NORTH CAROLINA

Appendix I – Required Attachments

Supporting Documentation – North Carolina Department of Insurance

Capacity of the Department - The North Carolina Department of Insurance has the capacity to implement the proposed project and to manage the grant funds as proposed in our budget. The Department of Insurance has been a federal grants' fund recipient numerous times in the past, and has shown an ability to manage the grant funds in accordance with each awards' requirements and with the proper diligence necessary as a steward of public funding. With the approval by the General Assembly of our request for additional staff positions, the Department now has the proper capacity to carry out our planned expanded role in health insurance premium review as outlined in the proposal.

Delineation of the Roles and Responsibilities of Project Staff -

Life & Health Division

Insurance Regulatory Analyst I

This position is responsible for approving or disapproving both standard and complex life and health insurance form filings and premium rate justifications (i.e. whole life products, individual health insurance and premium rate adjustments plus specialty health insurance coverages). While fewer complexes in relation to those decisions made by Analyst II's and above, the approval/disapproval process requires years of experience, training and education. Because of the impact of technical decisions made in the approval process of forms and rates, the Policy and Rate Analyst I will approve or disapprove many filings. The employee determines the correctness and appropriateness of the filing using the same general statutes, Department Rules and procedures used by the higher level Analysts and the same kind of quasi-actuarial statistical analysis is conducted.

Percent of Time Spent on Health Insurance Rate Review Activities: 50%

Minimum Training and Experience - Graduation from a four-year college or university with preferably a degree in business or economics or a related program including at least one course in statistics or college level mathematics and three years experience in policy and rate examination or underwriting, claims adjusting or financial/marketing analysis work; or an equivalent combination of training and experience.

Insurance Regulatory Analyst II

This employee is responsible for approving or disapproving the more complex life and health insurance filings of quasi-actuarial approval of rate justification (i.e. interest sensitive whole life, variable life, variable annuities, credit insurance, long term care, managed care, Medicare supplements, assumption reinsurance, etc.). Approval/disapproval at this level would include filings for multiple employer trusts, out of state associations, HMO's, PPO's, etc.

The appropriate application of state insurance laws and rules requires this position to coordinate general insurance requirements and specific statutory mandates in order to determine product compliance. Because of the number and scope of complexities added to this division, Analyst II's are assigned specific areas in which they become experts for the Department of Insurance and the State in general.

Percent of Time Spent on Health Insurance Rate Review Activities: 50%

Minimum Training and Experience - Graduation from a four-year college or university with a degree in business or economics or a related program including at least one course in statistics of college level mathematics and four years experience in policy and rate examinations, underwriting, claims adjusting work, or financial/marketing analysis; or an equivalent combination of training and experience.

Insurance Regulatory Analyst III

The Supervisor is responsible for supervision of the Policy and Rate Analysts I and II positions and directs activities of Administrative Assistants. This includes planning and structuring of the forms and rate approval process; organizing work distribution for all Analysts I and II positions on a rotating monthly basis; motivating employees to produce high quantities and quality of work and controlling their results through quality control measures. Overall training of all analysts and direction on special projects as required by legislative action is an integral part of this position.

The Supervisor approves/disapproves the most complex group and non group form and rate filings for domestic insurers, medical service organizations (BCBS), Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO), Fraternal Orders, Small Group Health insurance products, Long Term Care (LTC), variable life products, interest sensitive life products, equity indexed annuity products and Medicare Supplements (MedSup) requiring expertise in the application and interpretation of State insurance laws and regulations, including the impact of federal regulatory programs; i.e. Medicare supplements standardized by the Omnibus Budget Reconciliation Act of 1990 (OBRA 90).

Percent of Time Spent on Health Insurance Rate Review Activities: 25%

Minimum Training and Experience - Graduation from a four-year college or university with a degree in business or economics or a related program including at least one course in statistics or college level mathematics and five years experience in policy and rate examination, underwriting, claims adjusting work, or financial/marketing analysis; or an equivalent combination of training and experience.

Office Assistant IV

This position initially processes form or rate filings and company responses. This position will initially process all SERFF (System for Electronic Rate & Form Filings) filings directed to this Department. This position also assigns category codes to all new filings and enters the information into the Operations Tracking and Information System (OTIS) OTIS is a Database Management System (DBMS), an integrated collection of data, processes, and functions stored on a direct access storage device.

This position is responsible for individual health insurance rate adjustment approval or disapproval. This requires knowledge of insurance premium rates, Division specialty codes, statutes, and rules and regulations regarding rate increases.

Percent of Time Spent on Health Insurance Rate Review Activities: 75%

MINIMUM TRAINING AND EXPERIENCE

Graduation from high school and demonstrated possession of knowledge, skills and abilities gained through at least two years of office assistant/secretarial experience; or an equivalent combination of training and experience.

Actuarial Services Division

Actuary (2)

Responsible for assessing actuarial compliance of all domestic life insurers with the Standard Valuation Law (SVL).

- Actuarial review and or supervision of actuarial review of actuarial opinions and memorandums.
- Communicating results and recommendations to the Financial Evaluation Division.

- Keeping abreast of proposed NAIC Model Rules and Regulations pertaining to the SVL.

Responsible for the actuarial review of all individual accident & health rate revisions.

- Supervise the actuarial review of a sample of all individual accident & health rates.
- Each month, reviews a sample of recommendations and results to the Life & Health Division.

Responsible for providing actuarial assistance to other division in regard to life and health actuarial science.

- Actuarial review, on an as need basis, of new life insurance policy provisions.
- Actuarial review, on an as need basis, of new life insurance products.

Responsible for assessing actuarial compliance of all Health Maintenance Organizations with Article 67.

- Actuarial review and or supervision of actuarial review of all HMO licensing applications.
- Supervision of actuarial review of all HMO rates to assure rates are adequate, not excessive and not unfairly discriminatory.
- Actuarial review on a periodic basis of all HMO claim reserves as set forth in NCAC 16.0700.
- Communicating and or reviewing results and recommendations to the Life & Health and Managed Care Divisions in regard to this item.

Responsible for assessing actuarial compliance of all small employer group insurers with the Small Employer Group Act.

- Actuarial review of annual and periodic small employer group actuarial certification.
- Actuarial review of statutory demographic rating factors.
- Actuarial review of other rating factors for compliance with NCGS 58-50-130.
- Actuarial review of rating methodologies
- Communicating results and recommendations to the Life & Health Division.
- Keeping abreast of proposed NAIC Model Rules and Regulations pertaining to Small Employer Group Insurance.

Percent of Time Spent on Health Insurance Rate Review Activities: Actuary I – 100%, Actuary 2 – 50%

MINIMUM TRAINING AND EXPERIENCE:

Four-year degree in mathematics, business, or closely related field and completion of one of the professional actuary society exams; or an equivalent combination of training and experience.

Market Regulation Division

Insurance Regulatory Analyst I

Review all company marketing materials which include but not limited to:

- Management Agreements
- Agents Appointment and Terminations
- Sales and Advertising materials
- Sampling of all issued/declined policies/applications by line of business
- Sampling of all paid/denied claims by line of business
- Consumer Complaints

Percent of Time Spent on Health Insurance Rate Review Activities: 65%

Minimum Training and Experience - Graduation from a four-year college or university with preferably a degree in business or economics or a related program including at least one course in statistics or college level mathematics and three years experience in policy and rate examination or underwriting, claims adjusting or financial/marketing analysis work; or an equivalent combination of training and experience.

Insurance Regulatory Analyst II

The Analyst II may assist in meetings with company officials such as the pre-examination meeting which includes the EIC and the Analyst I and II. The EIC provides company officials with details of the examination process which includes, but not limited to the administration of the Market Conduct Examination including generating claims and underwriting populations including sampling techniques used by the Department. The areas of review are discussed in detail with the Analyst II giving specific examples of the items reviewed in the claims and underwriting on rating sections of the examination. The wrap-up meeting is conducted by the EIC. The general areas of concern are covered regarding the necessary administration of the report process. The Analyst II will be required to discuss specific areas, such as claims and underwriting, to articulate areas of concern. The EIC completes the wrap-up meeting answering any additional questions company personnel may have. The Analyst II acts as Supervising Examiner in the absence of the Examiner-In-Charge.

Review all company marketing materials which include but are not limited to:

- Consumer Complaints
- Management Agreements
- Agents Appointment and Terminations
- Sales and Advertising materials
- Sampling of all issued/declined policies/applications by line of business
- Sampling of all paid/denied claims by line of business
- Prepare a written report of the examination findings

Percent of Time Spent on Health Insurance Rate Review Activities: 45%

Minimum Training and Experience - Graduation from a four-year college or university with a degree in business or economics or a related program including at least one course in statistics of college

level mathematics and four years experience in policy and rate examinations, underwriting, claims adjusting work, or financial/marketing analysis; or an equivalent combination of training and experience.

Insurance Regulatory Analyst III

The primary purpose of the position is to regulate P&C and L&H insurers that offer commercial and private passenger automobile coverage, homeowner coverage, commercial coverage, worker's compensation coverage, life coverage, and accident and health coverage, etc. through the review of Policyholder Treatment, Marketing, Underwriting and Rating, and Claims records. The Examiner-In-Charge (EIC) will conduct and coordinate examination efforts with company officials and monitor examination work flow. Present all examination findings to company officials. Give company officials direction and prepare a written report of the examination findings. This position will prepare and conduct the pre-examination conference, and examination wrap-up conference. This position will also assist with the training of Analyst I & II personnel.

The EIC will conduct and coordinate the examination process. This includes but is not limited to meetings with company officials to discuss examination preparation at the pre-examination meeting, discussing examination findings at the wrap-up meeting, and act as lead contact person representing the Department. Meetings with company officials such as the pre-examination meeting include the EIC and the Analyst I and II. The EIC provides company officials with details of the examination process which includes, but not limited to the administration of the Market Conduct Examination including generating claims and underwriting populations including sampling techniques used by the Department. The areas of review are discussed in detail with the Analyst II giving specific examples of the items reviewed in the claims and underwriting on rating sections of the examination. The wrap-up meeting is conducted by the EIC. The general areas of concern are covered regarding the necessary administration of the report process. The Analyst II will be required to discuss specific areas, such as claims and underwriting, to articulate areas of concern. The EIC completes the wrap-up

meeting answering any additional questions company personnel may have. Act as the Supervising Examiner over the Analyst I & II. Provide training for the Analyst I and II.

Review all work performed by Analyst I & II and may actually include the review of specific areas regarding all aspects of company operations which includes but not limited to:

- Consumer Complaints
- Management Agreements
- Agent Appointments and Terminations
- Sales and Advertising materials
- Sampling of all issued/declined policies/applications by line of business
- Sampling of all paid/denied claims by line of business
- Prepare a written report of the examination findings

Percent of Time Spent on Health Insurance Rate Review Activities: 35%

Minimum Training and Experience - Graduation from a four-year college or university with a degree in business or economics or a related program including at least one course in statistics or college level mathematics and five years experience in policy and rate examination, underwriting, claims adjusting work, or financial/marketing analysis; or an equivalent combination of training and experience.

Financial Evaluation Division

Insurance Company Examiner Manager

Assumes a supervisory role in multiple, concurrent examinations of regulated entities. A Supervising Examiner is responsible for coordinating, supervising, conducting and participating in activities for examinations assigned by the Chief Examiner. This work is established by Statutes, Department

policies and procedures, AICPA Statements of Auditing Standards, the NAIC Financial Condition Examiners Handbook, and other similar professional guidelines.

Planning activities include directing or coordinating pre-examination meetings; compiling and evaluating information; reviewing and approving the EIC's assessment of risk, internal controls and reliance to be places on work performed by external auditors; reviewing and approving planning documents, including the Planning Memorandum, examination budget/staff assignments, and materiality levels; and reviewing and approving the EIC's planned examination approach.

During fieldwork, the Supervising Examiner is expected to: manage and direct the examination and analysis of the financial records relative to the business operations of assigned entities; make conclusions on the analysis and testing of financial data and; review completed staff work related to issues identified during planning, in high risk areas, and where exceptions were noted; and evaluate the appropriateness of actions/recommendations proposed by supporting staff;

The Supervising Examiner is responsible for ensuring that examinations are conducted in a cost efficient and expedient manner, within the examination budget, and for keeping the Chief Examiner informed of examination issues.

This position is expected to take a leadership role in the supervising and training of staff. Extensive interaction and consultation with management, consultants, and external parties is required.

During the wrap-up phase, the Supervising Examiner prepares or reviews the draft Report on Examination before forwarding to the Chief Examiner and other areas within the Department. Other duties during this phase include directing or participating in post-examination meetings with other sections within the Department to discuss examination findings and following up with the regulated entity until final acceptance/issuance of the Report.

Percent of Time Spent on Health Insurance Rate Review Activities: 100%

MINIMUM TRAINING AND EXPERIENCE:

Bachelor's degree from an accredited college or university, with the appropriate courses in accounting as defined in 21 NCAC 8A.0309 and other courses required to qualify as a candidate for the uniform certified public accountant examination, based on the examination requirements in effect at the time of graduation and four years of experience in auditing insurance company operations or closely related accounting or auditing work; or two years as a senior accountant with a CPA firm; or two years of experience as a corporate controller, manager of internal audit or similar role preceded by experience as a staff accountant for a CPA firm; or one year as an audit manager for a CPA firm; or equivalent combination of training and experience. All degrees must be received from appropriately accredited institutions.

Consumer Services Division

Insurance Complaint Analyst Supervisor

The primary purpose of this position is to supervise a team of Life and Health Complaint Analysts and Communication Specialists, in order to ensure that North Carolina consumers receive timely, accurate and thorough assistance with their insurance-related complaints and inquiries. Calls and complaints received can involve a wide range of insurance lines, including health, life, annuities, and disability.

Position is responsible for general oversight of Section, including the implementation/maintenance of office policies and work procedures, performance instruction/coaching for supervisees, and monitoring performance for adherence with Division/Section policies and procedures. This position also serves as first back-up for Division's Deputy, when Deputy is not present.

Position receives, screens, assigns, and tracks new complaints received by the Section. Position regularly reviews samples of Analysts' work, to ensure that correspondence with companies and consumers reflect an accurate understanding of applicable statutes/regulations, and that such correspondence displays appropriate clarity, grammar, spelling, etc. Position continuously monitors Analyst workloads to ensure equitable and appropriate distribution of complaints. Position also supervises Senior Analyst who (in turn) supervises Section's telephone-based Communication Specialists. As such, position is accountable for the accuracy and appropriateness of Section's call handling, and for ensuring adequate phone coverage (using Analysts for backup coverage as needed).

Position assists Deputy with conceptualization and implementation of market analysis activities, based on information gathered via complaint and call activity. Position maintains and encourages continuous communication with/between Section staff, and relays significant market trends and company-specific issues to Deputy as appropriate.

Percent of Time Spent on Health Insurance Rate Review Activities: 50%

Minimum Training and Experience Requirements - Graduation from a four-year college or university and three years of experience in insurance underwriting, claims, or policyholder service; or three years of experience as an Insurance Complaint Analyst; or graduation from high school and seven years of experience in insurance underwriting claims, or policyholder service; or an equivalent combination of training and experience.

Administration

Attorney III

This position will have primary responsibility for coordinating legal issues related to health care reform issues for the Department of Insurance. In that role the employee will work with Department legislative staff who coordinate with the NC legislature concerning statute changes; the NC Office of

Administrative Hearings for administrative rule changes; the National Association of Insurance Commissioners and development of Model Laws; and managers and employees within the NC Department of Insurance to answer questions and suggest procedures and processes; and the insurance and health care communities to answer questions. This position will work with all aspects of health care reform, including but not limited to the Exchange; insurance premiums; insurance rate litigation the ombudsmen program; financial oversight; actuarial activities; consumer questions; revisions to approved health insurance policies offered to NC citizens; investigations of insurance fraud and other prohibited activities; market regulation review; and all other aspects of implementing and administering health care reform.

Percent of Time Spent on Health Insurance Rate Review Activities: 100%

Minimum Training and Experience Requirements - Graduation from a recognized school of law and three years of progressively responsible professional legal experience; or an equivalent combination of training and experience.

Necessary Special Qualification - License to practice law in the State of North Carolina.

Work Plan and Time Line – North Carolina Department of Insurance

Action Item	Target Date for Completion
Recruit for new positions	3rd/4th Quarter 2010
Contract with third-party actuarial service to analyze DOI's rate review process and recommend improvements	3rd or 4th Quarter 2010
Draft proposed legislative language to adopt prior approval authority over association, small and large employer group rate filings	Early 4th Quarter 2010
Draft proposed legislative language and/or regulatory language to adopt any NAIC models relating to rate filing requirements and/or draft language to strengthen current data requirements to be in synch with data reporting requirements associated with PPACA and grant	Early 4th Quarter 2010
Draft proposed legislative changes related to enhancing consumer protections	Early 4th Quarter 2010
SERFF Enhancement (tentative)	4th Quarter 2010 or 3 months after uniform template released
Report from actuarial service on DOI rate review process due	Year end 2010
Draft proposed statutory or regulatory changes based upon report on our process from an actuarial service	1st Quarter 2011
Other NAIC-lead IT Enhancements (i-Site, databases, etc.)	No date available given the involvement of the NAIC to move forward with these changes
Effective Dates of New Legislation/Regulations increasing rate review authority, data requirements, etc.	Summer/Fall 2011
Collection of Data related to rate review activities and processes to show impact of enhancements	Ongoing
Contract with other outside entities as needed to promote the enhancement agenda, including use of outside actuaries to assist in some specific rate reviews, etc.	Ongoing

ATTACHMENT C

APPLICATION COVER SHEET AND CHECK-OFF LIST

Indentifying Information:

Grant Opportunity: **HHS Health Insurance Rate Review Grants-Cycle I**

DUNS #: 061816133 Grant Award: $1 million

Applicant: North Carolina Department of Insurance

Primary Contact Person, Name: Ernest Nickerson

Telephone Number: 919-807-6870 Fax number: 919-807-6858

Email address: ernest.nickerson@ncdoi.gov

APPLICATION COVER SHEET AND CHECK-OFF LIST

REQUIRED CONTENTS

A complete proposal consists of the following material organized in the sequence below: Please ensure that the project narrative is page-numbered. The sequence is:

- ☑ Cover Sheet
- ☑ Forms/Mandatory Documents (Grants.gov).

  The following forms must be completed with an original signature and enclosed as part of the proposal:

- ☑ SF-424: Application for Federal Assistance
- ☑ SF-424A: Budget Information
- ☑ SF-424B: Assurances-Non-Construction Programs
- ☑ SF-LLL: Disclosure of Lobbying Activities
- ☑ Additional Assurance Certifications
- ☑ Required Letter of support and Memorandum of Agreement
- ☑ Applicant's Application Cover Letter
- ☑ Project Abstract
- ☑ Project Narrative
- ☑ Work plan and Time Line
- ☑ Proposed Budget (Narrative/Justifications)
- ☑ Required Appendices
- ☑ Resume/Job Description for Project Director and Assistant Director

Budget Narrative — North Carolina Department of Insurance

The passage of Federal Healthcare Reform legislation focuses on the utilization of the health insurance market to effect national health care reform. This Reform creates a new and significant demand for health insurance products and will most certainly impact the North Carolina Department of Insurance. The Reform will immediately increase insurance forms filings as companies are required to change existing policies to conform to Federal law. This increase in filings must be reviewed and approved by DOI employees and will be followed closely by marketing efforts. The Reform will also require additional audit work to ensure compliance with the Federal and State Laws. Consumer complaints and investigation work will also increase. These requirements will create a tremendous initial and on-going demand on the Department of Insurance and will require staff resources not currently available.

The Reform will require new staff positions (13) with 11 being supported by the federal grant and administrative costs for a total of $1,000,000 being requested; and (2) positions being supported by state appropriations ($341,775). In addition to the direct costs the HealthCare Reform efforts will be supported by existing personnel provided by the North Carolina Department of Insurance.

