MARKET CONDUCT EXAMINATION REPORT
PROMPT PAY

of

MAMSI LIFE AND HEALTH INSURANCE COMPANY

as of

June 30, 2006

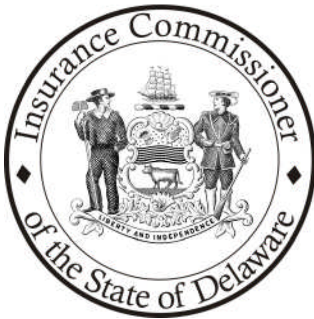
I, Matthew Denn, Insurance Commissioner of the State of Delaware, do hereby certify that the attached REPORT ON MARKET CONDUCT EXAMINATION, made as of JUNE 30, 2006 of the

MAMSI LIFE AND HEALTH INSURANCE COMPANY
PROMPT PAY

is a true and correct copy of the document filed with this Department.

ATTEST BY: ______________________

DATE: 26 JUNE 2007



In Witness Whereof, I HAVE HEREUNTO SET MY HAND AND AFFIXED THE OFFICIAL SEAL OF THIS DEPARTMENT AT THE CITY OF DOVER, THIS 26TH DAY OF JUNE 2007.

____
Insurance Commissioner

REPORT ON MARKET CONDUCT PROMPT PAY EXAMINATION

OF THE

MAMSI LIFE AND HEALTH INSURANCE COMPANY

AS OF

AUGUST 29, 2005

The above captioned Report was completed by examiners of the Delaware Insurance Department.

Consideration has duly been given to the comments, conclusions, and recommendations of the examiners regarding the status of the Company as reflected in the Report.

This Report is hereby accepted, adopted, and filed as an official record of this Department.

MATTHEW DENN
INSURANCE COMMISSIONER

DATED this 26TH day of JUNE, 2007.

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MAY 4, 2007

Honorable Matthew Denn
Insurance Commissioner
State of Delaware
841 Silver Lake Boulevard
Dover, Delaware 19904

Dear Commissioner Denn:

In compliance with instructions contained in Certificate of Examination Authority Number 06.726, and pursuant to statutory provisions, a limited scope, single state, target market conduct examination has been conducted of the affairs and practices of:

MAMSI Life and Health Insurance Company

hereinafter referred to as the "Company." The Company is incorporated under the laws of the State of Maryland. This examination reviewed the operations of the Company as they impact residents, policyholders, providers, and members residing in the State of Delaware or serving Delaware members of the Company. This examination focused on compliance with Delaware requirements for prompt, fair, and equitable settlement of claims for health care services

This report is as of June 30, 2006. It covers the period from January 1, 2006 through June 30, 2006.

The report of examination thereon is respectfully submitted.

EXECUTIVE SUMMARY

This executive summary addresses areas of concern identified as a result of the examination team's review of the Company's performance measured against the seven (7) examination

standards authorized by Certificate of Examination Authority Number 06.726. The examination standards are based on NAIC methodology. The scope of the market conduct examination was limited to verification of compliance with 18 Del. Admin. Code 1310 Standards for Prompt, Fair and Equitable Settlement of Claims for Health Care Services [Formerly Regulation 80].

The principal focus for this examination was compliance with the Delaware insurance laws related to prompt, fair and equitable settlement of claims for health care services. The standards and work plan utilized in this examination were approved by the Delaware Insurance Department.

This target examination tested for compliance with the provisions of 18 Del. Admin. Code 1310, relating to the timely, fair, and equitable payment of clean claims. The issues generating this examination include complaints from a number of providers concerning untimely payment of claims and claim denials.

Prompt Payment Standards 1-7 and other significant observations: The examiners found two (2) areas of concern resulting in failure of the Company to comply with Standard 1 and noted one issue relating to incorrect retraction of payments initially made timely relating to Coordination of Benefits (COB) with Medicare. The issues identified were:

- Claims submitted by policyholders on the carrier's standard form, with all of the required fields completed, were denied with reason code 337, "The claim is denied because the practitioner's tax identification number and specialty must be on the claim." The

carrier's standard form did not require the information required by denial code 337. The claims denied for code 337 were not processed in accordance with the requirements of 18 Del. Admin. Code 1310, specifically 18 Del. Admin Code 1310 § 4.6.

