance during the examination period.

ACCOUNTS AND RECORDS

The Company's books and records are fully automated. The Company, as a member of a holding company group, utilizes common systems for recording its transactions. The group's current general ledger system is a purchased package (Oracle PeopleSoft), which maintains GAAP, Statutory, and MLR data. The Company uses Eagle Wings filing software to produce its statutory Annual Statement. 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 deposit with the State of Mississippi complied with Miss. Code Ann. § 83-41-325. The following chart displays the Company's deposit at December 31, 2016:

Description	Par Value	Book Value	Fair Value
US Treasury Note	$600,000	$630,183	$620,016

FINANCIAL STATEMENTS

Introduction

The following financial statements reflect the same amounts reported by the Company and consist of a Statement of Assets, Liabilities, Capital and Surplus – Statutory at December 31, 2016, a Statement of Revenue and Expenses – Statutory for the year ended December 31, 2016, a Reconciliation of Capital and Surplus – Statutory for examination period ended December 31, 2016, and a Reconciliation of Examination Adjustments to Surplus – Statutory at December 31, 2016.

STATEMENT OF ASSETS, LIABILITIES, CAPITAL AND SURPLUS
DECEMBER 31, 2016

ASSETS

Bonds	$ 62,483,275
Cash, cash equivalents and short-term investments	69,755,877
Cash and invested assets	132,239,152
Investment income due and accrued	497,681
Uncollected premiums and agents' balances in the course of collection	10,182,108
Accrued retrospective premiums and contracts subject to redetermination	7,537,898
Amounts recoverable from reinsurers	9,719,292
Net deferred tax asset	3,599,995
Receivables from parent, subsidiaries and affiliates	55,449,032
Health Care and other amounts receivable	3,489,263
Aggregate write-ins for other than invested assets	701,689
Total Assets	**$ 223,416,110**

LIABILITIES, CAPITAL AND SURPLUS

Claims Unpaid	$ 102,286,562
Accrued medical inventive pool and bonus amounts	1,077,169
Unpaid claims adjustment expenses	1,490,301
Aggregate health policy reserves	2,264,512
Aggregate health claim reserves	1,904,327
Premiums received in advance	611,406
General expenses due or accrued	7,538,864
Current federal and foreign income tax payable and interest thereon	109,850
Ceded reinsurance premiums payable	6,985,271
Remittances and items not allocated	1,586,834
Payable for securities	779,058
Liability for amounts held under uninsured plans	11,067
Total Liabilities	**126,645,221**
Common capital stock	20
Gross paid in and contributed surplus	100,327,293
Unassigned funds (surplus)	(3,556,424)
Total Capital and Surplus	**96,770,889**
Total Liabilities, Capital and Surplus	**$ 223,416,110**

STATEMENT OF REVENUE AND EXPENSES
FOR YEAR ENDED DECEMBER 31, 2016

Member Months	3,584,250
Revenues	
Net premium income	$ 1,235,122,925
Change in unearned premium reserves and reserve for rate credits	(2,154,023)
Total revenues	$ 1,232,968,902
Expenses	
Hospital/medical benefits	$ 828,465,694
Other professional services	89,547,491
Prescription drugs	238,206,221
Incentive pool, withhold adjustments and bonus amounts	1,109,295
Net reinsurance recoveries	(69,158,484)
Total hospital and medical	1,088,170,217
Claims adjustment expenses, including cost containment expenses	51,086,044
General administrative expenses	110,392,942
Increase in reserves for life and accident and health contracts	(25,272,000)
Total underwriting deductions	1,224,377,203
Net underwriting gain or (loss)	8,591,699
Net investment income earned	953,879
Net realized capital gains (losses) less capital gains tax	8,368
Net investment gains (losses)	962,247
Net gain or (loss) from agents' or premium balances charged off	(492,797)
Aggregate write-ins for other income or expenses	(7,500)
Net income after capital gains tax and before all other federal income taxes	9,053,649
Federal and foreign income taxes incurred	160,874
Net Income	$ 8,892,775