The complexities of the Reform will require staff to have more education, training and experience to properly interpret and judge the subsequent changes in products that the industry must submit for approval and for the staff to audit the newly created sectors of the health care business. The State's and the National's highest priority concern is with regulating the health insurance industry. The State must be able to meet the required changes in products and administration in order to appropriately serve the citizens of North Carolina.

Appendix I – Required Attachments

Certification of Maintenance of Effort – North Carolina Department of Insurance

As of the date of submission of this grant request, the NC General Assembly is still in the session and the State's Budget has not been adopted. Consequently the Department of Insurance has not received a Certified Budget for FY2011. Overall the current proposal is for the Department to have its State appropriation reduced by 3.8 percent due to fiscal constraints the state is experiencing. However, none of the budget cuts will affect the health insurance rate review functions being performs by the current staff. In addition, the General Assembly has given approval for 13 new positions for the Department's efforts to expand oversight and the implementation of healthcare reform in North Carolina, thus demonstrating "maintenance of effort" and the desire to promote and improve healthcare in NC.

No existing state expenditures will be supplanted with grant funds.

North Carolina
DEPARTMENT OF INSURANCE
Wayne Goodwin | Commissioner of Insurance
TECHNICAL SERVICES GROUP

July 7, 2010 Submitted Electronically

To: Jacqueline Roche
The Office of Consumer Information and Insurance Oversight
Department of Health and Human Services

Re: Grants to States for Health Insurance Premium Review-Cycle I – CFDA # 93.511
Applicant: North Carolina Department of Insurance

Dear Ms. Roche:

Attached you will find an application from the North Carolina Department of Insurance for grant funding available under the Grants to States for Health Insurance Premium Review-Cycle I.

I am the Project Director for the grant project as well as the Senior Deputy Commissioner of the Department's Technical Services Group. The Life & Health Division, which is the division primarily responsible for premium rate review, is part of the Technical Services Group. Should you need to contact me, my contact information is as follows:

Ernest L. Nickerson, FLMI, ACS, AIRC, ARM, RHU
Senior Deputy Commissioner
Technical Services Group
North Carolina Department of Insurance
11 South Boylan Ave.
Raleigh, NC 27603
919-807-6871
ernest.nickerson@ncdoi.gov

The North Carolina Department of Insurance has existing authority to oversee and coordinate the activities proposed in the application or has provided a plausible plan for obtaining such authority. The North Carolina Department of Insurance is capable of, and has convened, a suitable working group of all relevant Divisions to assist in this project.

Commissioner Wayne Goodwin and the Department of Insurance are very excited about the opportunities that lie ahead with healthcare reform in North Carolina.

Sincerely,

Ernest L. Nickerson, FLMI, ACS, AIRC, ARM, RHU
Senior Deputy Commissioner
Technical Services Group

North Carolina
DEPARTMENT OF INSURANCE
Wayne Goodwin | Commissioner of Insurance
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Senior Deputy Commissioner
Technical Services Group

STATE OF NORTH CAROLINA
OFFICE OF THE GOVERNOR
20301 MAIL SERVICE CENTER • RALEIGH, NC 27699-0301

BEVERLY EAVES PERDUE
GOVERNOR

July 2, 2010

The Honorable Kathleen Sebelius
Secretary
U. S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Madam Secretary:

Enclosed please find the application from Insurance Commissioner Wayne Goodwin in response to the Department of Health and Human Services' Grant Invitation for FY 2010 CFDA: 93.511 for Health Insurance Premium, Review-Cycle I, dated June 7, 2010.

I support the state's application for this grant. Please contact me if I can be of further service.

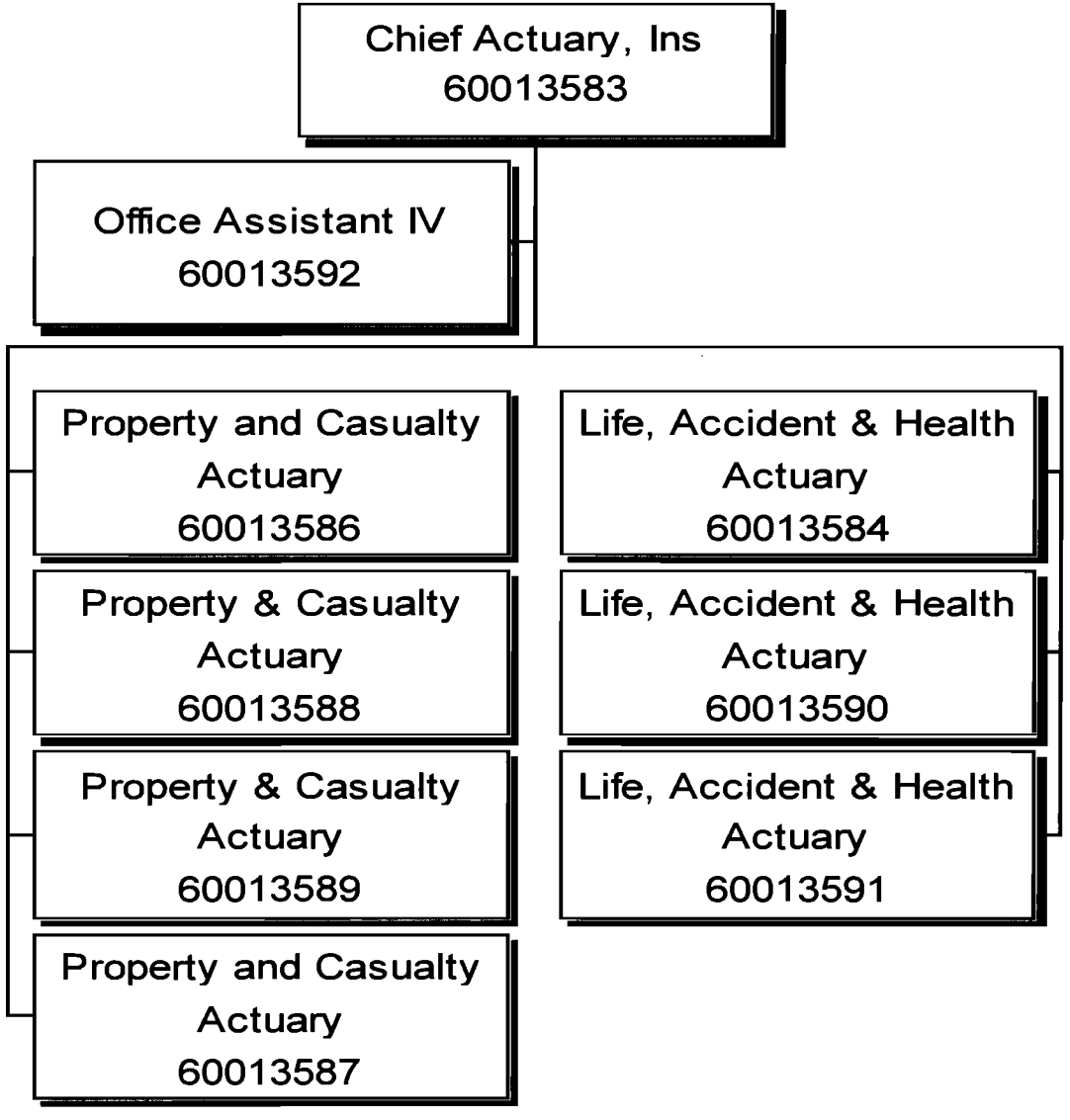
Sincerely,

Bev Perdue

Bev Perdue

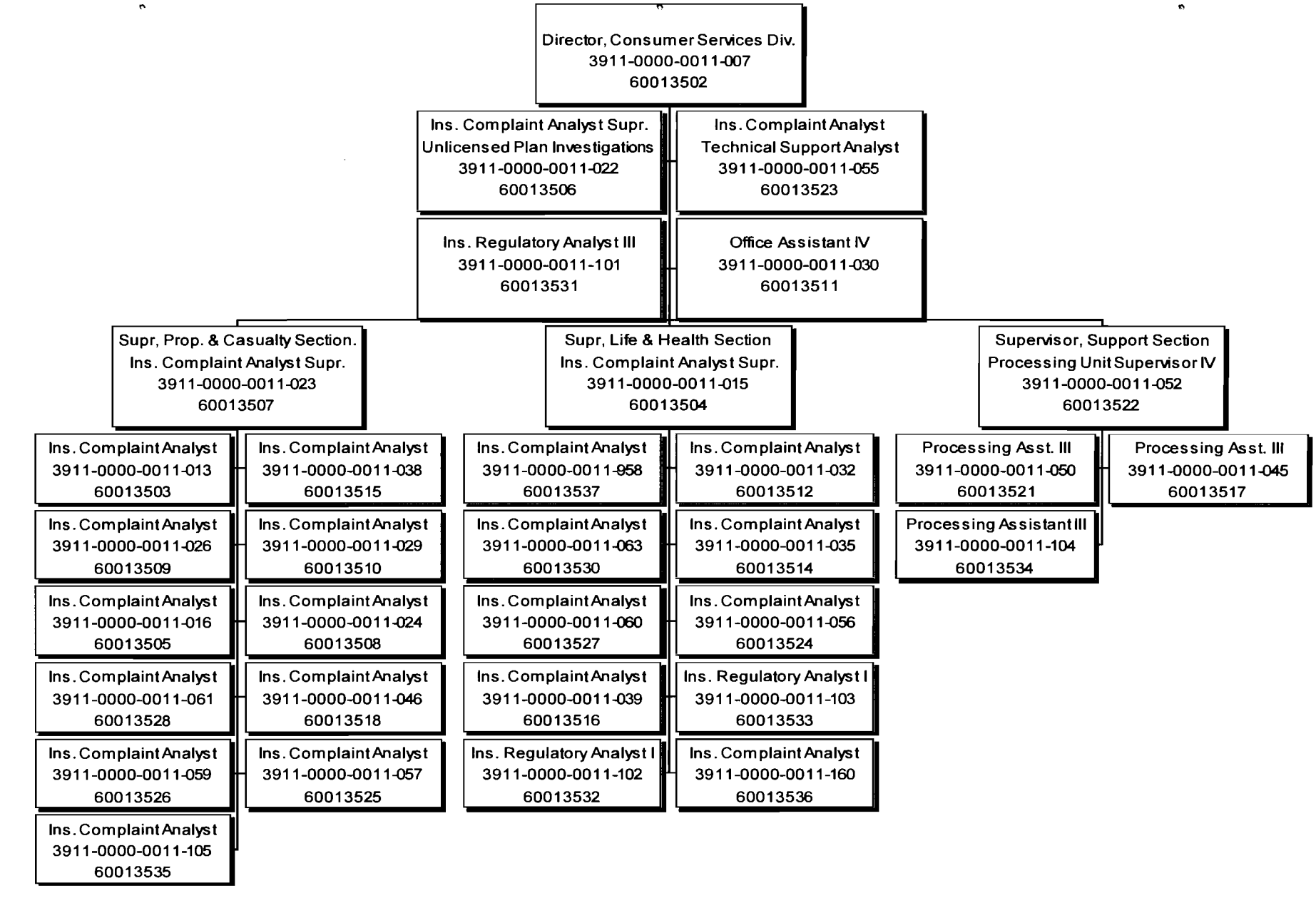
LOCATION: 116 WEST JONES STREET • RALEIGH, NC • TELEPHONE: (919) 733-5811
WWW.GOVERNOR.STATE.NC.US