- In addition, we noted subsequent retraction of $3,968.78 in claims that were part of our review relating to COB with Medicare. These claims relate to one policyholder and numerous providers. These claims were paid twice and retracted twice at the time of our inquiry. The policyholder had informed the company that they did not have Medicare coverage, which prompted the second payment. Upon inquiry by the examiners, the company promptly paid these claims for the third time.

HISTORY AND PROFILE

Mid Atlantic Medial Services, Inc. (MAMSI) acquired American Defender Life Insurance Company ("ADLIC") on December 31, 1992, following ADLIC's redomestication to the State of Maryland. ADLIC's name was changed to MAMSI Life and Health Insurance Company in 1993.

In 1993, the Company's sole line of business was to provide the indemnity health insurance coverage on point-of-service ("POS") health products sold by its affiliate HMOs, MD-Individual Practice Association (MDIPA") and Optimum Choice, Inc. ("OCI"). The indemnity health coverage was provided through "POS" policies underwritten by the Company. In 1994, the

Company began to market other insurance products. The Company also offers health care services through its affiliate home health care companies (HomeCall, Inc., HomeCall Pharmaceutical Services, Inc., HomeCall and Hospice Services, Inc.). On October 23, 2003, MAMSI, the parent company, entered into a definitive agreement to be acquired by UnitedHealth Group, Incorporated. The transaction was completed on February 10, 2004, after receiving all appropriate regulatory and shareholder approvals. The Company's operations are included in the consolidated federal income tax return of UnitedHealth Group Incorporated.

The management structure of the Company remained stable throughout the period of examination.

METHODOLOGY

This examination is based on standards approved by the Department, which are based on applicable Delaware Statutes, Rules, and Regulations as referenced herein and testing based on the NAIC methodology.

Some standards are measured using a single type of review, while others use a combination of the types of review. The types of review used in an examination fall into three general categories. The types of review are Generic, Sample, and Electronic.

A "Generic" review indicates that a standard was tested through an analysis of general data gathered by the examiner, or provided by the examinee in response to queries by the examiner.

A "Sample" review indicates that a standard was tested through direct review of a random sample of files using sampling methodology described in the NAIC Market Conduct Examiners Handbook.

An "Electronic" review indicates that a standard was tested through use of a computer program or routine applied to a download of computer records of the examinee. This type of review typically reviews 100% of the records of a particular type.

Tests were designed to adequately determine how the Company met each standard. Each standard tested is described and the result of testing is provided under the appropriate standard. Only standards tested are shown in this report of the limited scope examination.

Each Standard is accompanied by a "Comment" describing the purpose or reason for the Standard. The "Result" is indicated and the examiner's "Observations" are noted. In some cases a "Recommendation" is made. Comments, Results, Observations, and Recommendations are recited with each Standard.

The following sections are covered in a full scope market conduct examination. They are listed here clarify that this exam was limited to the claims area only.

A. COMPANY OPERATIONS/MANAGEMENT- not addressed on this exam

B. COMPLAINTS/GRIEVANCES-not addressed on this exam

C. MARKETING AND SALES- not addressed on this exam

D. NETWORK ADEQUACY- not addressed on this exam

E. PRODUCER LICENSING-not addressed on this exam

F. POLICYHOLDER SERVICE-not addressed on this exam

G. UNDERWRITING AND RATING-not addressed on this exam

H. CLAIMS

Comments: The evaluation of standards in this business area is based on Company responses to information requested by the examiner, discussions with the Company's staff, electronic testing of claim databases, and the review of claim files. This portion of the examination is designed to provide a view of how the company treats claimants and whether that treatment is in compliance with applicable statutes, rules, and regulations.

Prompt Payment Standard 1

The Company is using the Department's standards with regard to required elements for a clean claim when processing claims.

18 Del. Admin. Code 1310 § 4.0

Comments: This standard was designed and implemented to determine if the Company is properly identifying clean claims and if their definition of a "clean claim" is in compliance with 18 Del. Admin. Code 1310 § 4.0. Review methodology for this standard is generic, sample and electronic. The examiners reviewed the Company's procedures, training manuals, and internal communications. The examiners also interviewed claims personnel and did a walk-through of the

claims processing department and mailroom. A sample of adjudicated claims was reviewed by examiners.

Results: FAIL

The examiners identified the following two (2) reasons for failure.

(1) Claims submitted by policyholders on the carrier's standard form, with all of the required fields completed, were denied with reason code 337, "The claim is denied because the practitioner's tax identification number and specialty must be on the claim."
(2) The carrier's standard form did not require the information required by denial code 337.