RECONCILIATION OF CAPITAL AND SURPLUS
FOR EXAMINATION PERIOD ENDED DECEMBER 31, 2016

	2016	2015	2014	2013	2012
Capital and surplus prior reporting year	$ 66,791,073	$ 54,674,309	$ 44,962,029	$ 18,797,759	$ 30,731,428
Net income or (loss)	8,892,775	(25,162,927)	13,383,520	(2,611,362)	3,109,411
Change in net deferred income tax	(8,800,245)	11,624,829	(1,699,332)	1,535,547	497,598
Change in nonadmitted assets	(112,714)	(4,089,823)	(1,971,908)	(759,915)	(540,678)
Paid in	30,000,000	24,500,000	-	28,000,000	(15,000,000)
Correction of error	-	5,244,685	-	-	-
Net change in capital and surplus	29,979,816	12,116,764	9,712,280	26,164,270	(11,933,669)
Capital and surplus end of reporting period	$ 96,770,889	$ 66,791,073	$ 54,674,309	$ 44,962,029	$ 18,797,759

RECONCILIATION OF EXAMINATION ADJUSTMENTS TO SURPLUS
DECEMBER 31, 2016

There were no changes made to the assets, liabilities or capital and surplus reported by the Company for the year ended December 31, 2016. The Company's net worth, which totaled $96,770,889 as of the examination date, was determined to be reasonably stated and in compliance with Miss. Code Ann. § 83-41-325.

MARKET CONDUCT ACTIVITIES

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

Privacy
Complaint Handling
Producer Licensing
Underwriting and Rating
Grievance Procedures
Network Adequacy
Provider Credentialing
Claims

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 of 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 strategies.

Privacy

Examiners reviewed the Company's policies, practices and procedures regarding protection and disclosure of nonpublic personal information to verify compliance with applicable state laws regarding privacy. Examiners reviewed management's organizational control structure to ensure privacy regulatory requirements are properly disseminated, understood and monitored. Additionally, the Company's annual Security and Awareness / Employee Privacy training module was reviewed, noting it was complete and comprehensive and included HIPAA training materials covering confidentiality, security, and privacy concerns. The 2016 completion rate was 98.3%. Examiners determined that procedures are in place to ensure appropriate privacy notices are provided to customers in accordance with Mississippi Regulation 2001-1. It was also noted, through Connecticut's review of Information Technology General Controls, that access controls to enforce separation of duties to minimize the risk of system misuse and reduce opportunities for unauthorized modification or misuse of Personal Health Information (PHI) were determined to be effective.

No issues were noted related to the Company's policies, practices and procedures regarding privacy protection and compliance with applicable regulatory requirements.

Complaint Handling

The Company's policies, procedures and practices for handling complaints were reviewed as part of the Market Conduct examination. Management established the Central Escalation Unit ("CEU"), which receives and manages complaints. Examiners obtained and reviewed the MID Complaint Log, which included all UHCMS complaints made to the MID during the examination period and the Mississippi (MS) Complaint Log, which were all complaints made to UHCMS during the examination period. Examiners noted no unusual items. Additionally, the Company has a Quality Improvement Committee ("QIC"), which meets quarterly to review status of complaints and to resolve issues associated with the complaints. Examiners reviewed the Company's 3rd and 4th Quarter 2016 QIC meeting minutes noting no unusual items.

No issues were noted related to the Company's policies, practices and procedures regarding complaint handling.

Producer Licensing

For the period under examination, the Company relied upon producers who were licensed and appointed with the MID for commercial healthcare enrollments. The Company established the National Credentialing Department (NCD) to receive on-boarding information, and utilizes SIRCON Software Solutions ("SIRCON"), an external vendor, to register the licensing and appointment or termination of a producer. Producer information is entered into the system and reports are generated and reviewed daily to ensure processing is complete and timely. Once all on-boarding documentation requirements are satisfied, a confirmation from the MID is received through SIRCON, and the SIRCON status of the producer is automatically changed to issued. During the appointment process, each producer's license is verified to ensure it is valid and active. Examiners judgmentally selected, obtained and reviewed SIRCON daily reports, noting evidence of the tracking and monitoring of SIRCON approvals. Examiners also noted the appointment approval effective dates were within 15 days of the requested effective date or date of policy writing, providing evidence of compliance with Miss. Code Ann. § 83-17-75 (2). Examiners reviewed producer termination procedures and determined that reporting requirements are automated by the system, based on the credentialing analyst's input. Examiners obtained and reviewed a listing of terminated producers for UHCMS as of the examination date, noting no unusual items. Examiners also judgmentally selected two terminated producers, who were appointed in 2016, and reviewed the notices issued to the producers and to the MID to ensure notifications were sent in accordance with Miss. Code Ann. § 83-17-77.