NC DEPARTMENT OF INSURANCE
ACTUARIAL SERVICES DIVISION



June 2010

NC Department of Insurance
Consumer Services Division

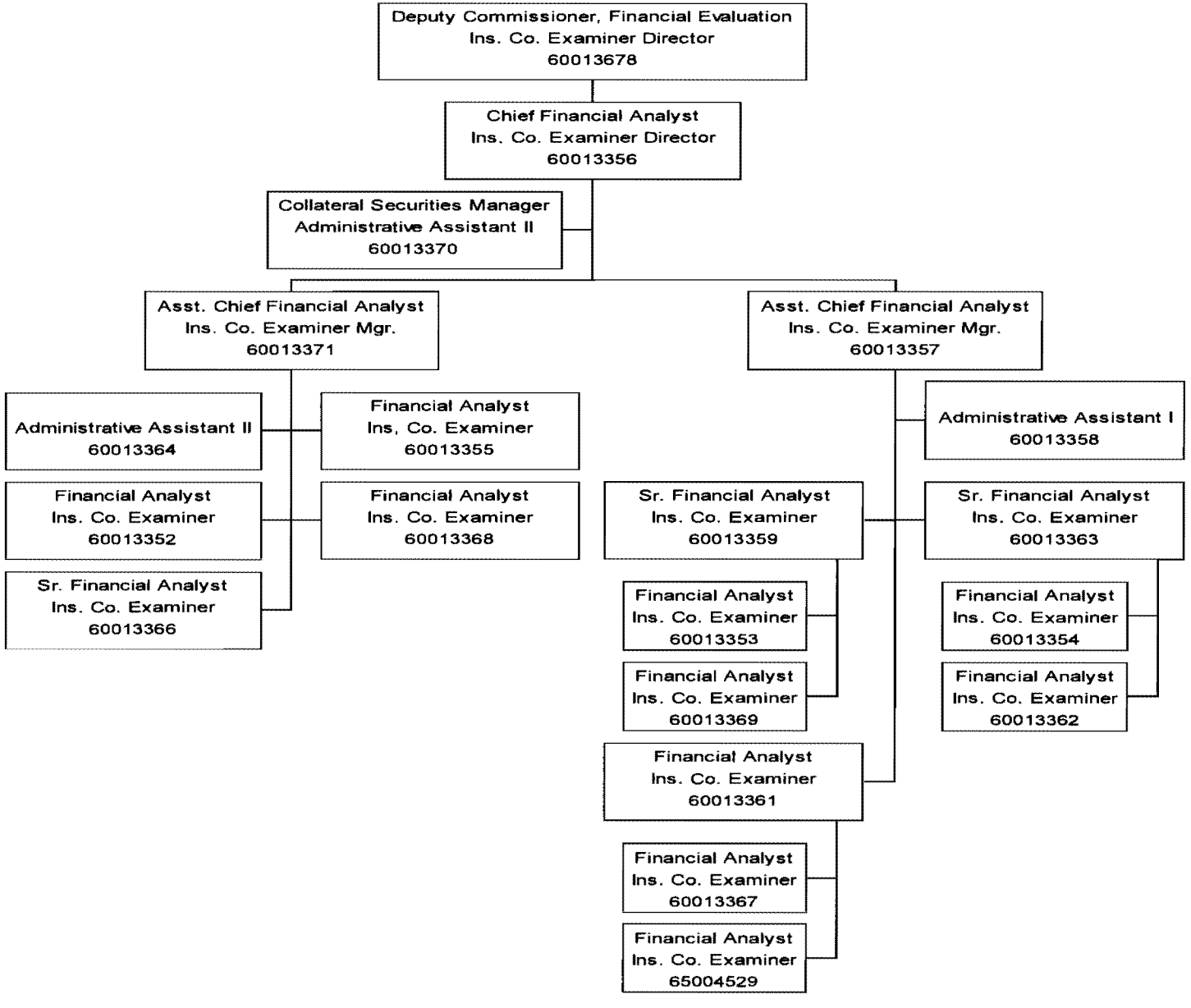


June 2010

NC DEPARTMENT OF INSURANCE

FINANCIAL EVALUATION DIVISION

FINANCIAL ANALYSIS SECTION

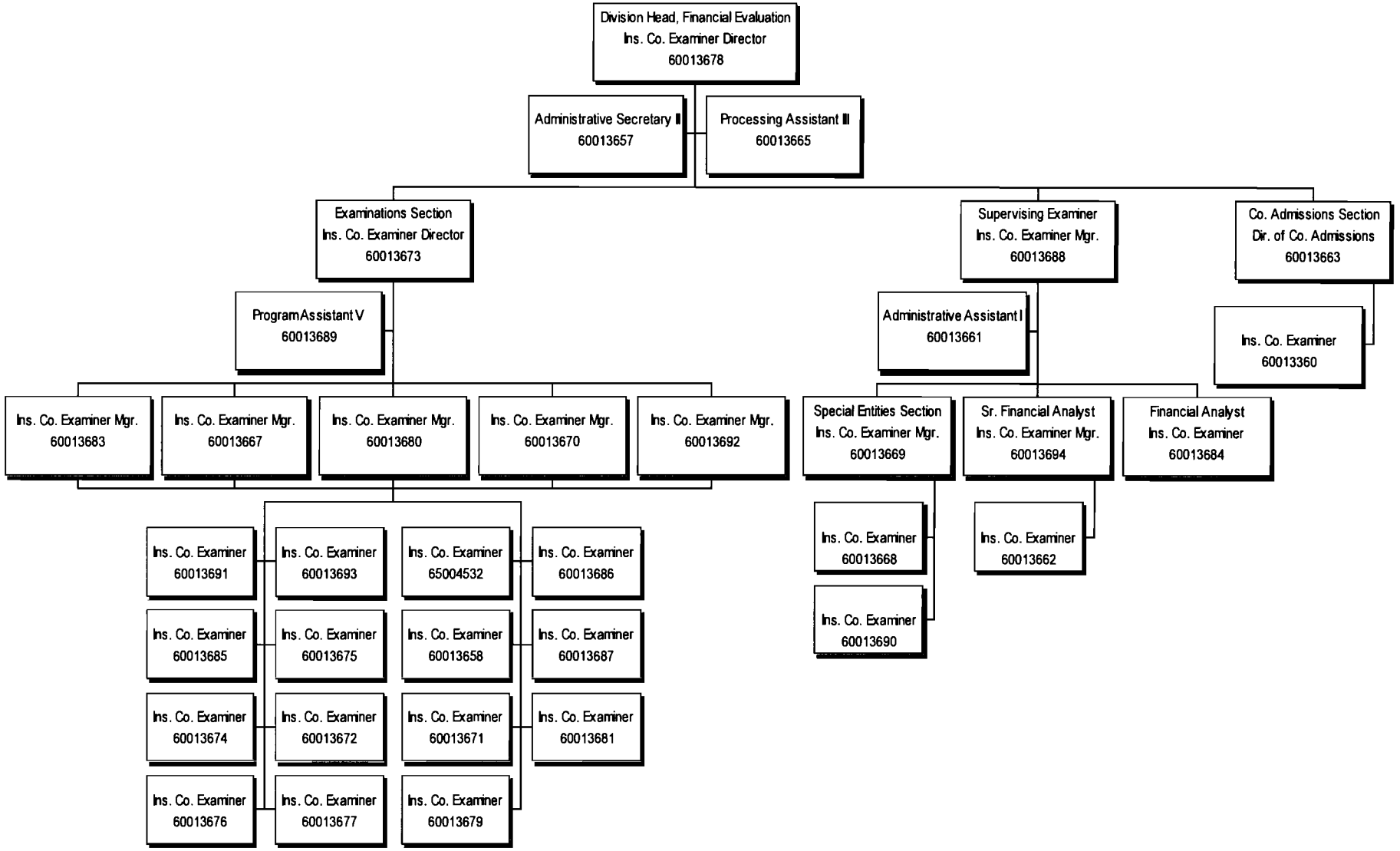


June 2010

NC DEPARTMENT OF INSURANCE

FINANCIAL EVALUATION DIVISION

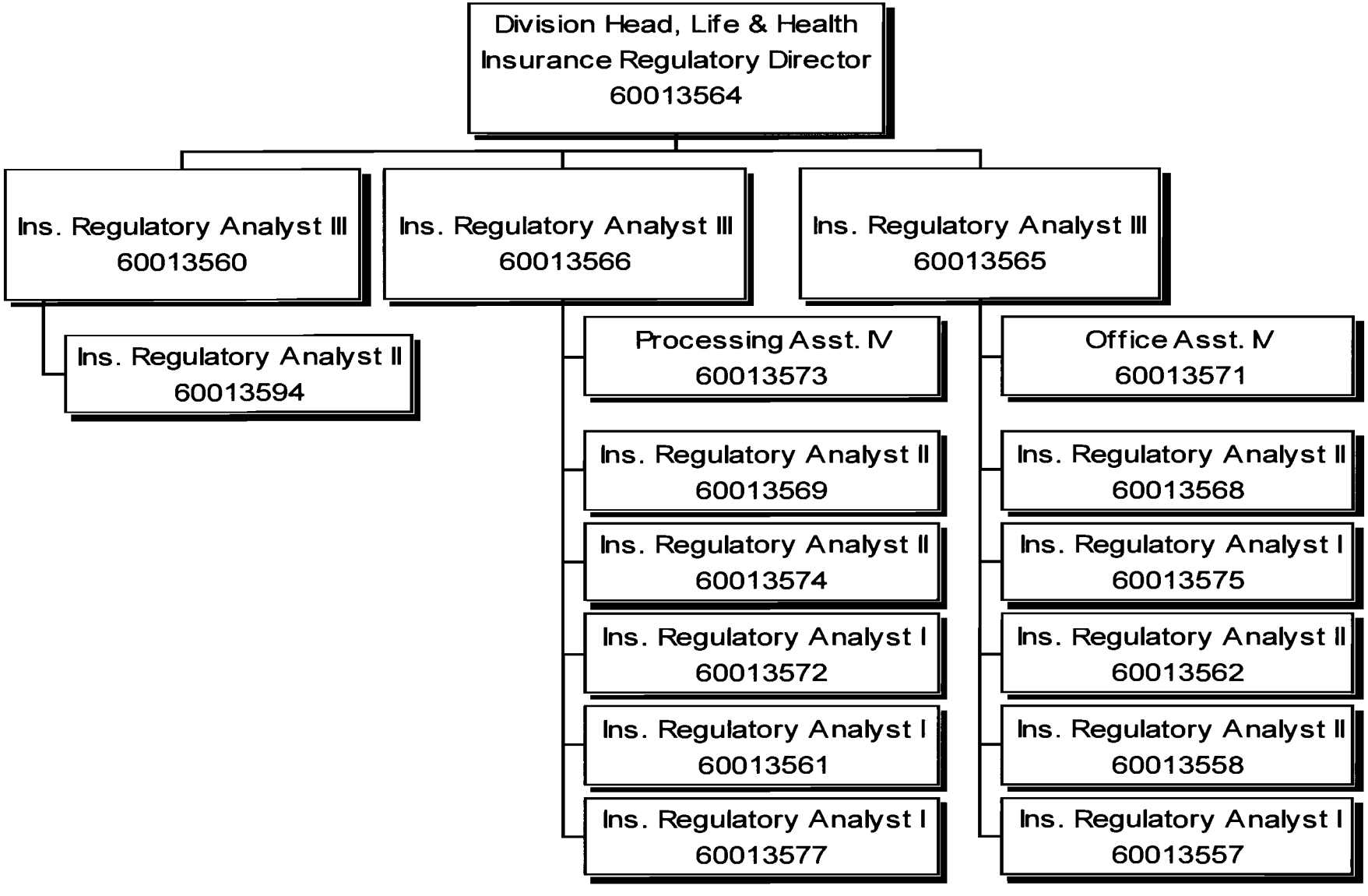
FINANCIAL EXAMINATION SECTION



June 2010

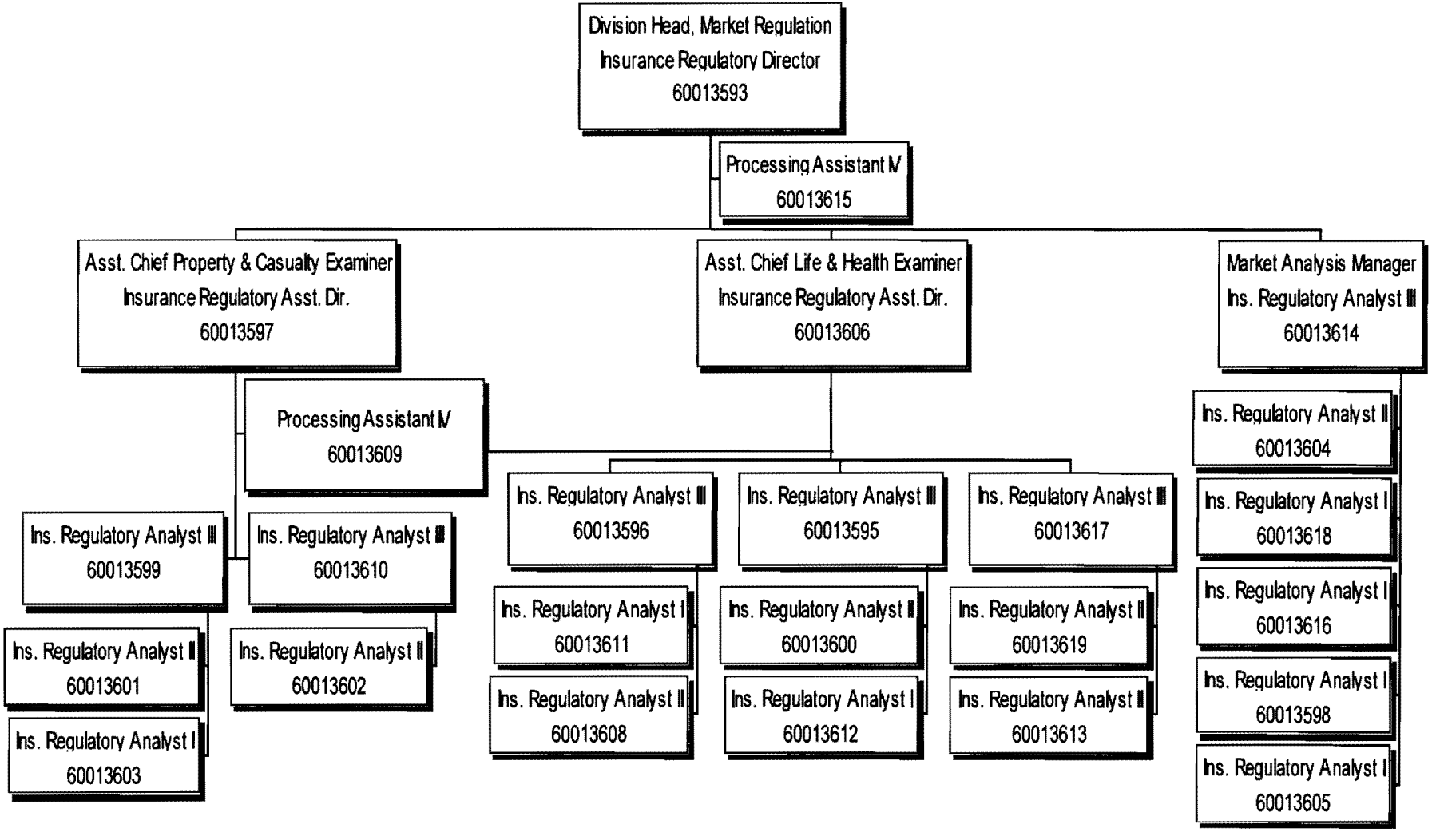
NC DEPARTMENT OF INSURANCE

LIFE & HEALTH DIVISION



June 2010

NC DEPARTMENT OF INSURANCE
MARKET REGULATION DIVISION



June 2010

Project Abstract — North Carolina Department of Insurance

Through an expansion of our prior approval authority to encompass all types of health insurance plans no matter the type of insurer, or the market or product involved, the North Carolina Department of Insurance intends to enhance our health insurance rate review process in this state for the Department, for insurers and most importantly for consumers. In addition to extending prior approval authority, the Department will seek legislative action to standardize the type of data required to be submitted by insurers with rate filings, require data be submitted consistent with information that will be required to be submitted to DHHS under PPACA and/or the grant award agreements, monitor and possibly participate in initiatives at the NAIC to enhance nationwide data collection and filing submission systems to facilitate the submission and collection of data related to our rate review process. We intend to increase consumer protections by seeking legislative action to require simplified summary information be required to be submitted with rate filings and to require that certain minimum information be considered public information and not allowed to be identified as "trade secret" in order that the information may be shared with the public. In order to design the best rate review process we can, the Department will request a report from a third party actuarial service which will analyze and make recommendations to our current process. That review will include recommendations on how to use public input to enhance our current activities. Given that most of our enhancements involve an increase in the Department's authority, or enhancements to current process, the majority of the proposed $1,000,000 budget is proposed for an expansion of rate review personnel and the related expenses ($826,548). The remaining money is proposed to be used to contract with outside actuarial firms or other entities to review our processes and/or perform special reviews of rate filings, and on staff trave/education. Through all of these initiatives the Department's goal is to make a system of health insurance rate review that provides strong regulatory controls that lead to a premium that is appropriate for the product provided and that is a fair, equitable system for both insurers and consumers.

§ 58-50-130. Required health care plan provisions.

(a) Health benefit plans covering small employers are subject to the following provisions:

(1) to (4) Repealed by Session Laws 1997-259, s. 5, effective July 14, 1997.

(4a) A carrier may continue to enforce reasonable employer participation and contribution requirements on small employers applying for coverage; however, participation and contribution requirements may vary among small employers only by the size of the small employer group and shall not differ because of the health benefit plan involved. In applying minimum participation requirements to a small employer, a small employer carrier shall not consider employees or dependents who have qualifying existing coverage in determining whether an applicable participation level is met. "Qualifying existing coverage" means benefits or coverage provided under: (i) Medicare, Medicaid, and other government funded programs; or (ii) an employer-based health insurance or health benefit arrangement, including a self-insured plan, that provides benefits similar to or in excess of benefits provided under the basic health care plan.

(4b) Late enrollees may only be excluded from coverage for the greater of 18 months or an 18-month preexisting-condition exclusion; however, if both a period of exclusion from coverage and a preexisting-condition exclusion are applicable to a late enrollee, the combined period shall not exceed 18 months. If a period of exclusion from coverage is applied, a late enrollee shall be enrolled at the end of that period in the health benefit plan held at the time by the small employer.

(5) Notwithstanding any other provision of this Chapter, no small employer carrier, insurer, subsidiary of an insurer, or controlled individual of an insurance holding company shall act as an administrator or claims paying agent, as opposed to an insurer, on behalf of small groups which, if they purchased insurance, would be subject to this section. No small employer carrier, insurer, subsidiary of an insurer, or controlled individual of an insurance holding company shall provide stop loss, catastrophic, or reinsurance coverage to small employers that does not comply with the underwriting, rating, and other applicable standards in this Act.

(6) If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all eligible employees of a small employer and their dependents. A small employer carrier shall not offer coverage to only certain individuals in a small employer group except in the case of late enrollees as provided in G.S. 58-50-130(a)(4).

(7), (8) Repealed by Session Laws 1997-259, s. 5.

(9) The health benefit plan must meet the applicable requirements of Article 68 of this Chapter.

(b) For all small employer health benefit plans that are subject to this section, the premium rates are subject to all of the following provisions:

(1) Small employer carriers shall use an adjusted-community rating methodology in which the premium for each small employer can vary only on the basis of the eligible employee's or dependent's age as determined under subdivision (6) of this subsection, the gender of the eligible employee

or dependent, number of family members covered, or geographic area as determined under subdivision (7) of this subsection, or industry as determined under subdivision (9) of this subsection. Premium rates charged during a rating period to small employers with similar case characteristics for same coverage shall not vary from the adjusted community rate by more than twenty-five percent (25%) for any reason, including differences in administrative costs and claims experience.

(2) Rating factors related to age, gender, number of family members covered, geographic location, or industry may be developed by each carrier to reflect the carrier's experience. The factors used by carriers are subject to the Commissioner's review.

(3) A small employer carrier shall not modify the premium rate charged to a small employer or a small employer group member, including changes in rates related to the increasing age of a group member, for 12 months from the initial issue date or renewal date, unless the group is composite rated and composition of the group changed by twenty percent (20%) or more or benefits are changed. The percentage increase in the premium rate charged to a small employer for a new rating period shall not exceed the sum of all of the following:

a. The percentage change in the adjusted community rate as measured from the first day of the prior rating period to the first day of the new rating period.

b. Any adjustment, not to exceed fifteen percent (15%) annually, due to claim experience, health status, or duration of coverage of the employees or dependents of the small employer.

c. Any adjustment because of change in coverage or change in case characteristics of the small employer group.

(4), (5) Repealed by Session Laws 1995, c. 238, s. 1.

(6) Unless the small employer carrier uses composite rating, the small employer carrier shall use the following age brackets:

a. Younger than 15 years;
b. 15 to 19 years;
c. 20 to 24 years;
d. 25 to 29 years;
e. 30 to 34 years;
f. 35 to 39 years;
g. 40 to 44 years;
h. 45 to 49 years;
i. 50 to 54 years;
j. 55 to 59 years;
k. 60 to 64 years;
l. 65 years.

Carriers may combine, but shall not split, complete age brackets for the purposes of determining rates under this subsection. Small employer carriers shall be permitted to develop separate rates for individuals aged 65 years and older for coverage for which Medicare is the primary payor and coverage for which Medicare is not the primary payor.

(7) A carrier shall define geographic area to mean medical care system. Medical care system factors shall reflect the relative differences in expected costs, shall produce rates that are not excessive, inadequate, or unfairly discriminatory in the medical care system areas, and shall be revenue neutral to the small employer carrier.

(8) The Department may adopt rules to administer this subsection and to assure that rating practices used by small employer carriers are consistent with the purposes of this subsection. Those rules shall include consideration of differences based on all of the following:

a. Health benefit plans that use different provider network arrangements may be considered separate plans for the purposes of determining the rating in subdivision (1) of this subsection, provided that the different arrangements are expected to result in substantial differences in claims costs.

b. Except as provided for in sub-subdivision a. of this subdivision, differences in rates charged for different health benefit plans shall be reasonable and reflect objective differences in plan design, but shall not permit differences in premium rates because of the case characteristics of groups assumed to select particular health benefit plans.

c. Small employer carriers shall apply allowable rating factors consistently with respect to all small employers.

(9) In any case where the small employer carrier uses industry as a case characteristic in establishing premium rates, the rate factor associated with any industry classification divided by the lowest rate factor associated with any other industry classification shall not exceed 1.2.

(c) Repealed by Session Laws 1993, c. 529, s. 3.7.

(d) In connection with the offering for sale of any health benefit plan to a small employer, each small employer carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of the following and shall provide this information to the small employer upon request:

(1) Repealed by Session Laws 1993, c. 529, s. 3.7.

(2) Provisions concerning the small employer carrier's right to change premium rates and the factors other than claims experience that affect changes in premium rates.

(3) Provisions relating to renewability of policies and contracts.

(4) Provisions affecting any preexisting conditions provision.

(5) The benefits available and premiums charged under all health benefit plans for which the small employer is eligible.

(e) Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(f) Each small employer carrier shall file with the Commissioner annually on or before March 15 an actuarial certification certifying that it is in compliance with this Act and that its

rating methods are actuarially sound. The small employer carrier shall retain a copy of the certification at its principal place of business.

(g) A small employer carrier shall make the information and documentation described in subsection (e) of this section available to the Commissioner upon request. Except in cases of violations of this Act, the information is proprietary and trade secret information and is not subject to disclosure by the Commissioner to persons outside of the Department except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction. Nothing in this section affects the Commissioner's authority to approve rates before their use under G.S. 58-65-60(e) or G.S. 58-67-50(c).

(h) The provisions of subdivisions (a)(1), (3), and (5) and subsections (b) through (g) of this section apply to health benefit plans delivered, issued for delivery, renewed, or continued in this State or covering persons residing in this State on or after January 1, 1992. The provisions of subdivisions (a)(2) and (4) of this section apply to health benefit plans delivered, issued for delivery, renewed, or continued in this State or covering persons residing in this State on or after the date the plan becomes operational, as designated by the Commissioner. For purposes of this subsection, the date a health benefit plan is continued is the anniversary date of the issuance of the health benefit plan. (1991, c. 630, s. 1; 1993, c. 408, s. 6; c. 529, ss. 3.2, 3.7; 1993 (Reg. Sess., 1994), c. 569, ss. 7, 8; c. 678, ss. 24, 25; 1995, c. 238, s. 1; c. 507, s. 23A.1(b); 1995 (Reg. Sess., 1996), c. 669, s. 1; 1997-259, ss. 5, 6; 1998-211, ss. 9.1, 10; 1999-132, s. 4.1; 2001-334, ss. 3, 12.3; 2006-154, s. 7.)

§ 58-51-80. Group accident and health insurance defined.

(a) Any policy or contract of insurance against death or injury resulting from accident or from accidental means which covers more than one person except blanket accident policies as defined in G.S. 58-51-75, shall be deemed a group accident insurance policy. Any policy or contract which insures against disablement, disease or sickness of the insured (excluding disablement which results from accident or from accidental means) and which covers more than one person, except blanket health insurance policies as defined in G.S. 58-51-75, shall be deemed a group health insurance policy or contract. Any policy or contract of insurance which combines the coverage of group accident insurance and of group health insurance shall be deemed a group accident and health insurance policy. No policy or contract of group accident, group health or group accident and health insurance, and no certificates thereunder, shall be delivered or issued for delivery in this State unless it conforms to the requirements of subsection (b).

(b) No policy or contract of group accident, group health or group accident and health insurance shall be delivered or issued for delivery in this State unless the group of persons thereby insured conforms to the requirements of the following subdivisions:

(1) Under a policy issued to an employer, principal, or to the trustee of a fund established by an employer or two or more employers in the same industry or kind of business, or by a principal or two or more principals in the same industry or kind of business, which employer, principal, or trustee shall be deemed the policyholder, covering, except as hereinafter provided, only employees, or agents, of any class or classes thereof determined by conditions pertaining to employment, or agency, for amounts of insurance based upon some plan which will preclude individual selection. The premium may be paid by the employer, by the employer and the employees jointly, or by the employee; and where the relationship of principal and agent exists, the premium may be paid by the principal, by the principal and agents, jointly, or by the agents. If the premium is paid by the employer and the employees jointly, or by the principal and agents jointly, or by the employees, or by the agents, the group shall be structured on an actuarially sound basis.

(1a) Under a policy issued to an association or to a trust or to the trustee or trustees of a fund established, created, or maintained for the benefit of members of one or more associations. The association or associations shall have at the outset a minimum of 500 persons and shall have been organized and maintained in good faith for purposes other than that of obtaining insurance; shall have been in active existence for at least five years; and shall have a constitution and bylaws that provide that (i) the association or associations hold regular meetings not less than annually to further purposes of the members; (ii) except for credit unions, the association or associations collect dues or solicit contributions from members; and (iii) the members, other than associate members, have voting privileges and representation on the governing board and committees. The policy is subject to the following requirements:

a. The policy may insure members of the association or associations, employees of the association or associations, or employees of

members, or one or more of the preceding or all of any class or classes for the benefit of persons other than the employee's employer.

b. The premium for the policy shall be paid from funds contributed by the association or associations, or by employer members, or by both, or from funds contributed by the covered persons or from both the covered persons and the association, associations, or employer members. The premium rates for each association policy shall be developed, and applied to the certificates thereunder, on an actuarially sound basis.

c. Repealed by Session Laws 1997-259, s. 8.

(1b) Under a policy issued to a creditor as defined in G.S. 58-57-5 who shall be deemed the policyholder, to insure debtors as defined in G.S. 58-57-5 of the creditor to provide indemnity for payments becoming due on a specific loan or other credit transaction as defined in G.S. 58-51-100, with or without insurance against death by accident, subject to the following requirements:

a. The debtors eligible for insurance under the policy shall be all of the debtors of the creditor whose indebtedness is repayable in installments, or all of any class or classes thereof determined by conditions pertaining to the indebtedness or to the purchase giving rise to the indebtedness. The policy may provide that the term "debtors" shall include the debtors of one or more subsidiary corporations, and the debtors of one or more affiliated corporations, proprietors or partnerships if the business of the policyholder and of such affiliated corporations, proprietors or partnerships is under common control through stock ownership, contract or otherwise.

b. The premium for the policy shall be paid from the creditor's funds, from charges collected from the insured debtors, or from both. A policy on which part or all of the premium is to be derived from the collection from the insured debtors or identifiable charges not required of uninsured debtors shall not include, in the class or classes of debtors eligible for insurance, debtors under obligations outstanding at its date of issue without evidence of individual insurability unless the group is structured on an actuarially sound basis. A policy on which no part of the premium is to be derived from the collection of such identifiable charges must insure all eligible debtors, or all except any as to whom evidence of individual insurability is not satisfactory to the insurer.

c. The policy may be issued only if the group of eligible debtors is then receiving new entrants at the rate of at least 100 persons yearly, or may reasonably be expected to receive at least 100 new entrants during the first policy year, and only if the policy reserves to the insurer the right to require evidence of individual insurability if less than seventy-five percent (75%) of the new entrants become insured.

d. Premiums for this coverage shall be actuarially equivalent to the rates authorized under Article 57 of Chapter 58 of the General Statutes for credit accident and health insurance.