Observation: Interviews and the Company's guidelines for clean claim processing indicate the Company is using the Department standards and definitions to identify clean claims. A review of a random sample of 100 claims consisting of 50 paid and 50 denied claims revealed two claims denied for reason code 337. Using Audit Command Language (ACL), the examiners further analyzed claims with reason code 337. The further analysis revealed 18 claims denied with reason code 337. The examiners reviewed all 18 claims. Of those 18 denials, 13 claims were policyholder claims submitted using the Company's standard form and denied with reason code 337.

***Recommendations*: It is recommended that all prior policyholder submitted claims denied with reason code 337 be reviewed and reprocessed for applicable payment in compliance with 18 Del. Admin. Code 1310. In addition, the Company should modify its standard**

claim form and/or its practices surrounding the member paid claims submitted on the Company's standard claim form.

Prompt Payment Standard 2

The Company is correctly processing claims that include unspecified, unclassified, or miscellaneous codes or data elements when an appropriate descriptive narrative is included. 18 Del. Admin. Code 1310 § 4.7

Comments: This standard was designed and implemented to determine if the Company is correctly processing claims which include unspecified, unclassified, or miscellaneous codes or data elements when an appropriate descriptive narrative is included and in compliance with 18 Del. Admin. Code 1310 § 4.7. Review methodology for this standard is generic and sample. The examiners reviewed the Company's procedures, training manuals, and internal communications. The examiners also interviewed claims personnel. A sample of adjudicated claims was reviewed by examiners.

Results: PASS

Observation: Reviews, interviews, and testing indicate the Company is processing claims in a manner that complies with this standard.

Prompt Payment Standard 3

The Company's clean claim processing is timely and in compliance with applicable statutes, rules and regulations.
18 Del. C. § 2304, 18 Del. Admin. Code 1310 § 6.0 and 7.0

Comments: This standard was designed and implemented to determine if the Company processes clean claims on a timely basis and in compliance with 18 Del. Admin. Code 1310 § 6.0, which requires adjudication within 30 days and 18 Del. Admin. Code 1310 § 7.0, which states "Within a 36 month period, three instances of a carrier's failure to comply with Section 6 of this Regulation shall give rise to a rebuttable presumption that the carrier has engaged in an unfair practice in violation of 18 Del.C. § 2304." Review methodology for this standard is generic, sample, and electronic. The examiners reviewed the Company's procedures, training manuals and internal communications and interviewed claims personnel. The examiners reviewed a random sample of 50 paid and 50 denied claims and an additional 19 denied claims adjudicated in excess of 30 days of receipt.

Results: PASS

Observation: Reviews, interviews, and testing indicate the Company is processing claims in a manner that complies with this standard.

Prompt Payment Standard 4

Proper payment is made on clean claims. 18 Del. Admin. Code 1310 § 6.1.1and 6.1.2

Comments: This standard was designed and implemented to determine: 1) if, at the time the Company determines an entire claim is payable, it pays the total allowable amount; and 2) to determine if, when only a portion of the claim is deemed payable, it pays the allowable portion in compliance with 18 Del. Admin. Code 1310 § 6.1.1 and 6.1.2. Review methodology for this standard is generic, sample and electronic. The examiners reviewed the Company's procedures, training manuals and internal communications, and interviewed claims personnel. The examiners reviewed a random sample of 50 paid and 50 denied claims and an additional 19 denied claims adjudicated in excess of 30 days of receipt.

Results: PASS

Observation: Reviews, interviews, and testing indicate the Company is processing claims in a manner that complies with this standard.

Prompt Payment Standard 5

The Company sends proper notification to the provider or claimant when either the entire claim or a portion of a claim will not be paid.

18 Del. Admin. Code 1310 § 6.1.2 and 6.1.3

Comments: This standard was designed and implemented to determine if, when the Company concludes an entire claim or a portion of a claim will not be paid, it sends proper notification to the provider or policyholder in compliance with 18 Del. Admin. Code 1310 § 6.1.2 and 6.1.3. Review methodology for this standard is generic and sample. The examiners reviewed a random sample of 50 paid and 50 denied claims and an additional 19 denied claims adjudicated in excess of 30 days of receipt.

Results: PASS

Observation: Review of the sample of claims indicate the Company is sending proper written notification to either the provider or policyholder when either an entire claim or portion of a claim will not be paid.