Underwriting and Rating

Patient Protection and Affordable Care Act

Guaranteed Availability

No issues were noted related to the Company's policies, practices and procedures regarding producer licensing. The Company's policies and practices for ensuring guaranteed availability of healthcare plans for individuals and groups under the Patient Protection and Affordable Care Act ("PPACA") were reviewed as part of the Market Conduct examination. Examiners determined the Company established a formal Regulatory Change Management Process ("RCMP") to manage changes with state and federal laws and regulations. Changes are communicated to all impacted

business areas so that systems and processes can be updated. When the PPACA mandated guaranteed availability, the systems driving the marketing, distribution, and enrollment of health plans were updated to ensure compliance. Examiners reviewed the RCMP procedures, noting no unusual items, and determining that audit controls, including distributed reports, are in place outlining requirements and responsibilities to implement the required guaranteed availability provisions. Examiners also noted that monthly reports are distributed appropriately to monitor completion status for these legislative items.

Training and Communication
Examiners reviewed UHG's "Health Reform News Alert" company-wide policy and procedure communique pertaining to guaranteed availability of coverage, verifying the requirement had been communicated to impacted business areas. Examiners also reviewed policies and procedures to ensure the Company had established training programs to educate its employees and producers about guaranteed availability regulation requirements for individual and group market health insurance coverage. Examiners noted the Company utilizes corporate on-line training sessions, email blasts and "open microphone" question and answer sessions throughout the year. These activities included training on guaranteed availability of healthcare coverage. Examiners also reviewed selected producer training materials, noting it included instructions to the producer to market to all public, key account, and group segments.

Individual Enrollment
Examiners determined that individual healthcare coverage is limited to participation in plans certified by the Health Insurance Marketplace to satisfy PPACA requirements. The Company ensures individuals can purchase its Qualified Health Plan (QHP) coverage by making the coverage available through its outside broker channel, direct sales unit, and internet marketing channels. In addition, the "on-exchange" plans are available through the internet website www.healthcare.gov. Examiners obtained and reviewed evidence that several plans were made available through its outside broker channel, direct sales unit and internet marketing channels throughout the examination period.

Group Enrollment Period
The Company permits small group employers to enroll at any time during the year, including outside the annual small group open enrollment period, and does not place any unallowable enrollment restrictions on small employers. Examiners reviewed UHG's 2016 "Health Reform News Alert", pertaining to unallowable enrollment restrictions for small employers, and determined the policies to be compliant. Additionally, examiners reviewed summarized production data for 2016, providing evidence that the Company offers availability and accepts groups throughout the year based on the origination and renewal dates.

Small Employer Group Requirements
Examiners determined the Company performs participation and employer contribution audits after an enrolled group is installed. These are performed to ensure the Company does not increase any requirement for minimum employee participation or modify any requirement for minimum employer contribution, applicable to a small employer at any time after the small employer has been accepted for coverage. Examiners obtained and reviewed, through judgmental selection, the Employer Information Audit Form used to verify this information. The form is signed by the

Employer, attesting to minimum contribution amounts among other current employee status information.

Group “Employees”

Examiners determined that the Company defines employee in accordance with the definitions determined in state and federal law. The Company uses the time period required under the federal law and reinforced by the MS Bulletin 2016-9. The Company ensures necessary systems updates of this information through the RCMP. Examiners obtained and reviewed the Company's policy bulletin definitions used as guidance in implementing regulatory requirements through its information systems processes. Generally, the Company calculates the average total number of employees for the employer, without regard to the number of hours the employee works, when determining group size for rating purposes, and the average total number of employees an employer employed on business days during the preceding calendar year is used when determining an employer's group size.