(2), (3) Repealed by Session Laws 1997-259, s. 8.

(c) The term "employees" as used in this section shall be deemed to include, for the purposes of insurance hereunder, employees of a single employer, the officers, managers, and employees of the employer and of subsidiary or affiliated corporations of a corporation employer, and the individual proprietors, partners, and employees of individuals and firms of which the business is controlled by the insured employer through stock ownership, contract or otherwise. With the exception of disability income insurance, employees shall be added to the group coverage no later than 90 days after their first day of employment. Employment shall be considered continuous and not be considered broken except for unexcused absences from work for reasons other than illness or injury. The term "employee" is defined as a nonseasonal person who works on a full-time basis, with a normal work week of 30 or more hours and who is otherwise eligible for coverage, but does not include a person who works on a part-time, temporary, or substitute basis. The term "employer" as used herein may be deemed to include the State of North Carolina, any county, municipality or corporation, or the proper officers, as such, of any unincorporated municipality or any department or subdivision of the State, county, such corporation, or municipality determined by conditions pertaining to the employment. When determining employee eligibility for a large employer, as defined in G.S. 58-68-25(10), an individual proprietor, owner, or operator shall be defined as an "employee" for the purpose of obtaining coverage under the employee group health plan and shall not be held to a minimum workweek requirement as imposed on other eligible employees.

(d) The term "agents" as used in this section shall be deemed to include, for the purposes of insurance hereunder, agents of a single principal who are under contract to devote all, or substantially all, of their time in rendering personal services for such principal, for a commission or other fixed or ascertainable compensation.

(e) The benefits payable under any policy or contract of group accident, group health and group accident and health insurance shall be payable to the employees, or agents, or to some beneficiary or beneficiaries designated by the employee or agent, other than the employer or principal, but if there is no designated beneficiary as to all or any part of the insurance at the death of the employee or agent, then the amount of insurance payable for which there is no designated beneficiary shall be payable to the estate of the employee or agent, except that the insurer may in such case, at its option, pay such insurance to any one or more of the following surviving relatives of the employee or agent: wife, husband, mother, father, child, or children, brothers or sisters; and except that payment of benefits for expenses incurred on account of hospitalization or medical or surgical aid, as provided in subsection (f), may be made by the insurer to the hospital or other person or persons furnishing such aid. Payment so made shall discharge the insurer's obligation with respect to the amount of insurance so paid.

(f) Any policy or contract of group accident, group health or group accident and health insurance may include provisions for the payment by the insurer of benefits to the employee or agent of the insured group, on account of hospitalization or medical or surgical aid for himself, his spouse, his child or children, or other persons chiefly dependent upon him for support and maintenance.

(g) Any policy or contract of group accident, group health or group accident and health insurance may provide for readjustment of the rate of premium based on the experience thereunder at the end of the first year, or at any time during any subsequent year based upon at least 12 months of experience: Provided that any such readjustment after the first year shall not be made any more frequently than once every six months. Any rate adjustment must be preceded by a 45-day notice to the contract holder before the effective date of any rate increase or any policy benefit revision. A notice of nonrenewal shall be given to the contract holder 45

days prior to termination. Any refund under any plan for readjustment of the rate of premium based on the experience under group policies and any dividend paid under the policies may be used to reduce the employer's or principal's contribution to group insurance for the employees of the employer, or the agents of the principal, and the excess over the contribution by the employer, or principal, shall be applied by the employer, or principal, for the sole benefit of the employees or agents.

(h) Nothing contained in this section applies to any contract issued by any corporation defined in Article 65 of this Chapter. (1945, c. 385; 1947, c. 721; 1951, c. 282; 1953, c. 1095, ss. 6, 7; 1987, c. 752, s. 19; 1989, c. 485, s. 41; c. 775, ss. 1, 2; 1991, c. 644, s. 11; c. 720, s. 88; 1991 (Reg. Sess., 1992), c. 837, s. 4; 1993, c. 408, ss. 3, 3.1; c. 409, s. 14; 1995, c. 507, ss. 23A.1(c), 23A.1(d); 1997-259, ss. 8, 9; 2000-132, s. 1; 2003-221, s. 12; 2005-223, ss. 1(a), 2(c).)

§ 58-51-85. Group or blanket accident and health insurance; approval of forms and filing of rates.

No policy of group or blanket accident, health or accident and health insurance shall be delivered or issued for delivery in this State unless the form of the policy contracts including the master policy contract, the individual certificates thereunder, the applications for the contract, and a schedule of the premium rates pertaining to such form or forms, have been filed with and the forms approved by the Commissioner. (1945, c. 385; 1991, c. 720, s. 34.)

§ 58-51-95. Approval by Commissioner of forms, classification and rates; hearing; exceptions.

(a) No policy of insurance against loss or expense from the sickness, or from the bodily injury or death by accident of the insured shall be issued or delivered to any person in this State nor shall any application, rider or endorsement be used in connection therewith until a copy of the form thereof and of the classification of risks and the premium rates, or, in the case of cooperatives or assessment companies the estimated cost pertaining thereto, have been filed with the Commissioner.

(b) No such policy shall be issued, nor shall any application, rider or endorsement be used in connection therewith, until the expiration of 90 days after it has been so filed unless the Commissioner shall sooner give his written approval thereto.

(c) The Commissioner may within 90 days after the filing of any such form, disapprove such form

(1) If the benefits provided therein are unreasonable in relation to the premium charged, or

(2) If it contains a provision or provisions which are unjust, unfair, inequitable, misleading, deceptive or encourage misrepresentation of such policy.

(d) If the Commissioner shall notify the insurer which has filed any such form that it does not comply with the provisions of this section or sections, it shall be unlawful thereafter for such insurer to issue such form or use it in connection with any policy. In such notice the Commissioner shall specify the reasons for his disapproval and state that a hearing will be granted within 20 days after request in writing by the insurer.

(e) The Commissioner may at any time, after a hearing of which not less than 20 days' written notice shall have been given to the insurer, withdraw his approval of any such form on any of the grounds stated in this section. It shall be unlawful for the insurer to issue such form or use it in connection with any policy after the effective date of such withdrawal of approval. The notice of any hearing called under this paragraph shall specify the matters to be considered at such hearing and any decision affirming disapproval or directing withdrawal of approval under this section shall be in writing and shall specify the reasons therefor: Provided, that the provisions of this section shall not apply to workers' compensation insurance, accidental death or disability benefits issued supplementary to life insurance or annuity contracts, medical expense benefits under liability policies or to group accident and health insurance.

(f) An insurer may revise rates chargeable on policies subject to this section, other than noncancellable policies, with the approval of the Commissioner if the Commissioner finds that the revised rates are not excessive, not inadequate, and not unfairly discriminatory; and exhibit a reasonable relationship to the benefits provided by the policies. The approved rates shall be guaranteed by the insurer, as to the policyholders affected by the rates, for a period of not less than 12 months; or as an alternative to the insurer giving the guarantee, the approved rates may be applicable to all policyholders at one time if the insurer chooses to apply for that relief with respect to those policies no more frequently than once in any 12-month period. The rates shall be applicable to all policies of the same type; provided that no rate revision may become effective for any policy unless the insurer has given the policyholder written notice of the rate revision 45 days before the effective date of the revision. The policyholder must then pay the revised rate in order to continue the policy in force. The Commissioner may adopt reasonable rules, after notice and hearing, to require the submission of supporting data and such information as the Commissioner considers necessary to determine whether the rate revisions meet these standards. In adopting the rules under this subsection, the Commissioner may

require identification of the types of rating methodologies used by filers and may also address issue age or attained age rating, or both; policy reserves used in rating; and other recognized actuarial principles of the NAIC, the American Academy of Actuaries, and the Society of Actuaries.

(g) For policies subject to this section, an individual health insurer shall not increase an individual's renewal premium for continued health insurance coverage under the terms of the individual's health insurance policy based on any health status-related factors in relation to the individual or a dependent of the individual, including:

(1) Health status.
(2) Medical condition (including physical and mental illnesses).
(3) Claims experience.
(4) Duration from issue.
(5) Receipt of health care.
(6) Medical history.
(7) Genetic information.

(h) Every policy that is subject to this section and that provides individual accident and health insurance benefits to a resident of this State shall return to policyholders benefits that are reasonable in relation to the premium charged. The Commissioner may adopt rules or utilize existing rules to establish minimum standards for loss ratios of policies on the basis of incurred claims experience and earned premiums in accordance with accepted actuarial principles and practices to assure that the benefits are reasonable in relation to the premium charged. Every insurer providing policies in this State subject to this section shall not less than annually file for approval its rates, rating schedules, and supporting documentation to demonstrate compliance with the applicable loss ratio standards of this State as adopted by the Commissioner. All filings of rates and rating schedules shall comply with the standards adopted by the Commissioner. The filing shall include a certification by an individual who is either a Fellow or an Associate of the Society of Actuaries or a Member of the American Academy of Actuaries that the rates are not excessive, not inadequate, and not unfairly discriminatory; and that the rates exhibit a reasonable relationship to the benefits provided by the policy. Nothing in this subsection shall require an insurer to provide certification with respect to a previous rate period, or to require an insurer to reduce properly filed and approved rates before the end of a rate period. This subsection does not apply to any long-term care policy issued in this State on or after February 1, 2003, and noncancellable accident and health insurance.

(i) For any long-term care policy issued in this State on or after February 1, 2003, an insurer shall on or before March 15 of each year:

(1) Provide to the Commissioner an actuarial certification listing all of its long-term care policy forms available for sale in this State as of December 31 of the prior year, stating that the current premium rate schedule for each form is sufficient to cover anticipated costs under moderately adverse experience and stating that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated.
(2) For any policy form for which the statement in subdivision (1) of this subsection cannot be made or is qualified, submit a plan of corrective action to the Commissioner for approval.

(j) For purposes of this section, accident and health insurance means insurance against death or injury resulting from accident or from accidental means and insurance against

disablement, disease, or sickness of the insured. This includes Medicare supplemental insurance, long-term care, nursing home, or home health care insurance, or any combination thereof, specified disease or illness insurance, hospital indemnity or other fixed indemnity insurance, short-term limited duration health insurance, dental insurance, vision insurance, and medical, hospital, or surgical expense insurance or any combination thereof. Notwithstanding any other provision to the contrary, subsection (h) of this section does not apply to disability income insurance. (1951, c. 784; 1979, c. 755, s. 15; 1989, c. 485, s. 56; 1991, c. 636, s. 3; c. 720, s. 4; 2001-334, s. 17.3; 2005-223, s. 1(b); 2005-412, ss. 1(a), 1(b).)

§ 58-65-40. Supervision of Commissioner of Insurance; form of contract with subscribers; schedule of rates.

No hospital service corporation shall enter into any contract with subscribers unless and until it shall have filed with the Commissioner of Insurance a specimen copy of the contract or certificate and of all applications, riders, and endorsements for use in connection with the issuance or renewal thereof to be formally approved by him as conforming to the section of this Article entitled "Subscribers' contracts," and conforms to all rules and regulations promulgated by the Commissioner of Insurance under the provisions of this Article and Article 66 of this Chapter. The Commissioner of Insurance shall, within a reasonable time after the filing of any such form, notify the corporation filing the same either of his approval or of his disapproval of such form.

No corporation subject to the provisions of this Article and Article 66 of this Chapter shall enter into any contract with a subscriber after the enactment hereof unless and until it shall have filed with the Commissioner of Insurance a full schedule of rates to be paid by the subscribers to such contracts and shall have obtained the Commissioner's approval thereof. The Commissioner may refuse approval if he finds that such rates are excessive, inadequate, or unfairly discriminatory; or do not exhibit a reasonable relationship to the benefits provided by such contracts. At all times such rates and form of subscribers' contracts shall be subject to modification and approval of the Commissioner of Insurance under rules and regulations adopted by the Commissioner, in conformity to this Article and Article 66 of this Chapter. (1941, c. 338, s. 4; 1989, c. 485, s. 57.)

§ 58-65-45. Public hearings on revision of existing schedule or establishment of new schedule; publication of notice.

Whenever any hospital service corporation licensed under this Article and Article 66 of this Chapter makes a rate filing or any proposal to revise an existing rate schedule or contract form, the effect of which is to increase or decrease the charge for its contracts, or to set up a new rate schedule, and such rate schedule is subject to the approval of the Commissioner, such hospital service corporation shall file its proposed rate change or contract form and supporting data with the commissioner, who shall review the filing in accordance with the standards in G.S. 58-65-40. Such rate revision or new rate schedule with respect to individual subscriber contracts shall be guaranteed by the insurer, as to the contract and certificate holders thereby affected, for a period of not less than 12 months; or with respect to individual subscriber contracts as an alternative to giving such guarantee, such rate revision or new rate schedule may be made applicable to all individual contracts at one time if the corporation chooses to apply for such relief with respect to such contracts no more frequently than once in any 12-month period. Such rate revision or new rate schedule shall be applicable to all contracts of the same type; provided that no rate revision or new rate schedule may become effective for any contract holder unless the corporation has given written notice of the rate revision or new rate schedule not less than 30 days prior to the effective date of such revision or new rate schedule. The contract holder thereafter must pay the revised rate or new rate schedule in order to continue the contract in force. The Commissioner may promulgate reasonable rules, after notice and hearing, to require the submission of supporting data and such information as is deemed necessary to determine whether such rate revisions meet these standards. At any time within 60 days after the date of any filing under this section or G.S. 58-65-40, the Commissioner may give written notice to the corporation of a fixed time and place for a hearing on the filing, which time shall be no less than 20 days after notice is given. In the event no notice of hearing is issued within 60 days from the date of any filing, the filing shall be deemed to be approved, subject to modification by the Commissioner as authorized by G.S. 58-65-40. In the event the Commissioner gives notice of a hearing, the corporation making the filing shall, not less than 10 days before the time of the hearing, cause to be published in a daily newspaper or newspapers published in North Carolina, and in accordance with the rules and regulations of the Commissioner of Insurance, a notice, in the form and content approved by the Commissioner, setting forth the nature and effect of such proposal and the time and place of the public hearing to be held. If the Commissioner does not issue an order within 45 days after the day on which the hearing began, the filing shall be deemed to be approved, subject to modification by the Commissioner as authorized by G.S. 58-65-40. (1953, c. 1118; 1985, c. 666, s. 60; 1989, c. 485, s. 58.)

§ 58-65-60. Subscribers' contracts; required and prohibited provisions.

(a) Every contract made by a corporation subject to the provisions of this Article and Article 66 of this Chapter shall be for a period not to exceed 12 months, and no contract shall be made providing for the inception of benefits at a date later than one year from the date of the contract. Any such contract may provide that it shall be automatically renewed for a similar period unless there shall have been one month's prior written notice of termination by either the subscriber or the corporation.

(b) Contracts may be issued that entitle one or more persons to benefits under those contracts. Persons entitled to benefits under those contracts, other than the certificate holder, may only be the certificate holder's spouse, lawful or legally adopted child of the certificate holder or the certificate holder's spouse, or any other person who resides in the same household with the certificate holder and is dependent upon the certificate holder.

(c) Every contract entered into by any such corporation with any subscriber thereof shall be in writing and a certificate stating the terms and conditions thereof shall be furnished to the subscriber to be kept by him. No such certificate form, other than to group subscribers of groups of 10 or more certificate holders or those issued pursuant to a master group contract covering 10 or more certificate holders shall be made, issued or delivered in this State unless it contains the following provisions, provided, however, groups between five and 10 certificate holders complying with and maintaining eligibility status under regulations approved by the Commissioner of Insurance for group enrollment may be cancelled if such participation falls below the minimum participation of five certificate holders; or if the group takes other group hospital, medical or surgical coverage:

(1) A statement of the amount payable to the corporation by the subscriber and the times at which and manner in which such amount is to be paid; this provision may be inserted in the application rather than in the certificate. Application need not be attached to certificate.

(2) A statement of the nature of the benefits to be furnished and the period during which they will be furnished.

(3) A statement of the terms and conditions, if any, upon which the contract may be cancelled or otherwise terminated at the option of either party. The statement shall be in the following language:

a. "Renewability": Any contract subject to the provisions of this subdivision is renewable at the option of the subscriber unless sufficient notice in writing of nonrenewal is mailed to the subscriber by the corporation addressed to the last address recorded with the corporation.

b. "Sufficient notice" shall be as follows:

1. During the first year of any such contract, or during the first year following any lapse and reinstatement, or reenrollment, a period of 30 days.

2. During the second and subsequent years of continuous coverage, a number of full calendar months most nearly equivalent to one fourth the number of months of continuous coverage from the first anniversary of the date of issue or reinstatement or reenrollment, whichever date is more recent, to the date of mailing of such notice.

3. No period of required notice shall exceed two years, and no renewal hereunder shall renew any such contract for any period beyond the required period of notice except by written agreement of the subscriber and corporation.

The contract may be modified, terminated or cancelled by the corporation at any time at its option, upon:

a. Nonpayment by the subscriber of fees or dues as required.

b. Failure or refusal by the subscriber to comply with rate or benefit changes approved by the Commissioner under G.S. 58-65-45.

c. Failure or refusal by the subscriber after 30 days' written notice to subscriber to transfer into hospital, medical, or dental service plan serving the area to which the subscriber has changed residence and is eligible for or to which corporation is required to transfer by interplan agreement of transfer.

(4) A statement that the contract includes the endorsement thereon and attached papers, if any, and together with the applications contains the entire contract.

(5) A statement that if the subscriber defaults in making any payment, under the contract, the subsequent acceptance of a payment by the corporation at its home office shall reinstate the contract, but with respect to sickness and injury, only to cover such sickness as may be first manifested more than 10 days after the date of such acceptance.

(d) In every such contract made, issued or delivered in this State:

(1) All printed portions shall be plainly printed;

(2) The exceptions from the contract shall appear with the same prominence as the benefits to which they apply; and

(3) If the contract contains any provision purporting to make any portion of the articles, constitution or bylaws of the corporation a part of the contract, such portion shall be set forth in full.

(e) A service corporation may issue a master group contract with the approval of the Commissioner if the contract and the individual certificates issued to members of the group comply in substance to the other provisions of this Article and Article 66 of this Chapter. The contract may provide for the adjustment of the rate of the premium or benefits conferred as provided in the contract, and in accordance with an adjustment schedule filed with and approved by the Commissioner. If the contract is issued, altered or modified, the subscribers' contracts issued under that contract are altered or modified accordingly, all laws and clauses in subscribers' contracts to the contrary notwithstanding. Nothing in this Article and Article 66 of this Chapter shall be construed to prohibit or prevent the same. Forms of such contract shall at all times be furnished upon request of subscribers thereto.

(e1) Employees shall be added to the master group coverage no later than 90 days after their first day of employment. Employment shall be considered continuous and not be considered broken except for unexcused absences from work for reasons other than illness or injury. The term "employee" is defined as a nonseasonal person who works on a full-time basis, with a normal work week of 30 or more hours and who is otherwise eligible for coverage, but does not include a person who works on a part-time, temporary, or substitute basis.