Prompt Payment Standard 6

The Company makes additional information requests for determination of propriety of payment in accordance with statutes, regulations, and rules.
18 Del. Admin. Code 1310 § 6.1.4, 6.2 and 6.3

Comments: This standard was designed and implemented to determine if the Company is making proper requests for additional information to assure that claims are not inappropriately denied. 18 Del. Admin. Code 1310 § 6.1.4 states "if the carrier needs additional information from a provider or policyholder who is submitting the claim to determine the propriety of payment of a claim, the carrier shall request in writing that the provider or policyholder provide documentation that is relevant and necessary for clarification of the claim." 18 Del. Admin. Code 1310 § 6.2 states in part, "A carrier who requests information under this subsection shall take action… within 15 days of receiving properly requested information." 18 Del. Admin. Code 1310 § 6.3 limits requests to one per claim except for coordination of benefits information and to determine if a claim is a duplicate.

Review methodology for this standard is generic, sample and electronic. The examiners reviewed the Company's procedures, training manuals, and internal communications. The examiners reviewed a random sample of 50 paid and 50 denied claims and an additional 19 denied claims adjudicated in excess of 30 days of receipt.

Results: PASS (with comment below)

Observation: When the Company requires additional information to determine the propriety of payment, the Company denies the claim and requests additional information concurrently. The denial is a full denial affording the subscriber all rights normally associated with a denial. This is considered a "soft denial." Upon receipt of the resubmitted request for payment for the same service and the requested information, the Company creates a new claim in its claim system which is assigned a new claim number. The new claim number is the original claim number with a pre-fix of "R" or "N". An "R" indicates an adjustment and an "N" indicates a new final payment. Even though the resubmission appears in the system as a new claim, the Company's procedures anticipate re-adjudication of the resubmission within 15 days.

Prompt Payment Standard 7

The Company makes interest payments on claims where appropriate and so ordered in compliance with statutes, rules, and regulations.

18 Del. Admin. Code 1310 § 8.0

Comments: This standard was designed and implemented to determine if the Company made proper interest payments when so ordered. Review methodology for this standard is generic.

Results: PASS

Observation: No interest payments on claims have been ordered to date.

H. Additional Findings

During the review of claims, the examiners noted 7 errors regarding the Company's claims handling pertaining to COB. All the claims belonged to the same member. The Company

initially paid the claims timely. In a routine COB audit, the Company received information that Medicare was the primary payer and the Company had overpaid the claims. The Company retracted the payments. Later, the member contacted the Company and indicated that she did not have Medicare, Part B making the Company the primary payer. The Company confirmed this within one day and coded the claims for payment the next day. For some reason not determined, the claim payments were again retracted as overpayments. They remained unpaid until identified by the examiner.

Upon request of the examiner, the Company reprocessed and paid 16 claims totaling $3,968.78, for the same individual, who's COB had been handled inappropriately.

Although the prompt pay standards do not appear to be violated, the Company may have issues with their COB procedures that effect timely and correct payment of claims.

Recommendation: **It is recommended that the Company should review its procedures for COB to assure that appropriate claims are not incorrectly denied. Also relating to the individual policyholder that recently received payment for the third time on good claims we recommend the company specifically confirm that these claims are not retracted at a later time to assure that the mistake uncovered and corrected during this examination is not reversed by the company.**

SUMMARY

The Company is a Maryland domiciled health insurer that provides health care coverage in the commercial markets.

This examination focused on compliance with Delaware prompt pay laws and regulations.

Recommendations have been made to address the areas of concern noted during the examination. These are summarized below.

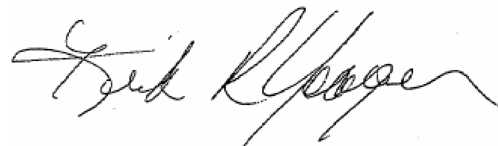
LIST OF RECOMMENDATIONS

It is recommended that all prior policyholder submitted claims denied with reason code 337 be reviewed and reprocessed for applicable payment in compliance with 18 Del. Admin. Code 1310. In addition, the Company should modify its standard claim form and/or its practices surrounding the member paid claims submitted on the Company's standard claim form.

It is recommended that the Company should review its procedures for COB to assure that appropriate claims are not incorrectly denied. Also relating to the individual policyholder that recently received payment for the third time on good claims we recommend the company specifically confirm that these claims are not retracted at a later time to assure that the mistake uncovered and corrected during this examination is not reversed by the company.

CONCLUSION

The examination was conducted by the undersigned and respectfully submitted,



Market Conduct Examiner-in-Charge
Delaware Insurance Department