Waiting Period

The Company’s policies and procedures, developed through the RCMP ensure the Company does not apply any waiting period which exceeds regulatory requirements. Examiners reviewed and analyzed UHG's "Health Reform News Alert" addressing the waiting period and determined it adequately addresses the maximum 90-day waiting period and is consistent with the HHS, DOL and the Treasury definition of “waiting period.”

Pre-Existing Conditions

Implemented procedures developed through the RCMP ensure the Company complies with the pre-existing conditions provisions of the PPACA. Examiners reviewed UHG's distributed "Health Reform News Alert" that covers procedures for pre-existing conditions and noted it “prohibits discriminatory marketing or plan design that discourage enrollment based on health needs in coverage, as well as discrimination based on race, color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical dependency, quality of life or other health conditions.” Examiners reviewed the Company’s underwriting policies and procedures and analyzed the Company's policy statements, determining the policy statements appear to adequately address the specific pre-existing condition prohibited exclusions identified in 45 CFR §147.108 and 45 CFR §146.111.

Coverage Renewals

Examiners determined the Company has established and implemented policies and procedures regarding guaranteed renewability of individual and small group market health insurance coverage in accordance with regulations. Examiners reviewed UHG's distributed "Health Reform News Alert" pertaining to guaranteed renewability of coverage as evidence the requirement had been addressed and a policy was established and distributed to its businesses, including UHCMS.

Coverage Discontinuance

Examiners determined the Company has established policies and procedures regarding discontinuance and non-renewal of healthcare coverage. These regulatory requirements are managed through the Company’s RCMP.

For discontinuance, the Company follows state and federal regulations to provide access to a similar plan or any other existing plan of the employer's choice. In the case of a market withdrawal, wherein the MID institutes a marketing ban, the Company is aware a market withdrawal requires a five year ban, and it would discontinue sales on the license after providing appropriate notices. Examiners determined that the Company has systems in place to ensure proper notices are provided directly by the Company, by review of selected screen shots to ensure proper discontinuance notices had been provided for discontinuances in 2016. Also, examiners reviewed the small business employer discontinuance letter template and noted that the letter offers a similar plan, identifies benefit changes in the plan offered, and informs the business that employees will be sent a notice.

Other Underwriting and Rating Matters

Rate Changes

Examiners determined that rates are updated on an annual basis, typically involving significant analysis by the Company. The coordinated financial examination work included review of the internal controls and risk mitigation strategies for the Company's rate setting process with no issues noted. Examiners verified that the Company participates in the NAIC's System for Electronic Rates and Forms Filing (SERFF), and determined that the Company files and awaits the MID’s approval (at least 60 days prior to the proposed effective date) before making rate changes effective in accordance with state law.

Policy Forms

Examiners reviewed the Company's Policy Form Approval Procedures, noting no unusual items or issues. The approval process includes subject matter points of contact and routines for addressing questions and possible objections. The detailed process culminates with a pre-submission review, approval by the MID through the SERFF, and a Company email that is widely distributed and contains form distribution procedures.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

The Company’s policies and practices for administering COBRA benefits to individuals to continue their group coverage for specified periods of time were reviewed as part of the Market Conduct examination. Examiners reviewed the policies and procedures for COBRA administration, and determined the Company's administration system automatically tracks, monitors and administrates key aspects of the program. The system has programmed controls for strictly-defined qualifying events (e.g. subsequent disability or social security benefits), benefit periods, and qualified beneficiaries. Examiners obtained and reviewed data from the Company's COBRA tracking system used to monitor participants (beneficiaries) and qualifications for participation in COBRA, noting the data provides adequate evidence that appropriate activity-based qualification codes and dates are captured and monitored.

No issues were noted related to the Company’s policies, practices and procedures regarding underwriting and rating.

Grievance Procedures

Examiners noted policies and procedures existed for handling first-level review of grievances involving an adverse determination, grievances not involving an adverse determination, and

grievances from covered persons, or authorized representatives, pursuant to applicable state statutes, rules and regulations. The Company established a CEU with policies and procedures to ensure employees appropriately review and resolve clinical and administrative appeals and grievances. The CEU utilizes letter templates, based on state grievance and appeal requirements, that are updated as new state requirements are identified by the CEU and the Company's National Compliance teams. The CEU monitors appeals and grievances inventory daily, utilizing its Escalated Tracking System (ETS), and reports results for quarterly review by the QIC. Examiners reviewed selected QIC meeting minutes verifying review and approval and noted no unusual items.