(e2) Whenever an employer master group contract replaces another group contract, whether this contract was issued by a corporation under Articles 1 through 67 of this Chapter, the liability of the succeeding corporation for insuring persons covered under the previous

group contract is (i) each person is eligible for coverage in accordance with the succeeding corporation's plan of benefits with respect to classes eligible and activity at work and nonconfinement rules must be covered by the succeeding corporation's plan of benefits; and (ii) each person not covered under the succeeding corporation's plan of benefits in accordance with (i) above must nevertheless be covered by the succeeding corporation if that person was validly covered, including benefit extension, under the prior plan on the date of discontinuance and if the person is a member of the class of persons eligible for coverage under the succeeding corporation's plan.

(e3) When determining employee eligibility for a large employer, as defined in G.S. 58-68-25(10), an individual proprietor, owner, or operator shall be defined as an "employee" for the purpose of obtaining coverage under the employee group health plan and shall not be held to a minimum workweek requirement as imposed on other eligible employees.

(f) Any hospitalization contract renewed in the name of the subscriber during the grace period shall be construed to be a continuation of the contract first issued. (1941, c. 338, s. 7; 1947, c. 820, ss. 3, 4; 1955, c. 679, ss. 1-3; 1957, c. 1085, s. 1; 1961, c. 1149; 1989, c. 775, s. 4; 1991, c. 720, ss. 38, 88; 1991 (Reg. Sess., 1992), c. 837, s. 4; 1993, c. 408, s. 4; c. 409, s. 24; 1995, c. 507, s. 23A.1(e); 1997-259, s. 17; 2001-417, s. 12; 2005-223, s. 2(a).)

§ 58-67-50. Evidence of coverage and premiums for health care services.

(a) (1) Every enrollee residing in this State is entitled to evidence of coverage under a health care plan. If the enrollee obtains coverage under a health care plan through an insurance policy or a contract issued by a hospital or medical service corporation, whether by option or otherwise, the insurer or the hospital or medical service corporation shall issue the evidence of coverage. Otherwise, the health maintenance organization shall issue the evidence of coverage.

(2) No evidence of coverage, or amendment thereto, shall be issued or delivered to any person in this State until a copy of the form of the evidence of coverage, or amendment thereto, has been filed with and approved by the Commissioner.

(3) An evidence of coverage shall contain:

a. No provisions or statements which are unjust, unfair, inequitable, misleading, deceptive, which encourage misrepresentation, or which are untrue, misleading or deceptive as defined in G.S. 58-67-65(a); and

b. A clear and complete statement, if a contract, or a reasonably complete summary, if a certificate of:

1. The health care services and insurance or other benefits, if any, to which the enrollee is entitled under the health care plan;
2. Any limitations on the services, benefits, or kind of benefits, to be provided, including any deductible or copayment feature;
3. Where and in what manner information is available as to how services may be obtained;
4. The total amount of payment for health care services and the indemnity or service benefits, if any, which the enrollee is obligated to pay with respect to individual contracts, or an indication whether the plan is contributory or noncontributory with respect to group certificates;
5. A clear and understandable description of the health maintenance organization's method of resolving enrollee complaints;
6. A description of the reasons, if any, for which an enrollee's enrollment may be terminated for cause, which reasons may include behavior that seriously impairs the health maintenance organization's ability to provide services or an inability to establish and maintain a satisfactory physician-patient relationship after reasonable efforts to do so have been made.

Any subsequent change may be evidenced in a separate document issued to the enrollee.

(4) A copy of the form of the evidence of coverage to be used in this State, and any amendment thereto, shall be subject to the filing and approval requirements of subsection (b) unless it is subject to the jurisdiction of the Commissioner under the laws governing health insurance or hospital or medical service corporations in which event the filing and approval

provisions of such laws shall apply. To the extent, however, that such provisions do not apply the requirements in subsection (c) shall be applicable.

(b) (1) Premium approval. – No schedule of premiums for coverage for health care services, or any amendment to the schedule, shall be used in conjunction with any health care plan until a copy of the schedule or amendment has been filed with and approved by the Commissioner.

(2) Individual coverage. – Premiums shall be established in accordance with actuarial principles for various categories of enrollees. Premiums applicable to an enrollee shall not be individually determined based on the status of the enrollee's health. Premiums shall not be excessive, inadequate or unfairly discriminatory; and shall exhibit a reasonable relationship to the benefits provided by the evidence of coverage. The premiums or any premium revisions for nongroup enrollee coverage shall be guaranteed, as to every enrollee covered under the same category of enrollee coverage, for a period of not less than 12 months. As an alternative to giving this guarantee for nongroup enrollee coverage, the premium or premium revisions may be made applicable to all similar categories of enrollee coverage at one time if the health maintenance organization chooses to apply for the premium revision with respect to the categories of coverages no more frequently than once in any 12-month period. The premium revision shall be applicable to all categories of nongroup enrollee coverage of the same type; provided that no premium revision may become effective for any category of enrollee coverage unless the HMO has given written notice of the premium revision to the enrollee 45 days before the effective date of the revision. The enrollee must then pay the revised premium in order to continue the contract in force. The Commissioner may adopt reasonable rules, after notice and hearing, to require the submittal of supporting data and such information as the Commissioner considers necessary to determine whether the rate revisions meet the standards in this subdivision. In adopting the rules under this subsection, the Commissioner may require identification of the types of rating methodologies used by filers and may also address standards for data in HMO rate filings for initial filings, filings by recently licensed HMOs, and rate revision filings; data requirements for service area expansion requests; policy reserves used in rating; incurred loss ratio standards; and other recognized actuarial principles of the NAIC, the American Academy of Actuaries, and the Society of Actuaries.

(3) Group coverage. – Employer group premiums shall be established in accordance with actuarial principles for various categories of enrollees, provided that premiums applicable to an enrollee shall not be individually determined based on the status of the enrollee's health. Premiums shall not be excessive, inadequate, or unfairly discriminatory, and shall exhibit a reasonable relationship to the benefits provided by the evidence of coverage. The premiums or any revisions to the premiums for employer group coverage shall be guaranteed for a period of not less than 12 months. No premium revision shall become effective for any category of group coverage unless the HMO has given written notice of the premium revision to the master group contract holder upon receipt of the group's finalized benefits or 45 days before the effective date of the revision, whichever is earlier. The

master group contract holder thereafter must pay the revised premium in order to continue the contract in force. The Commissioner may adopt reasonable rules, after notice and hearing, to require the submittal of supporting data and such information as the Commissioner considers necessary to determine whether the rate revisions meet the standards in this subdivision.

(c) The Commissioner shall, within a reasonable period, approve any form if the requirements of subsection (a) of this section are met and any schedule of premiums if the requirements of subsection (b) of this section are met. It shall be unlawful to issue the form or to use the schedule of premiums until approved. If the Commissioner disapproves the filing, the Commissioner shall notify the filer. In the notice, the Commissioner shall specify the reasons for disapproval. A hearing will be granted within 30 days after a request in writing by the person filing. If the Commissioner does not approve or disapprove any form or schedule of premiums within 90 days after the filing for forms and within 45 days after the filing for premiums, they shall be deemed to be approved.

(d) The Commissioner may require the submission of whatever relevant information he deems necessary in determining whether to approve or disapprove a filing made pursuant to this section.

(e) Every health maintenance organization shall provide at least minimum cost and utilization information for group contracts of 100 or more subscribers on an annual basis when requested by the group. Such information shall be compiled in accordance with the Data Collection Form developed by the Standardized HMO Date Form Task Force as endorsed by the Washington Business Group on Health and the Group Health Association of America on November 19, 1986, and any subsequent amendments. (1977, c. 580, s. 1; 1979, c. 876, s. 1; 1987, c. 631, s. 9; 1989, c. 485, s. 59; 1991, c. 195, s. 1; c. 644, s. 13; c. 720, s. 36; 1995, c. 193, s. 59; 1997-474, s. 3; 1997-519, s. 1.3; 2001-334, ss. 8.1, 17.4; 2001-487, ss. 106(a), 106(b); 2008-124, s. 5.3; 2009-173, s. 1.)

11 NCAC 12 .0321 RATE FILING: HMO

(a) All schedules of premiums for enrollee coverage for health care services, or amendment thereto, shall be filed in duplicate in accordance with 11 NCAC 12 .0307(b)(5), indicating whether the schedule is original or amended.

(b) All filings shall be accompanied by:

(1) A certification by the chief executive officer of the corporation that the premiums applicable to an enrollee are not individually determined based on the status of his health;

(2) A certification by an actuarial expert that such premiums are established in accordance with actuarial principles for various categories of enrollees and are not excessive, inadequate, or unfairly discriminatory;

(3) Actuarial data supporting the schedule of premiums;

(4) Such other data deemed necessary by the commissioner to determine whether to approve or disapprove the filing;

(c) Actuarial data and rates required by this Rule shall be filed in triplicate.

History Note: *Authority G.S. 58-67-50; 58-67-150;*
Eff. January 22, 1980;
Amended Eff. February 1, 1992.

11 NCAC 12 .0329 SUBMISSION REQUIREMENTS: FORM AND RATE FILINGS

Any insurer, as defined by G.S. 58-1-5(3), that files with the Commissioner for review or approval product forms of life, annuity, accident and health, multiple employer welfare arrangements or managed care provider contract forms and supporting documents, or premium rates, shall comply with the following:

(1) Include a cover letter, or the NAIC Adopted Uniform Transmittal Document in lieu thereof, that:
  (a) Includes the name and address of the submitting company.
  (b) States the company issuing the form.
  (c) Includes the toll-free telephone number and valid electronic e-mail address of the filer.
  (d) Provides a unique identifying form number of each form submitted and its descriptive title.
  (e) Indicates whether the form is new or a form revision.
  (f) Identifies, for any revised forms, the form being replaced by its form number, assigned tracking number, and approval date.

(2) Submitted either via:
  (a) Paper.
  (b) Electronic E-Mail compressed in Adobe Acrobat.
  (c) The National Association of Insurance Commissioners system for electronic rate and form filings (SERFF).

(3) Using the following forms and formats:
  (a) Variable text or benefit ranges shall be in brackets.
  (b) If applications, riders, endorsements or certificates are filed separately, the filer shall indicate policy forms with which they are used.
  (c) Rates by age and mode of payment, including a signed actuarial memorandum, shall be attached to each form requiring a premium.
  (d) Forms shall include a unique form number located in the lower left-hand corner of the first page.
  (e) Filing shall be comprised of one clean copy of the entire submission.
  (f) Electronic submissions shall be formatted in Portable Document Format Adobe Acrobat.
  (g) Red-line side by side comparisons shall be provided with initial submissions that are revising previously-approved forms. An officer of the company shall provide a statement certifying that no changes, other than those red-lined, were made to the form(s).
  (h) Red-line side by side comparisons shall be provided with each resubmission of forms revised during the review process as requested by the Commissioner.

(4) Rates:
  (a) Individual or non-group accident and health products subject to Chapter 58 of the General Statutes shall demonstrate and describe the development of the requested premium. All 30 of the State's "Additional Data Requirements" as required in 11 NCAC 16 .0205 shall be addressed.
  (b) Credit involuntary unemployment insurance, credit life, credit accident and health, and credit property products subject to Article 57 of Chapter 58 of the General Statutes shall demonstrate and describe the development of the requested premium. All applicable data elements as required in 11 NCAC 16. 0400 or 16 .0500 shall be addressed;
  (c) Health maintenance organizations subject to Article 67 of Chapter 58 of the General Statutes shall demonstrate and describe the development of the requested premium. All data elements as required in 11 NCAC 16 .0400 and 16 .0600 shall be addressed;
  (d) Service Corporations subject to Article 65 of Chapter 58 of the General Statutes shall demonstrate and describe the development of the requested premium adjustment in accordance with sound actuarial principles and standards.

(5) No form or rate shall be deemed approved by statute unless the filer provides the Commissioner with written notice.

(6) Submissions that have been disapproved and are not brought into compliance within 60 days of initial receipt shall be closed. File closure shall not prevent revised subsequent submissions but such will be treated as a new filing.

(7) The Commissioner may reject and disapprove incomplete submissions.

History Note: *Authority G.S. 58-2-40; 58-51-1; 58-51-95; 58-54-20; 58-54-35; 58-55-30; 58-55-31; 58-57-30; 58-58-1; 58-65-1; 58-65-40; 58-67-50; 58-67-150;*
Eff. July 1, 2006.

SECTION .0200 - INDIVIDUAL ACCIDENT AND HEALTH INSURANCE

11 NCAC 16 .0201 MINIMUM LOSS RATIO STANDARDS

(a) For individual accident and health insurance policies and riders delivered in this State, the standard minimum guideline loss ratio for conditionally renewable, guaranteed renewable, and noncancelable medical expense, loss of income, and other type coverages (but not including long-term care insurance policies issued in this State on or after February 1, 2003) shall be as promulgated by the National Association of Insurance Commissioners for such coverages as of the issue date of such policies and riders.

(b) If a company fails to satisfy NAIC minimum future or lifetime loss ratio standards for a particular type of coverage, then to comply with the loss ratio standards in Paragraph (a) of this Rule, the company shall:

(1) Combine the experience of such policy form(s) with other forms with similar type of coverage for which the pooling of experience is actuarially justified;

(2) Provide premium credits or refunds;

(3) Decrease premium rates for one or more subsequent rating periods; or

(4) Implement an actuarially justified alternative proposal.

History Note: *Authority G.S. 58-2-40; 58-3-275; 58-51-95; 58-63-15(7)b;*
Eff. March 1, 1992;
Amended Eff. July 1, 2006.

11 NCAC 16 .0205 DATA REQUIREMENTS FOR RATE REVISION SUBMISSION

(a) With respect to any individual accident and health insurance policy governed by Articles 1 through 64 of Chapter 58 for which an adjustment of premium rate is allowed by law, the insurer shall submit an actuarial memorandum describing and demonstrating the development of any requested premium rate revision. The actuarial memorandum shall contain a subsection identified as "Additional Data Requirements." The initial rate revision filing shall be submitted to and stamped received by the Department's Life and Health Division. An insurer shall submit all data required by this Rule within 45 days after the date that the initial rate revision filing is stamped received. Subsequent data submissions on incomplete initial rate revision filings shall be made directly to the Department's Actuarial Services Division within the 45 day period. The following data is required in the "Additional Data Requirements" subsection:

(1) Identification of the submitted data as North Carolina or countrywide and consistent use of this data identification throughout this Section.

(2) Identification of all previously approved policy forms included in the rate revision submission, by North Carolina policy form number.

(3) The month, year, and percentage amount of all previous rate revisions.

(4) The month and year that the rate revision is scheduled to be implemented (hereinafter referred to as the "implementation date").

(5) The type of renewability provision contained in each policy form; e.g., guaranteed renewable.

(6) The type of coverage provided by each policy form; e.g., medical expense.

(7) Identification of the type of rating methodology; e.g., issue age, attained age, community rate or other.

(8) The National Association of Insurance Commissioners minimum guideline loss ratio and, if different, the insurer's minimum guideline loss ratio.

(9) The average annual premium for North Carolina and countrywide before and after the implementation of the rate revision.

(10) The number of North Carolina and countrywide policyholders affected by the rate revision.

(11) The requested rate revision percentage attributable to experience.

(12) The requested rate revision percentage attributable to changes in benefits promulgated by Medicare, if applicable, and the calculation used to develop this percentage.

(13) Identification and actuarial justification of all groupings of policy forms.

(14) The historical calendar year earned premium subdivided by duration and expressed on an actual and a current premium rate basis for the period of time from the earliest date that experience is recorded to the most recent date experience is recorded.

(15) The "expected" incurred loss ratios by duration based upon original pricing assumptions for all policy durations considered in the original pricing.

(16) The "expected" lapse rates by duration based upon original pricing assumptions for all policy durations considered in the original pricing, including assumptions for voluntary lapse rates and mortality rates.

(17) The "actual" lapse rates for duration one through the duration coinciding with the calendar year for which the most recent experience is recorded.

(18) The historical calendar year incurred claims, for other than Medicare supplement insurance, covering the period of time from the earliest date that experience is recorded to the most recent date experience is recorded.

(19) The historical calendar year incurred claims, for Medicare supplement insurance, expressed on an actual and a current benefit level basis covering the period of time from the earliest date experience is recorded to the most recent date experience is recorded.

(20) A count of the number of incurred claims for each calendar year of data provided; which means the total number of claims reported during the calendar year (whether paid or in the process of payment), plus the number of incurred but not reported claims at the end of the calendar year, minus the number of incurred but not reported claims at the beginning of the calendar year. For disability income insurance, only the initial claim payment for each period of disablement shall be counted. For each type of medical expense benefit, only the initial claim payment per cause shall be counted; for example, payments for continuation of a claim, such as refills on a prescription drug, are to be excluded from the incurred claim count.

(21) An estimation of the amount of policy year exposure contributed by all policyholders within each calendar year of data provided.

(22) A statement declaring whether this is an open block of business or a closed block of business.

(23) An estimation of the annual earned premium on new issues stated at the current premium rate basis for the period of time from the date that the most recent experience is last recorded to a date not exceeding the fifth year following the implementation date.

(24) The number of months that the rate will be guaranteed to an individual policyholder.

(25) The rate revision implementation method, such as the next premium due date following a given date, the next policy anniversary date, or otherwise; if otherwise, an explanation must be included.

(26) A statement declaring the month and year of the earliest anticipated date of the next rate revision.

(27) An explanation and actuarial justification of the apportionment of the aggregate rate revision within each policy form or between policy forms that have been grouped; and a demonstration that the apportionment of the aggregate rate revision yields the same premium income as if the rate revision had been applied uniformly.

(28) An explanation and actuarial justification, if applicable, for changing any factor that affects the premium.

(29) An explanation of the effect that the rate revision will have on the incurred loss ratio on those policies in force for three years or more as exhibited in the Medicare Supplement Experience Exhibit of the Annual Statement.

(30) The name, address, and telephone number of an insurance company representative who will be available to answer questions relating to the rate revision.

(b) For the following individual accident and health policies, except Medicare supplement and long-term care, data is not required to be subdivided by policy year duration; and the data in Subparagraphs (a)(15), (a)(16), and (a)(17) of this Rule may be omitted:

(1) short term non-renewable; e.g., airline trip, student, or accident;

(2) annual renewable term that are repriced every year; and

(3) any closed block of business for which all in force policies have exceeded the seventh year duration.

History Note: *Authority G.S. 58-2-40(1); 58-51-95; 58-63-15(7)b;*
Eff. June 1, 1992;
Amended Eff. August 1, 2005; February 1, 1994; October 1, 1993; January 1, 1993.

11 NCAC 16 .0602 HMO GENERAL FILING REQUIREMENTS

(a) All schedules of premiums for enrollee coverage for health care services and amendments to schedules of premiums that are filed with the Department shall be submitted to and stamped received by the Life and Health Division and indicate whether the filing is an original or amended filing. All data requirements prescribed by this Section must be submitted within 30 days after the date that the filing is stamped received, or the filing will be deemed to be disapproved. Subsequent data submissions for rate filings deemed to be in non-compliance with this Section shall be made directly to the Department's Actuarial Services Division within the 30 day period.

(b) All filings shall be accompanied by:

(1) A certification by a qualified actuary that the premiums applicable to an enrollee are not individually determined based on the status of his health and that such premiums are established in accordance with actuarial principles for various categories of enrollees and are not excessive, inadequate, or unfairly discriminatory.

(2) Actuarial data supporting the schedule of premiums as prescribed by 11 NCAC 16 .0603, 11 NCAC 16 .0604, 11 NCAC 16 .0605, 11 NCAC 16 .0206 and 11 NCAC 16 .0207.

(c) All data and schedules that are required to be filed by this Section shall be filed in duplicate.

(d) As used in Paragraph (b) of this Rule, "qualified actuary" means an individual who is an Associate or Fellow of the Society of Actuaries or a Member of the American Academy of Actuaries and has at least three years of substantive experience in the HMO or another managed health care field.

History Note: *Authority G.S. 58-67-50(b); 58-67-150;*
Eff. April 1, 1995;
Amended Eff. February 1, 1996.

11 NCAC 16 .0603 HMO RATE FILING DATA REQUIREMENTS

All HMO rate filings shall include the following data:

(1) Identification and a brief description of the HMO model type;

(2) Identification of the enrollee issue basis, whether individual or group;

(3) Identification and a brief description of the type of rating methodology, such as community rating, community rating by class, adjusted community rating, credibility rating, or other;

(4) Identification and listing of all rate classification factors, such as age, gender, geographic area, industry, group size, or effective date;

(5) A brief, summary description and numerical demonstration of the development of the capitated rate, including a listing of sources used;

(6) A brief, summary description and numerical demonstration of the development of any portion of the premium rate developed for fee-for-service claims, including a listing of sources used;

(7) A brief, summary description of the claim reserving methodology and the incorporation of claim reserves into the premium rate;

(8) A brief, summary description of the procedure and assumptions used to convert the total per member per month cost to the proposed premium rates; including assumptions for the distribution of community rated contracts by contract type, the ratios by tier to the single rate, and the average number of members in each contract type;

(9) The projected monthly incurred loss ratios for the period of time equal to the number of months for which the rates will be in effect, plus the number of months the rates will be guaranteed;

(10) The percentage of the per member per month premium for administrative expenses and for surplus.

History Note: *Authority G.S. 58-67-50(b); 58-67-150;*
Eff. April 1, 1995.

11 NCAC 16 .0604 INITIAL HMO RATE FILING DATA REQUIREMENTS AND STANDARDS

(a) All initial HMO rate filings shall include, in addition to the data required by 11 NCAC 16 .0603, the following data:

(1) A comparison of the rates to other HMO rates with the same effective date in North Carolina for similar benefit plans.

(2) A completed diskette, provided by the Actuarial Services Division of the Department, containing a three-year financial projection that details total membership, revenues and expenses, and that includes a statement of cash flow, a balance sheet, and a statement of working capital and net worth.

(b) All initial HMO rate filings shall use in the rate development a total retention loading of:

(1) no greater than 25.0% of the total premium rate for full-service HMO products issued on a group basis;

(2) no greater than 35.0% of the total premium rate for single-service HMO products issued on a group basis;

(3) no greater than 35.0% of the total premium rate for full-service HMO products issued on an individual basis;

(4) no greater than 45.0% of the total premium rate for single-service HMO products issued on an individual basis.

(c) If an HMO uses a total retention loading which is less than the maximum limit cited in Paragraph (b) of this Rule minus 15.0%, then the following supporting documentation shall be included in the filing:

(1) a listing of each of the specific components which make up the total retention loading expressed as a percentage of premium;

(2) a brief description of the methodology employed to obtain each of the components which make up the total retention loading;

(3) a brief explanation as to why any of the components which make up the total retention loading have changed and a statement of opinion from an officer of the HMO that these changes are permanent in nature;

(4) a brief, summary description of the impact of any special fee negotiations or contract arrangements which affect the premium rates; identification of specific hospitals or physician groups is not required;

(5) a comparison of the rates to other HMO rates with similar benefit plans.

(d) All HMO's must project a positive net income after taxes in each of the last 12 months of the three year financial projection.

History Note: *Authority G.S. 58-67-10(d)(1); 58-67-50(b); 58-67-150;*
Eff. April 1, 1995.

11 NCAC 16 .0605 HMO EXPANSION REQUEST DATA REQUIREMENTS

All HMO expansion requests shall include, in addition to the data required by 11 NCAC .0603, the following data:

(1) a comparison of the actual financial results, including total membership, revenues, and expenses, to the projected financial results for at least the most recent 12-month period;

(2) a completed diskette, provided by the Actuarial Services Division of the Department, containing a three-year financial projection that details total membership, revenues, and expenses, and that includes a statement of cash flow, a balance sheet, and a statement of working capital and net worth for both the existing service area and the proposed area of expansion.

History Note: *Authority G.S. 58-67-10(d)(1); 58-67-50(b); 58-67-150;*
Eff. April 1, 1995.

11 NCAC 16 .0606 HMO RATE REVISION FILING DATA REQUIREMENTS

All HMO rate revision filings shall include, in addition to the data required by 11 NCAC 16 .0603, the following data:

(1) a brief, summary description of the scope and reason for any rate revision, including the methodology employed to determine the revised rates;

(2) the number of months the rates will be in effect and the number of months the rates will be guaranteed;

(3) the dates and average percentage amounts of:

(a) all prior rate revisions in North Carolina during the preceding three years, and

(b) the current rate revision request;

and quarterly rate increases shall be shown in comparison to both the immediately preceding quarter and the corresponding quarter of the previous 12-month period;

(4) the North Carolina average annual per member per month premium revenue before and after the rate revision;

(5) a brief, summary explanation of any deviations in actual versus expected utilization rates or medical costs that may be used to justify a premium rate revision;

(6) identification and a brief, summary description of the derivation of any trend factor used to project medical expenses;

(7) a comparison of the actual financial results, including total membership, revenues, and expenses, to the projected financial results for at least the most recent 12-month period;

(8) a completed diskette, provided by the Actuarial Services Division of the Department, that contains a financial projection for the period of time equal to the number of months the rates will be in effect plus the number of months the rates will be guaranteed, that details total membership, revenues, and expenses, and that includes a statement of cash flow, a balance sheet, and a statement of working capital and net worth.

History Note: *Authority G.S. 58-67-50(b); 58-67-150;*
Eff. April 1, 1995.

11 NCAC 16 .0607 HMO INCURRED LOSS RATIO STANDARDS

(a) The following apply to all HMO rate revision filings:

(1) The application of a requested rate increase or decrease shall result in an average incurred loss ratio projected for North Carolina over the period required in 11 NCAC 16 .0606(8) of this Section which is not less than:

(A) 75.0% for full-service HMO products issued on a group basis;

(B) 65.0% for single-service HMO products issued on a group basis;

(C) 65.0% for full-service HMO products issued on an individual basis;

(D) 55.0% for single-service HMO products issued on an individual basis;

(2) If the average incurred loss ratio projected for North Carolina over the period required in 11 NCAC 16 .0606(8) of this Section, is greater than the minimum limit cited in Subparagraph (a)(1) of this Rule plus 15.0%, then the following supporting documentation shall be included in the filing:

(A) a listing of each of the specific components which make up the total retention loading expressed as a percentage of premium;

(B) a brief description of the methodology employed to obtain each of the components which make up the total retention loading;

(C) a brief explanation as to why any of the components which make up the total retention loading have changed and a statement of opinion from an officer of the HMO that these changes are permanent in nature;

(D) a brief, summary description of the impact of any special fee negotiations or contract arrangements which affect the premium rates; identification of specific hospitals or physician groups is not required;

(E) a comparison of the rates to other HMO rates with similar benefit plans.

(b) The following apply to all initial HMO rate filings and HMO expansion requests:

(1) The average incurred loss ratio projected for North Carolina over the last 12 months of the three year financial projection period shall be no less than:

(A) 75.0% for full-service HMO products issued on a group basis;

(B) 65.0% for single-service HMO products issued on a group basis;

(C) 65.0% for full-service HMO products issued on an individual basis;

(D) 55.0% for single-service HMO products issued on an individual basis;

(2) If the average incurred loss ratio projected for North Carolina over the last 12 months of the three year financial projection is greater than the minimum limit cited in Subparagraph (b)(1) of this Rule plus 15.0%, then the following supporting documentation shall be included in the filing:

(A) a listing of each of the specific components which make up the total retention loading expressed as a percentage of premium;

(B) a brief description of the methodology employed to obtain each of the components which make up the total retention loading;

(C) a brief explanation as to why any of the components which make up the total retention loading have changed and a statement of opinion from an officer of the HMO that these changes are permanent in nature;

(D) a brief, summary description of the impact of any special fee negotiations or contract arrangements which affect the premium rates; identification of specific hospitals or physician groups is not required;

(E) a comparison of the rates to other HMO rates with similar benefit plans.

History Note: *Authority G.S. 58-67-50(b); 58-67-150;*
Eff. April 1, 1995.

SECTION .0800 - SMALL EMPLOYER GROUP HEALTH INSURANCE ACTUARIAL CERTIFICATION

11 NCAC 16 .0801 SMALL EMPLOYER GROUP HEALTH INSURANCE ACTUARIAL CERTIFICATION

(a) To fulfill the requirements of G.S. 58-50-130(f), each small employer group carrier, as defined in G.S. 58-50-110(23), shall use the following language in its actuarial certification:

(1) The opening paragraph shall indicate the actuary's relationship to the carrier and the actuary's qualifications to provide the certification.

(A) For a carrier actuary, the opening paragraph shall read as follows:
"I, (name and title of actuary), am an (officer, employee) of (name of carrier) and am a member of the American Academy of Actuaries. I am familiar with G.S. 58-50-130."

(B) For a consulting actuary, the opening paragraph shall read as follows:
"I, (name and title of consulting actuary), am associated with (name of actuarial consulting firm) and am a member of the American Academy of Actuaries. I have been involved in the preparation of the small employer group health insurance premium rates for the (name of carrier) and am familiar with G.S. 58-50-130."

(2) A scope paragraph shall be included, which shall include the following language:
"I have examined the actuarial assumptions and methodology used by (name of carrier) in determining small employer group health benefit plan premium rates and the procedures used by (name of carrier) in implementing the small employer group health benefit plan rating provisions of G.S. 58-50-130.

(3) If the actuary has examined the underlying records, the scope paragraph shall include the following language:
"I have examined the underlying records and summaries of data used by (name of carrier) in determining small employer group health benefit plan premium rates and procedures used by (name of carrier) in implementing the small employer group health benefit plan rating provisions of G.S. 58-50-130."

(4) If the actuary has not examined the underlying records, but has relied upon listings and summaries of data prepared by an officer of the company, the scope paragraph shall include the following language:
"I have not examined the underlying records used by (name of carrier) in determining small employer group health benefit plan premium rates and procedures used by (name of carrier) in implementing the small employer group health benefit plan rating provisions of G.S. 58-50-130. I have relied upon listings and summaries of data prepared by (name and title of company officer) as certified in the attached statement."

(5) The certification paragraph shall read as follows:
"I certify that for the period from January 1, (year) to December 31, (year) the rating method(s) of (name of carrier) are actuarially sound and that:

(A) The rating factors used by (name of carrier) in its adjusted community rating (ACR) methodology are being applied consistently, not being applied individually in the final premium rate charged to an employee, and being applied uniformly to the premium rate charged to all eligible employee enrollees in a small employer group.

(B) Periodic adjustment factors that give recognition to medical claim or medical inflation trends are based on (name of carrier)'s entire small employer group health benefit plan business, the same in a given month for a new and a renewing small employer group with the exception of Part (J) of this Subparagraph, and the same for 12 consecutive months for a given small employer group.

(C) All small employer groups within a given medical care system have the same medical care system factor.

(D) The medical care system factors produce rates that are not excessive, not inadequate and are not unfairly discriminatory in the medical care system areas and are revenue neutral to the small employer group carrier for its small group business in North Carolina.

(E) The medical care system factors reflect only the relative differences in expected costs.

(F) Rate differences because of differences in health benefit plan design only reflect benefit differences.

(G) Participation and contribution requirements do not vary by policy form.

(H) Stop loss, catastrophic, or reinsurance coverage provided to small employers complies with the underwriting, rating, and other applicable standards in G.S. 58-50-100 through G.S. 58-50-156.

(I) The percentage increase in the premium rate charged to a small employer for a new rating period does not exceed the sum of the following: the percentage change in the ACR as measured from the first day of the previous rating period to the first day of the new rating period, any adjustment, not to exceed 15 percent annually, because of claim experience, health status, or duration of coverage of the employees or dependents of the small employer, and any adjustment because of change in coverage or change in case characteristics of the small employer group.

(J) Any adjustment because of duration of coverage only reflects a difference between first year and renewal coverage.

(K) (Name of carrier) uses an ACR methodology as prescribed in G.S.58-50-130(b)(1) and that the premium rates charged during a rating period to small employer groups with similar case characteristics for the same coverage do not deviate from the adjusted community rate by more than 25 percent for any reason, including differences in administrative costs and claims experience.

(L) Differences in administrative costs, defined as all non-medical care costs, within a policy form are reflected within the 25 percent deviation from the ACR.

(M) (Name of carrier) only uses the following demographic factors, as prescribed by G.S. 58-50-130(b)(2): age, gender, family size, medical care system, and industry.

(N) All small employer group health benefit plans are guaranteed issue as prescribed by G.S. 58-68-40.

(O) The industry rate factor associated with any industry classification divided by the lowest industry rate factor associated with any other industry classification shall not exceed 1.2.

(P) All small employer group health benefit plan premium rates are guaranteed for 12 months as prescribed in G.S. 58-50-130(b)(3).

(Q) All small employer group health benefit plan premium rate increases include a common premium rate increase shared by all small employer group business.

(R) The premium rates exhibit a reasonable relationship to the benefits provided by the policies and are not excessive, are not inadequate, and are not unfairly discriminatory."

(b) The certifying actuary shall include a description and a sample numerical demonstration of how the small employer group health benefit plan premium rates were tested for compliance.

(c) If the certifying actuary has not examined the underlying records or summaries, the person or persons who performed the examination of the underlying records or summaries shall provide the following certification, which shall be signed, dated, and attached to the actuarial certification:

"I, (name and title of certifying officer), am (title) of (name of insurer). I hereby affirm that the listings and summaries of data for (name of carrier) prepared for and submitted to (name of certifying actuary) were prepared under my direction and, to the best of my knowledge and belief, are accurate and complete."

(d) If the certifying actuary submits a qualified certification, the following information must be attached to the small employer group actuarial certification:

(1) A description of the incident or incidents that resulted in the certifying actuary submitting a qualified certification.

(2) A submission of a remedial plan to bring the incidents described in Paragraph (d)(1) of this Rule into compliance with G.S. 58-50-130(b).

History Note: *Authority G.S. 58-2-40; 58-50-130;*
Eff. December 1, 2007.

Summary of Rate and Premium Regulation in North Carolina
NC Department of Insurance - Life & Health Division

	Pertaining to Rates		Pertaining to Premiums at Initial Issue and Renewal
Product Type	**Rates Upon Initial Product Approval**	**Change to Rate Formulas, Methods, or Factors**	
Individual Major Medical Market			
Individual	For L&H insurer indemnity plans, including PPO, but excluding BCBS (L&H Insurer plans): GS 58-51-95(a) & (c) • Prior approval of rates. • Policy form must contain benefits that are reasonable in relation to premium charged.	For L&H insurer indemnity plans, including PPO, but excluding BCBS (L&H Insurer plans): GS 58-51-95(f), (g), & (h) • Prior approval of rates. • Rates must be adequate, not excessive, not unfairly discriminatory, and bear a reasonable relationship to the benefits. • Renewal premium increases may not be individually determined based on a person's health status. • Every policy shall return to policyholders benefits that are reasonable in relation to the premium charged. Insurers must submit annual rate filings demonstrating compliance with this requirement.	For L&H insurer indemnity plans, including PPO, but excluding BCBS (L&H Insurer plans): GS 58-51-95(f) • Premiums must be good for at least 12 months. • Minimum of 45 days' notice of change must be given to policyholders.
	For HMO plans: GS 58-67-50(b) • Prior approval of rates. • Rates must be adequate, not excessive, not unfairly discriminatory, and bear a reasonable relationship to the benefits.	For HMO plans: GS 58-67-50(b) • Same as for initial rates for HMO individual plans.	For HMO plans: GS 58-67-50(b) • Premiums may not be individually determined based on a person's health status. • Premiums must be good for at least 12 months. • Minimum of 45 days' notice of change must be given to policyholders.
	For Hospital/Medical Service (BCBS) plans: GS 58-65-40 & 45 • Same as above for HMO plans. • DOI may hold a public hearing on rates for a new product.	For Hospital/Medical Service (BCBS) plans: GS 58-65-40 & 45 • Same as above for HMO plans. • DOI may hold a public hearing on any change in rating formula or factors. • Every policy shall return to policyholders benefits that are reasonable in relation to the premium charged. Insurers must submit annual rate filing demonstrating compliance with this requirement.	For Hospital/Medical Service (BCBS) plans: GS 58-65-40 & 45 • Same as above for HMO plans, except minimum of 30 days' notice of change must be given to policyholders.
Association (membership comprised of individuals)	• Subject to regulation for large group, i.e., prior approval of rates.	• Subject to regulation for large group, appropriate to type of carrier, i.e., no regulation over rate changes unless HMO or BCBS plan.	• Subject to regulation for large group, i.e., limits on frequency of adjustments and required advance notice of premium change applicable to carrier type.

Summary of Rate and Premium Regulation in North Carolina
NC Department of Insurance - Life & Health Division

Product Type	Pertaining to Rates: Rates Upon Initial Product Approval	Pertaining to Rates: Change to Rate Formulas, Methods, or Factors	Pertaining to Premiums at Initial Issue and Renewal
Employer Group Major Medical Market			
Small Group (1-50 employees)	For L&H Insurer plans: GS 58-50-130(b) • Rating formula is defined in law. Each carrier must develop a community rate based upon their entire block of small groups covered under the specific benefit plan. That rate may then be adjusted by factors to account for case characteristics – age, gender, geographic location, family composition and industry, to arrive at an adjusted community rate (ACR) for each group. The carrier is permitted an additional adjustment of up to +/- 25% from the ACR to reflect the group's experience or administrative expenses (up to +/-15% for renewals). • Review authority for rating factors. • Rating factors must be consistently applied to all small employer groups. • Rating method must be based upon commonly accepted actuarial assumptions/sound actuarial principles. • Rate filings must be accompanied by actuarial certification that rating methods are actuarially sound and rates comply with rating law.	For L&H Insurer plans: GS 58-50-130(b) • Annually all insurers submit their rating factors and provide a retrospective certification of compliance with the small group rating law and actuarial soundness of rating methods.	For L&H Insurer plans: GS 58-50-130(b) • Premium-setting methodology is defined in law. Starting with a community rate, carriers may apply factors for case characteristics to arrive at an ACR for each employer group. Additional adjustment of up to +/- 25% from ACR reflecting the individual experience of the group or administrative expenses for the group is permitted (up to +/-15% for renewals). • Initial premiums must be good for at least 12 months unless the group's composition changes by > 20%. • Renewal premiums must be good for at least 12 months unless the group's composition changes by > 20%. • Minimum 45 days' notice of change must be given to policyholders. • Premium change at renewal cannot exceed the sum of the percentage change in the carrier's new ACR (i.e., experience of all small groups) and 15% to reflect claims experience, health status or duration of coverage for the specific group.
	For HMO & BCBS plans: GS 58-50-130(b)& 58-67-50(b)/ 58-65-40, 45 & 60 • Prior approval of rates and/or rating factors, which, in addition to complying with the above, must be adequate, not excessive, not unfairly discriminatory, and bear a reasonable relationship to benefits. • DOI may hold hearing on BCBS rates	For HMO & BCBS plans: GS 58-50-130(b) & 58-67-50(b)/ 58-65-40, 45 & 60 • Same as above for Insurer plans, except rates and/or changes to rate factors are subject to prior approval. HMOs must receive approval of rates annually, even if no change. • Otherwise, same as for initial HMO & BCBS rates.	For HMO & BCBS plans: GS 58-50-130(b) & 58-67-50(b)/ 58-68-40, 45 & 60 • Same as above for Insurer plans, except that, for BCBS, minimum of 30 days' notice to policyholders when a premium will change.