No issues were noted related to the Company's policies, practices and procedures regarding grievances.

Network Adequacy

Examiners reviewed the network adequacy policies and procedures that apply to UHCMS. Performance against the established standards is measured and evaluated by the Company on an annual basis. At least annually, reports on accessibility are presented for review by the Company's Quality Oversight Committee ("QOC"). The assessments are conducted in accordance with state, federal and regulatory requirements, and corrective actions are identified and implemented to improve availability. Examiners reviewed selected QOC meeting minutes, which provided evidence these reviews were performed. Examiners also reviewed the Southeast Region 2016 Annual Assessment of Network Adequacy, which included UHCMS, for evidence of review and approval of the plan, noting no unusual items.

No issues were noted related to the Company's policies, practices and procedures regarding network adequacy.

Provider Credentialing

Examiners noted that the Company's Credentialing Policy Work Group ("CPWG") meets weekly with UHG's Legal department to review state and federal credentialing guideline changes. The CPWG updates the State Addendum on a quarterly basis, or more often as needed, and the Credentialing Plan is updated annually. Examiners obtained and reviewed the current Credentialing Plan and Mississippi Credentialing Regulatory Addendum, noting it addressed initial credentialing, re-credentialing and ongoing monitoring and reporting activities. There were no unusual items.

Examiners also determined that sanction information from state licensing boards, the Office of the Inspector General (OIG), and other sanctioning bodies is collected by the Company and communicated daily to UCS Clinical Sanctions. UCS Clinical Sanctions reviews the information, triages the cases, and facilitates further analysis and dispositions. For OIG exclusions and sanctions, any provider who is ineligible, excluded or debarred from Medicare and Medicaid federal and state programs are terminated for all lines of businesses.

No issues were noted related to the Company's policies, practices and procedures regarding provider credentialing.

Claims

The examination team determined that a limited claims review was necessary due to the fact that the coordinated financial examination covered claims handling for all lines of business, and UHCMS was also concurrently undergoing a separate target market conduct examination covering its claims handling activity. The coordinated financial examination work appropriately placed reliance on control testing and substantive procedures around claims handling systems and processes used in the administration of claims for all entities, including UHCMS. The effectiveness of selected internal controls for member eligibility, member and provider installation, and accuracy and completion of claim benefits and payments were tested and determined to be designed appropriately and operating effectively.

No issues were noted related to the Company's policies, practices and procedures regarding claims administration.

COMMITMENTS AND CONTINGENT LIABILITIES

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

SUBSEQUENT EVENTS

Effective January 1, 2017, the Company exited the individual exchange business in Mississippi. This business represented 6.4% of total direct premiums written as of December 31, 2016.

The Company received cash contributions to gross paid and contributed surplus of $20,000,000, $20,000,000, and $25,000,000 on June 30, 2017, August 11, 2017, and September 29, 2017, respectively, from UHC.

As of December 31, 2017, UHCMS established $28,006,000 in premium deficiency reserves in its financial statements.

The Company's Mississippi CAN contract with the DOM was renewed through June 30, 2020 and includes an option for two (2) one-year extensions thereafter. The Company's CHIP contract with the DOM was renewed through June 30, 2018 and includes an option for one (1) one-year extension thereafter.

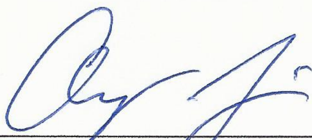
ACKNOWLEDGMENT

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

Examiner-In-Charge:	Andy Jennings, CFE, ARM
Examiners:	Laura Clark, CPA Darren Smith
Supervising Examiner:	John Humphries, ASA, MAAA, CFE, AES, MCM, CISA
Department Designee:	Mark Cooley, CFE

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

Respectfully submitted,



Andy Jennings, CFE
Examiner-In-Charge
Risk & Regulatory Consulting, LLC

Mark Cooley, CFE
MS Insurance Department Designee