Summary of Rate and Premium Regulation in North Carolina
NC Department of Insurance - Life & Health Division

Product Type	Pertaining to Rates		Pertaining to Premiums at Initial Issue and Renewal
	Rates Upon Initial Product Approval	Change to Rate Formulas, Methods, or Factors	
Employer Group Major Medical Market (cotinued)			
Large Group (51+ employees)	For L&H Insurer plans: GS 58-51-80 & 85 • Prior approval of rates. • Group must be rated on an actuarially sound basis. For HMO & BCBS plans: GS 58-67-50(b), 58-65-40, 45 & 60 • Prior approval of rates and/or rating factors - which must be adequate, not excessive, not unfairly discriminatory, and bear a reasonable relationship to the benefits. • DOI may hold hearing on BCBS rates.	For L&H Insurer plans: None. For HMO & BCBS plans: GS 58-67-50(b), 58-65-40, 45 & 60 • Prior approval of rates and/or rating factors - which must be adequate, not excessive, not unfairly discriminatory, and bear a reasonable relationship to the benefits. HMOs must receive approval of rates annually, even if no change. • DOI may hold hearing on BCBS rates.	For L&H Insurer plans: GS 58-51-80 & 85 • Initial group policyholder premiums must be good for at least 12 months. • Premiums for a group policyholder may be adjusted every 6 months after the initial 12-month period, based upon 12 months of experience. For HMO & BCBS plans: GS 58-67-50(b), 58-65-40, 45 & 60 • Renewal premium rates must be good for at least 12 months. • Minimum notice of 45 days (30 days for BCBS) to the policyholder when a premium rate will change.
Association (membership comprised of employers)	• Subject to requirements for large or small groups, depending on size of member employers, and appropriate to the type of carrier (i.e., insurance company, HMO or hospital/medical service corporation.)	• Subject to requirements for large or small groups, depending on size of member employers, and appropriate to the type of carrier (i.e., insurance company, HMO or hospital/medical service corporation.)	• Subject to requirements for large or small groups, depending on size of member employers, and appropriate to the type of carrier (i.e., insurance company, HMO or hospital/medical service corporation.)

North Carolina Department Of Insurance
Actuarial Services Division

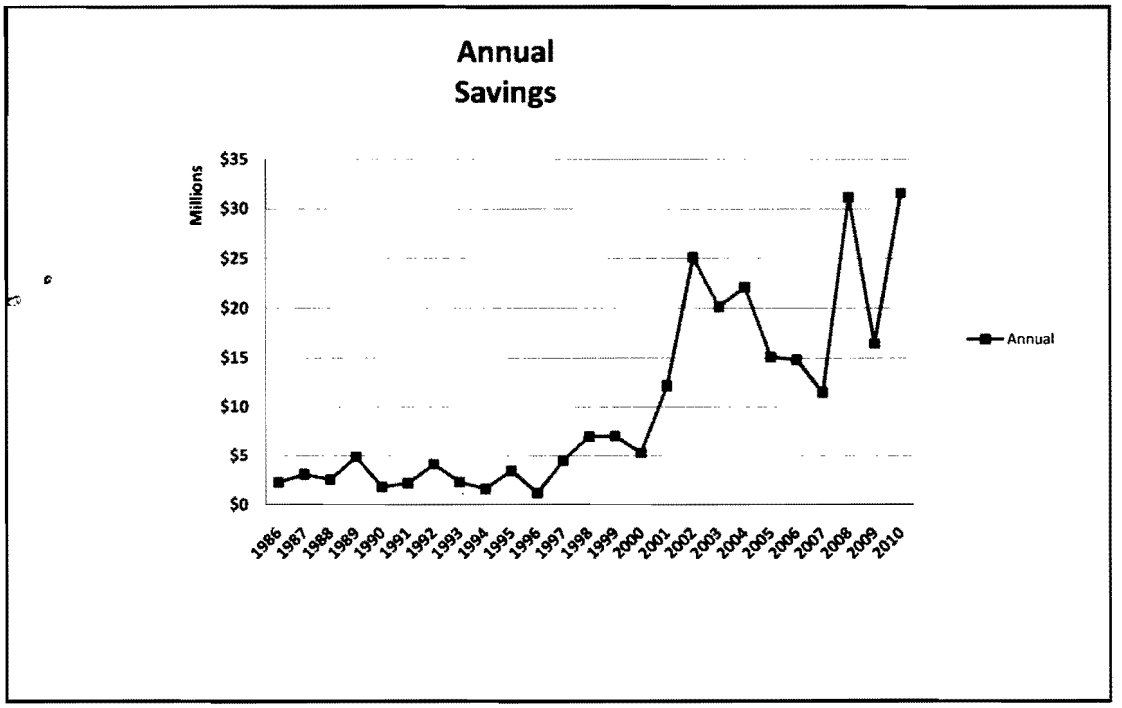
Individual Accident & Health and Medicare Supplement
Average Annual Rate Revision Percentages - 1993 Thru 2010(To-Date)

	TOTAL			MEDICARE SUPPLEMENT Includes BCBSNC			OTHER Accident & Health Includes BCBSNC			BCBSNC Blue Advantage		
Eff. Year	Average Requested	Average Approved		Average Requested	Average Approved		Average Requested	Average Approved		Average Requested	Average Approved	
1993	12.6%	12.1%	-0.5%	7.1%	6.6%	-0.5%	21.1%	20.6%	-0.5%			
1994	6.7%	6.3%	-0.3%	2.4%	2.3%	-0.1%	14.3%	13.6%	-0.7%			
1995	13.9%	13.2%	-0.7%	13.1%	12.2%	-0.9%	16.5%	16.4%	-0.1%			
1996	12.0%	11.7%	-0.3%	10.4%	10.1%	-0.3%	15.2%	15.1%	-0.2%	New Product	New Product	
1997	16.4%	14.5%	-1.9%	14.4%	13.9%	-0.6%	22.6%	16.4%	-6.1%	0.0%	0.0%	0.0%
1998	15.4%	14.3%	-1.1%	13.7%	12.4%	-1.3%	21.1%	20.8%	-0.3%	14.0%	14.0%	0.0%
1999	15.2%	14.3%	-0.9%	14.2%	12.8%	-1.4%	17.6%	17.6%	0.0%	14.9%	14.9%	0.0%
2000	15.1%	14.5%	-0.6%	11.0%	10.4%	-0.6%	22.9%	22.3%	-0.6%	16.8%	16.8%	0.0%
2001	16.5%	15.2%	-1.3%	10.9%	10.3%	-0.6%	24.8%	22.5%	-2.3%	10.6%	5.9%	-4.7%
2002	16.6%	14.0%	-2.6%	10.9%	9.5%	-1.3%	26.7%	21.8%	-4.9%	15.8%	8.1%	-7.7%
2003	15.0%	13.2%	-1.9%	9.1%	8.4%	-0.8%	23.2%	19.8%	-3.4%	18.6%	14.0%	-4.6%
2004	10.3%	8.5%	-1.7%	8.1%	7.1%	-1.0%	12.7%	10.1%	-2.6%	6.8%	3.9%	-2.9%
2005	9.7%	8.6%	-1.1%	8.2%	7.2%	-1.0%	11.1%	10.0%	-1.1%	7.4%	6.5%	-0.9%
2006	10.6%	9.7%	-0.9%	7.5%	7.2%	-0.3%	13.3%	11.8%	-1.4%	11.3%	9.9%	-1.5%
2007	5.5%	4.8%	-0.7%	5.2%	4.6%	-0.6%	5.6%	4.9%	-0.7%	4.6%	4.0%	-0.6%
2008	13.6%	12.0%	-1.6%	8.3%	7.7%	-0.5%	16.2%	14.1%	-2.1%	21.3%	18.4%	-2.9%
2009	9.3%	8.5%	-0.8%	8.4%	8.0%	-0.4%	9.8%	8.7%	-1.1%	9.6%	8.5%	-1.1%
2010	11.0%	9.4%	-1.6%	8.0%	7.3%	-0.7%	12.6%	10.5%	-2.0%	14.8%	12.2%	-2.6%
Avg	12.5%	11.4%	-1.1%	9.5%	8.8%	-0.7%	17.1%	15.4%	-1.7%	11.9%	9.8%	-2.1%

North Carolina Department Of Insurance

Individual Accident & Health and Medicare Supplement
Rate Revision Filings - Savings For 1986 - 2010(To-Date)

Eff Year	Calendar Year Savings	Cumulative Savings
1986	$2,269,059	$2,269,059
1987	$3,090,665	$5,359,724
1988	$2,550,243	$7,909,967
1989	$4,878,188	$12,788,155
1990	$1,801,161	$14,589,316
1991	$2,185,269	$16,774,585
1992	$4,116,732	$20,891,317
1993	$2,300,656	$23,191,973
1994	$1,601,172	$24,793,145
1995	$3,465,626	$28,258,771
1996	$1,184,905	$29,443,676
1997	$4,512,250	$33,955,926
1998	$6,998,604	$40,954,530
1999	$7,027,065	$47,981,595
2000	$5,293,660	$53,275,255
2001	$12,186,495	$65,461,750
2002	$25,134,579	$90,596,329
2003	$20,176,826	$110,773,155
2004	$22,142,865	$132,916,020
2005	$15,111,315	$148,027,335
2006	$14,822,976	$162,850,311
2007	$11,486,327	$174,336,638
2008	$31,180,778	$205,517,416
2009	$16,429,889	$221,947,305
2010	$31,605,090	$253,552,395



Project Narrative — North Carolina Department of Insurance

Current Rate Review Process

- **General Health Insurance Rate Regulation**

Licensing Requirements – The North Carolina Department of Insurance (the Department) licenses all insurers who carry on the business of insurance within North Carolina and authorizes the specific types of insurance in which the insurer may engage. An insurer licensed in North Carolina and authorized to write health insurance coverage in North Carolina may include traditional insurers who have accident and health insurance authority, a Medical Service Corporation or a Health Maintenance Organization (HMO). In addition to the general authority afforded through the license, the insurer must submit to the Department for prior approval all insurance policy forms and rates for any health insurance plan the insurer intends to market in North Carolina. This prior approval requirement applies across all types of health insurance plans (i.e. preferred provider, indemnity, point of service, HMO, etc.) and across all health insurance markets (individual/non-employer group, small and large employer group). In reviewing the policy forms and rates associated with a health insurance plan, the Department's Life and Health Division applies all applicable statutory and regulatory requirements to the product and the rates. When necessary, the Life and Health Division collaborates with the Actuarial Services Division for the actuarial review of rate justification, but it is the Life and Health Division that is ultimately responsible for approval or disapproval actions involving rate filings.

Rating Rules – Requirements for rating and the use of case characteristics vary according to the type of insurer involved and the market in which the health plan is used. Likewise, the Department's rate review process also varies accordingly.

Individual Health – Insurers are required to submit rate filings at least annually, and these filings require the Department's approval prior to implementation. Individual health insurance premiums must be guaranteed for a period of not less than 12 months to the policyholder and require a 45-day prior notification period before implementing a rate increase on an individual. These filings must satisfy applicable incurred loss ratio standards. For individual health insurance there is no required rating methodology although most carriers use attained age rating. Monthly or quarterly trend factors which build in automatic rate increases by calendar date are not allowed. Medical underwriting and an assignment of a rating tier at issue is currently allowed, however, an individual's renewal premium cannot be increased due to any health status related factor including duration from issue.

Small Employer Group (Small Group) – The Department has authority to review the rating factors used in the small employer group (employers with 1-50 eligible employees) health insurance market. Insurers must submit this information to the Department at the point that they submit a small group market entry filing, when they submit new policy forms for use with new plans, and whenever they change the demographic factors. Small group health insurance rates must be calculated using an adjusted community rating methodology with ±25% rating bands for underwriting and administrative expense differences. The rating factors used by small group insurers are subject to review and, in some cases, prior approval. Insurers are limited to five demographic factors – age, gender, number of family members covered, geographic location and industry. Small group rates are guaranteed for 12 months unless the group's composition changes by more than 20% or there are changes made to the benefits. Annual small group rate increases are limited to the increase in the adjusted community rate plus the increase due to change in benefits or case characteristics (rating factors) plus an adjustment not to exceed 15% for group specific claims experience, health status or duration of coverage.

Large Employer Group (Large Group) – Insurers are statutorily required to submit an actuarial demonstration detailing the development of the premium rates for any health insurance product when the product is first submitted to the Department for approval. Health insurance premiums for traditional "life and health insurance companies" must be rated on an actuarially sound basis as certified by an actuary. Amendments to the rates charged by those insurers are not required to be submitted to the Department. However, many insurers do as a matter of business submit these revisions to the Department on a "file and use" basis. For Medical Service Corporations and HMOs, the Department reviews and approves the rating factors and/or the rates the insurer is proposing for use with health plans, both initially and any revisions thereto. Revisions to the factors that Medical Service Corporations use must be approved by the Department. HMO insurers must submit an annual rate filing to the Department for approval. For HMO and Medical Service Corporation group health insurance, there is considerable flexibility with rating methodologies as long as they are developed on an actuarially sound basis. Generally speaking, changes in a group's premium rate must be preceded by no less than a 30-day notice to the policyholder, although in some cases the notice period is longer.

HMO Specific Information – Insurers are required to submit rate filings at least annually and require the Department's approval prior to implementation. HMO premiums must be guaranteed for a period of not less than

12 months and require a 45-day notification period prior to implementing a rate increase. These filings must satisfy applicable incurred loss ratio standards.

Attachment I contains copies of our laws and regulations pertaining to health premium review for all three markets. Also included is a chart entitled "Summary of Rate and Premium Regulation in North Carolina" which outlines the information described above.

- **Health Insurance Rate Review and Filing Requirements**

Description of Data Included in Rate Filings

Individual Health – For an individual health insurance rate revision submission, the filer must submit an Actuarial Memorandum which describes and demonstrates the development of any requested premium rate revision. Title 11 North Carolina Administrative Code (NCAC) 16.0205 specifies the "Additional Data Requirements." (See Attachment I.) The regulation includes a requirement for general information such as policy form identification and justification of groupings, number of North Carolina policies and average annual premium before and after the proposed revision, as well as historical experience data including earned premium and incurred claims from inception. The incurred loss ratio is defined as incurred claims divided by earned premiums and calculated based upon current National Association of Insurance Commissioners (NAIC) SSAPs (Statutory Statements of Accounting Practices). Durational data is typically required in order to recognize the effects of medical underwriting. Experience is typically provided on an annual basis, however, monthly data is provided when credible by the larger insurers. North Carolina specific experience is accepted if credible, otherwise country-wide data is required. Actuarial justification for any proposed apportionment of the rate revision is also required.

Small and Large Employer Group – Generally, no specific data requirements are dictated by statute or rule for small group and large group rate revisions.

HMO Specific Information – HMO rate filings must include the data requirements specified by Title 11 NCAC 16.0602, 16.0603, 16.0604, 16.0605, and 16.0606. (See Attachment I.) The HMO rate revision filing includes group rating methodology, base rates and all rating factors such that group specific rates may be reproduced, as well as three-year monthly financial projections which are used to demonstrate projected incurred loss ratios and risk based capital requirements.

Rate Review Process

Life and Health Division Process – All rate filings, whether revising the rate on a previously approved health insurance plan or submitted with a plan initially submitted for approval, are filed with the Life and Health Division. Those filings are received via the mail, via electronic mail and via the NAIC's System for Rate and Form Filings (SERFF). Filings received by mail or electronic mail are formatted, scanned, and/or uploaded to SERFF by the Division's Administrative Assistant. All received filings are then reviewed by a supervisor in the Division who makes an assignment of the filing to an analyst or to the Division's Filing Coordinator. The analyst/coordinator performs an initial review to assure that the filing contains the required information needed to proceed. For filings which are subject to the Department's prior review or approval, the rates are referred to an Actuary in the Actuarial Services Division. If the filing is not subject to prior review/approval or if the filing is deficient in any way, the analyst/coordinator takes the appropriate action and communicates the action to the insurer. If the filing is referred to Actuarial Services Division, the analyst/coordinator awaits a recommendation from Actuarial Services before proceeding with an action on the filing.

Actuarial Services Division Process

Individual Health – For an individual health insurance rate revision submission, the additional data requirements are used to generate an independent analysis of the proposed rate revision by the reviewing staff actuary. Historical experience is actuarially adjusted and used to project future results. Linear regression is performed on actual versus expected incurred claim ratios and/or on incurred loss ratios adjusted to a current rate level basis. Past experience is accumulated with interest while future experience is discounted with interest for the lifetime loss ratio calculation. The justified rate increase indication is determined as the amount required to reduce the projected future loss ratio down to the allowable incurred loss ratio subject to the constraint of also satisfying the lifetime incurred loss ratio requirement.

Small Employer Group – For small group insurance, all insurers are required to submit annually by March a retrospective actuarial certification stating that they rated all of their small employer groups in the previous calendar year in accordance with the statutory requirements. These certifications are reviewed by the staff actuary and any deficiencies identified result in the insurer being instructed to take all necessary actions to resolve the deficiencies. Additionally, if an insurer revises any of the rating factors to be used with their small group business, the insurer must submit the changes to the Department along with an actuarial certification of compliance with the

applicable rating requirements. A staff actuary is involved in the review of small group rates when an insurer enters the small group market, when factors are revised and the insurer involved is either an HMO or a Medical Service Corporation, and whenever the Life and Health Division staff analyst believes additional input from an actuary is warranted.

Large Employer Group – The rating factors, and any changes thereto, used by Medical Service Corporations must be filed with the Department for our prior approval. A staff actuary reviews those submissions although extensive flexibility is provided the insurer in developing those factors for use in this large group market. For large group insurers who are neither a Medical Service Corporation nor an HMO, North Carolina law does not require that changes to large group rates be submitted to the Department, although many insurers do submit the rates for our information. This means that involvement of the Actuarial Services Division in the review of large employer group rates is limited. Information relating to HMOs plans is provided in the next section.

HMO Specific Information – For HMO rate revision filings, all rating methodologies and rating factors are reviewed for reasonableness. The company's justification for their proposed aggregate percentage rate increase is examined based upon past experience, medical trend levels and other anticipated changes. An actual versus projected analysis is performed for the most recent 12 months of historical experience. This provides an indication for how well the HMO has forecasted net income components such as membership, medical and administrative expenses. The assumptions used in the HMO's submitted three-year monthly financial projections are reviewed for reasonableness and the projections may be adjusted based upon the actual versus projected ratios. The financial projections include net income, cash flow and balance sheet as well as a risk based capital forecast. The adjusted projections are reviewed for compliance with incurred loss ratio and risk based capital requirements.

Staffing & Resources – Currently no private sector consultants are used for review of health rate filings. Two staff actuaries are involved with the review of health insurance rate filings. Actuary 1, an FSA, MAAA reviews all individual accident and health and Medicare supplement rate filings, all HMO large group filings and health insurance contract reserves. Actuary 2, an ASA, MAAA, FCA reviews all small group rate filings and certifications, BCBSNC Group Rating Formula filings, Multiple Employer Welfare Arrangements (MEWAs), and health insurance claim reserves. The Life and Health Division staff currently involved in the rate review process includes a Supervising Analyst, a Senior Policy and Rate Analyst, a Policy and Rate Analyst, a Life and Health Filing Coordinator, and an Administrative Assistant. Other Departmental resources related to rate review include

the involvement of the staffs in the Consumer Services and Market Regulation Divisions who are involved in the retrospective review based upon consumer complaints and market conduct examinations. In addition to the staff resource, the Department devotes IT resources including a computer network, internet access, personal computers, software to perform analysis and to communicate internally and externally, software to track and house data related to the rate review, archival and backup computer systems, and IT technical support. There are also resources for educational opportunities for staff and other miscellaneous items such as purchase of other equipment, statute books and travel.

Criteria for Legal Authority and Rate Evaluation

Individual Health – Statutory authority for rate review/approval is provided by North Carolina General Statute (NCGS) 58-51-95 for individual health insurance, NCGS 58-67-50 for HMOs, and NCGS 58-65-40 and NCGS 58-65-45 for Medical Service Corporations. These filings are reviewed in order to ensure that the application of a requested revision produces rates that are not excessive, not inadequate and not unfairly discriminatory. Additionally, the NAIC Model "Guidelines for Filing of Rates for Individual Health Insurance Forms" (July 2000) provides general guidelines and the methodology used to determine that benefits are reasonable in relation to premiums. This includes meeting or exceeding minimum projected future and lifetime incurred loss ratio standards. A rate may be deemed excessive if the loss ratio standards are not satisfied. A rate may be deemed inadequate if the total premium is insufficient to cover the claims and administrative expenses. A rate is not unfairly discriminatory if it reflects equitable differences in expected risk.

Small and Large Employer Group – Small group health plans are subject to NCGS 58-50-130 for all types of insurers while statutory authority for large group rates is provided by NCGS 58-51-80 and 85 for large group health insurance, NCGS 58-67-50 for HMOs, and NCGS 58-65-40, 45 and 60 for Medical Service Corporations. For HMOs and Medical Service Corporations, proposed changes in rates are required to produce rates which are not excessive, not inadequate and not unfairly discriminatory.

HMO Specific Information – HMO rate filings which extend the approved twelve month effective period are evaluated such that the projected incurred loss ratio is within the required range as specified by Title 11 NCAC 16.0607 and projected risk based capital satisfies NCGS 58-12-2 through 58-12-70. In addition, the reviewing actuary will follow guidance provided by Actuarial Standard of Practice No. 8, "Regulatory Filings for Health Plan Entities."

Grounds for Rate Approval, Modification and Rejection

If any component of a filing is not in compliance with North Carolina law or the filing contains unjustified rating factors it will be disapproved. All data requirements must be satisfied or a filing may be closed. If the independent analysis of the Department's staff actuary produces an indication that is less than the rate increase proposed by the company, the actuary will negotiate with the company and recommend a reduced rate increase amount for approval.

Individual Health – For individual health insurance, the primary factors that are considered in the analysis include but are not limited to the following: the effective date of the increase; the level of benefits provided; the type of rating methodology; the average annual premium before and after the proposed revision; the historical incurred loss ratio experience (on a calendar year and durational basis); the accuracy, consistency and credibility of the experience data; the past rate revision history (earned premiums are adjusted to a current premium rate level basis in order to determine the underlying trend and account for the magnitude of all previous rate revisions); the projected medical trend levels determined by NCDOI analysis; the company's anticipated or projected medical trend level and how this was determined; the NAIC minimum guideline loss ratio or company allowable loss ratio if greater; the actual and expected total terminations (lapse plus mortality); whether or not the block is open or closed; actuarial justification for any proposed apportionments of the rate revision; and the financial condition of the company where appropriate.

HMO Specific Information – For HMO rate revisions, the primary factors that are considered in the analysis include but are not limited to the following: the effective date of the increase; the level of benefits provided; the type of rating methodology; the average annual premium before and after the proposed revision; the actual versus projected ratios for membership, premium revenue, medical and administrative expenses; the anticipated impact of provider contract changes; projected medical trend levels including the cost and utilization components; all financial projection assumptions; the projected incurred loss ratios; risk based capital modeling and the projected risk based capital ratios; actuarial justification for changes to rating factors; and the financial condition of the company where appropriate.

Prospective or Retrospective Approval/Modification/Rejection – Individual health insurance, Medical Service Corporation group rate factor amendments and HMO group health insurance rates require prior approval and may be modified or rejected on a prospective basis. For small group health insurance carriers, a retrospective

certification is required. The Market Regulation Division reviews rates on an ongoing retrospective basis. Typically, Market Regulation Division requests any overcharges be reimbursed (or credited if the group is still active) directly to the impacted employer group or individual insureds. If any penalties result from market conduct violations, penalties assessed from the exam are shared among the county school systems in those counties in which the violations occurred.

Factors that Trigger Retrospective Review – For individual health insurance, Medical Service Corporation group rate factor amendments and HMO group health insurance, there is not currently a formal retrospective review of rates. Otherwise, the main triggers for retrospective reviews by the Market Regulation Division are market conduct examination mandates of domestic insurers, notifications from other Department divisions of potential issues, self-reports from insurers and overall market analysis reviews which may include information received from other states through the NAIC. If an insurer's use of an incorrect rate filing results in overcharges of premium rates, the insurer is instructed to implement immediate corrective action/remediation. The corrective action could include premium refunds or credits.. An insurer normally implements additional internal control measures to ensure that only rate filings approved for the corresponding quarters are used. Retrospective reviews are handled on a case-by-case basis.

Evidence of Modification/Negotiation – For all individual accident and health and Medicare supplement rate revision filings, the Department tracks average rate increase percentages requested versus approved by effective year. In addition, savings to North Carolina consumers are calculated as the difference in the percentage requested and percentage approved multiplied by the average annual premium per policy multiplied by the in force policy count. This data is provided in Attachment II.

- **Current Level of Resources and Capacity for Rate Review (IT and System Capacity)**

The Department uses the SERFF system to track and house all form, rate, and other related filings submitted to the Life and Health Division. SERFF makes the assignment of multiple reviewers possible. SERFF permits the joint review of the filing across multiple divisions and multiple reviewers. Communication between the Department and the insurer's filer is made within SERFF; this facilitates the process to bring filings into compliance, including changes to the submission to accommodate requests for more information or statutory deficiencies. It also serves as a record of the process on each filing submitted. Lastly, SERFF provides a certain amount of reporting and aggregation of data that assist the Department in evaluating our processes and in responding to inquiries for

information. For individual health insurance, the independent analysis is performed using Excel based spreadsheets with Visual Basic macros. For the HMO rate revision filing, the financial projections are required in Excel format such that the net income statement, cash flow and balance sheet are linked. In addition, the NAIC I-Site database may be accessed for information. Data for summary reporting is recorded manually by the staff actuary and accumulated in Excel spreadsheets.

- **Current Level of Resources and Capacity for Rate Review (Budget and Staffing)**

Overall Total Budget and Revenue for the Insurance Department & Current Resources Allocated to Rate Review – The FY2010 operating budget for the Department of Insurance included State appropriations of $30,379,484 and external receipts of $7,434,468 for a total budget of $37,813,952. The budget included expenditure of $2.1 million for work directly related to the insurance rate review functions and duties.

Description of Insurance Department Staff Responsible for Rate Review – See the information provided in Appendix I as it relates to current staff involved in rate review processes including the State's minimum education and/or professional experience for each position classification identified.

Historical Filing Volume – The Department received 551 health insurance related rate-only filings in calendar year 2009. Of those filings, 274 were filings related to types of insurance identified as being subject to the provisions of the PPACA. The majority of the PPACA subject filings were identified as related to group major medical insurance. The Department estimates that our review of rate-only filings is completed on average within 40 days of receipt, including interim data requests and clarifications with the insurance company. Note that these numbers do not reflect reviews of rates that accompany insurance policy forms submitted for the Department's approval.

- **Consumer Protections**

Public Disclosure – Chapter 132 of the North Carolina General Statutes provides broad access to public documents. Health Insurance Rate filings in which no assertions of confidentiality are made by the insurance company are readily available online on the Department's website at the following link: http://infoportal.ncdoi.net/filelookup.jsp?divtype=3. However, it should be noted that North Carolina's public records law includes the following exception:

> ***N.C. General Statute § 132-1.2. Confidential information***
> *Nothing in this Chapter shall be construed to require or authorize a public agency or its subdivision to disclose any information that:*
> *Meets all of the following conditions:*

Constitutes a "trade secret" as defined in G.S. 66-152(3).
Is the property of a private "person" as defined in G.S. 66-152(2).
Is disclosed or furnished to the public agency in connection with the owner's performance of a public contract or in connection with a bid, application, proposal, industrial development project, or in compliance with laws, regulations, rules, or ordinances of the United States, the State, or political subdivisions of the State.
Is designated or indicated as "confidential" or as a "trade secret" at the time of its initial disclosure to the public agency.

Insurance companies often assert that a rate filing or portions of a rate filing are confidential trade secrets within the meaning of NCGS 132-1.2. When a company makes trade secret status assertions in their filings, the Department generally accepts such status assertions. If subsequently a public records request is received at the Department for the records, the Department's process is to provide the company a notice of the public records request advising that the Department will release the records in 10 days unless the insurance company exercises their opportunity to legally establish trade secret status of the records through court action. Likewise, subject to other exceptions, information is readily available on the Department's website or upon request.

Consumer Transparency & Involvement – No requirement currently exists under North Carolina law to require insurers to produce summaries of their rate changes for the public. Likewise, no requirement currently exists under North Carolina law to require insurers to give consumers prior notice of pending rate revision filings. The North Carolina Commissioner of Insurance generally has the discretion and statutory authority to hold public hearings on rate filings, and the insurer making the rate filing can request a hearing in certain circumstances. The North Carolina Administrative Procedures Act would apply to the hearings. There is no statutory requirement for public comment; however, the Commissioner has the discretion to solicit public comments.

Inquiries and Complaints - The Department's Consumer Services Division receives consumer inquiries and complaints. The total number of inquiries and complaints received for calendar years 2008 and 2009 are found in the chart below. For purposes of this report, the reason code "premiums and rating" is defined to involve an insurer's premium, rating structure, or manual rules (ratings), alleging that the insurer improperly classified the applicant's risk level and therefore charged an excessive premium. The "rate classification" reason code is defined to involve the rate classification applied to the insured, based on risk level/class.

FILE TYPE	REASON CODE	TIME PERIOD (calendar year)	
		2008	2009
Inquiries	Premium & Rating	3	5
	Rate Classification	0	0
Complaints	Premium & Rating	217	191

	Rate Classification	13	7

Note: The numbers above only reference WRITTEN communication received from consumers. The Consumer Services Division does not log individual phone calls, and therefore this data does not reflect call volume relating to health insurance premiums and rates.

- **Examination Oversight**

Market Regulation took action against one insurance company in 2008 and 2009 directly related to health insurance rates. The company's premium rate calculations were not consistent with the rate filing approved by the Department, a deemed apparent violation of the provisions of NCGS 58-67-50. The results revealed premium rate overcharges to the employer group, and the company was instructed to remediate the overcharges by issuing refunds to affected employer groups for each year a premium rate overcharge was discovered. As a result of the Department's findings, a total of $145,778 was refunded and/or credited to the employer groups. Additionally, the Company made a collection reversal of $277 for one employer group. There were 26 affected policyholders identified. The Department did not hold formal hearings in 2008 and 2009 directly related to health insurance rates.

Proposed Rate Review Enhancements

The Department will use grant awards to develop and/or make improvements to our existing rate review practices as well as developing and implementing new processes associated with new authority that we intend to seek from the North Carolina General Assembly. Specifically, the Department intends to enhance our rate review processes in the following manners:

Expanding the scope of current review and approval activities – The Department will seek through legislative action in the N.C. General Assembly's 2011 session to extend the Commissioner's prior approval authority to include the small and large group market and association group plans sold to individuals for implementation as soon as is practical. With an increase in the volume of rate filings that will require our review, we expect to request a change to the time frames the statute gives the Department to act upon a filing before it is deemed approved. Our proposal will also include requiring that association group plans be subject to the same statutory review/approval standards as are applicable to true individual health insurance plans. These initiatives will increase the Department's review/approval authority to all types of health insurance insurers, plans and markets. It also will result in an increase in the volume of rate filings that are to be reviewed by the Department, and therefore will require the addition of new staff across several divisions since we are currently staffed to capacity with our existing level of authority. Proposed staffing requirements are discussed below. The Department expects that by increasing

our authority to review all types of health insurance rate filings, we will be able to monitor and regulate the health insurance markets more effectively and be more responsive to insurance consumers seeking information relating to their insurance and premiums. Further, we will be able to better respond to public officials and agencies as well as the news media, among others. Other than costs associated with new staffing which will be detailed below, the Department does not expect this enhancement to have specific costs associated with it.

Improving rate filing requirements – The Department intends to propose adoption of NAIC model laws or regulations relating to rate review that are associated with PPACA through 2011 legislation. This will keep North Carolina in compliance with uniformity standards which are intended to make the regulatory process less burdensome for insurers. The Department, either through adoption of the models or by our own proposed legislation or regulations, will strengthen the current data requirements associated with rate review in order to enhance our rate review activities by making specific aspects more rigorous. Additionally, the data reporting requirements found in the grant agreement will be added to our existing state data requirements so we can collect and report the information to the Secretary. Other ideas which are being considered include strengthening the initial rate filing requirements including more rate review upfront when an insurance plan is proposed new for approval; the use of additional loss ratio tests; and the review of administrative expenses, investment income, pricing margins, surplus levels and other factors. Enhanced requirements will result in more in depth review of rate revision filings with the potential for more filings to be disapproved or negotiated. Other than costs associated with additional staffing to assist in the new reviews and actuarial consultant reports (both detailed below), the Department does not expect this enhancement to have specific costs associated with it.

Enhancing rate review process – Staffing - The Department's workload will increase in response to PPACA's expanding many of our current operations to new products or markets and increasing our activities related to rate review. Further, implementing PPACA's medical loss ratio and rate review will require the addition of a qualified staff actuary as well as other staff and will also require the use of outside actuarial consultants. To meet the new work requirements, the Department proposed to the North Carolina General Assembly the addition of 13 new positions to be assigned healthcare reform duties. Eight of those positions are expected to be directly related to new and enhanced rate review activities. The new positions were approved by the General Assembly in the 2010 session. The Department will begin the hiring process immediately upon grant award notification. New staffing will allow the Department to increase the degree and detail of rate reviews. Further, additional staff could allow the

Department to streamline the rate review process and respond in a timelier manner. The Department expects $826,548 to be budgeted for salary and fringe benefits associated with this new staff. In addition to the hiring of new staff, the Department will solicit an independent actuarial firm to audit and review our current rate review process and make recommendations for enhancing the process including any recommended law changes. To the extent feasible, the Department will take that report under advisement and consider implementation of the recommendations made within it. Should that report recommend special market or type of product actuarial reviews, the Department may contract with outside actuaries to perform those activities. Contracts with outside actuarial firms or other entities are budgeted to be $150,000. The Department expects the requests for bids associated with the first actuarial review to be issued in the third quarter of 2010 with a report due by the end of 2010 in order to permit the submission of legislation should it be warranted. Travel costs will amount to $23,452

Enhancing rate review process-IT capacity - Given the NAIC's Speed to Market initiatives and the role SERFF plays in the rate and form filing and review process, it has been considered logical and cost effective to utilize SERFF in meeting many IT requirements as outlined in the grant. Based on the provisions of the grant and at the request of states, the NAIC has estimated the cost of leveraging SERFF. To that end, the NAIC has provided a description of deliverables, timeline and estimated cost. Because the information provided by the NAIC is based on limited knowledge of the HHS reporting requirements and will be refined once the uniform template and definitions for data reporting are provided, a cost estimate is not included here. The Department supports uniformity and intends to monitor this effort. It may contribute funds identified for use with contracts with outside entities to participate in this initiative. In addition to enhancements to SERFF, consideration may be given to contributing to the NAIC for enhancements to the NAIC I-Site database, development of other internal IT databases which could be accessed by Actuarial Services and the Life and Health Divisions, and the purchase of software to assist with rate review such as Towers Watson Medical Manual and Software.

Enhancing consumer protection standards – Because of issues with insurers identifying much of their rate submissions as proprietary, as permitted under N.C. law, the Department would propose increasing transparency to consumers by setting minimum standards of information submitted with a rate filing as a public record. Expectations are that at a minimum, the information which must be reported to the Secretary as outlined in the grant agreement would be mandated as public information. In addition, we will seek authority to require a standardized consumer-friendly summary of the rate filing be produced by insurers and submitted to the

Department along with all rate revision requests. That information will be available for the public to access through the Department's public web portal, and will be available upon request to the insurer. As part of the contract to review our rate review process, the Department may also seek input on how to enhance public participation in the rate review process. Some ideas which could be considered would be the use of public hearings to facilitate consumer input on proposed rate revisions, public comment periods, and involvement of consumer advisory boards. Other ideas that could be considered would require insurers to post minimal information on their websites relating to how rates are developed and increased and develop criteria which would automatically trigger a hearing for the public in relation to a rate filing. We expect to enhance our consumer complaint data collection to better identify complaints associated with rates and to better identify possible insurers for market regulation follow up. The Department does not expect these enhancements to require specific costs other than those associated with increased staffing.

Plan for Reporting to the Secretary on Rate Increase Patterns

The Department will comply with the reporting requirements outlined in statute and the grant agreement. The Department will adopt any standards of data submission that may be found within any models adopted by the NAIC relating to rate review. Additionally, the Department will engage in efforts on a national basis through the NAIC to standardize data submission, collection and reporting through the NAIC using SERFF or a similar application. If national efforts are not attained, or until such time as they are, the Department will seek authority to require the submission of data from insurers with all rate review filings. We will require the data be submitted in a standard format which can easily be analyzed and transferred to software for aggregation, analysis and submission to the Secretary. Many of the items identified in the Funding Opportunity Announcement are already required to some degree by our statutes and regulations. These statutes and/or rules will be updated to reflect the additional data required in order that N.C. may meet the reporting requirements.

Optional Data Center Funding – The Department will NOT be dedicating funds for the Data Center during this grant cycle.

GRANTS.GOV

Grant Application Package

Opportunity Title:	"Grants to States for Health Insurance Premium Review-C
Offering Agency:	Ofc of Consumer Information & Insurance Oversight
CFDA Number:	93.511
CFDA Description:	Affordable Care Act (ACA) Grants to States for Health I
Opportunity Number:	RFA-FD-10-999
Competition ID:	ADOBE-FORMS-B
Opportunity Open Date:	06/07/2010
Opportunity Close Date:	07/07/2010
Agency Contact:	Gladys Melendez-Bohler Grant Specialist E-mail: Gladys.Melendez-Bohler@fda.hhs.gov Phone: 301-827-7168

[redacted]

This opportunity is only open to organizations, applicants who are submitting grant applications on behalf of a company, state, local or tribal government, academia, or other type of organization.

*** Application Filing Name:** NC Dept of Insurance Grant Application

Mandatory Documents

Move Form to Complete

Move Form to Delete

Mandatory Documents for Submission

- Project/Performance Site Location(s)
- Budget Information for Non-Construction Program
- Assurances for Non-Construction Programs (SF-42
- Project Abstract
- Project Narrative Attachment Form
- Objective Work Plan

Optional Documents

- Basic Work Plan
- Project Abstract Summary
- Other Attachments Form

Move Form to Submission List

Move Form to Delete

Optional Documents for Submission

[redacted]

Enter a name for the application in the Application Filing Name field.

- This application can be completed in its entirety offline, however, you will need to login to the Grants.gov website during the submission process.
- You can save your application at any time by clicking the "Save" button at the top of your screen.
- The "Save & Submit" button will not be functional until all required data fields in the application are completed and you clicked on the "Check Package for Errors" button and confirmed all data required data fields are completed.

Open and complete all of the documents listed in the "Mandatory Documents" box. Complete the SF-424 form first.

- It is recommended that the SF-424 form be the first form completed for the application package. Data entered on the SF-424 will populate data fields in other mandatory and optional forms and the user cannot enter data in these fields.

- The forms listed in the "Mandatory Documents" box and "Optional Documents" may be predefined forms, such as SF-424, forms where a document needs to be attached, such as the Project Narrative or a combination of both. "Mandatory Documents" are required for this application. "Optional Documents" can be used to provide additional support for this application or may be required for specific types of grant activity. Reference the application package instructions for more information regarding "Optional Documents".

- To open and complete a form, simply click on the form's name to select the item and then click on the => button. This will move the document to the appropriate "Documents for Submission" box and the form will be automatically added to your application package. To view the form, scroll down the screen or select the form name and click on the "Open Form" button to begin completing the required data fields. To remove a form/document from the "Documents for Submission" box, click the document name to select it, and then click the <= button. This will return the form/document to the "Mandatory Documents" or "Optional Documents" box.

- All documents listed in the "Mandatory Documents" box must be moved to the "Mandatory Documents for Submission" box. When you open a required form, the fields which must be completed are highlighted in yellow with a red border. Optional fields and completed fields are displayed in white. If you enter invalid or incomplete information in a field, you will receive an error message.

Click the "Save & Submit" button to submit your application to Grants.gov.

- Once you have properly completed all required documents and attached any required or optional documentation, save the completed application by clicking on the "Save" button.
- Click on the "Check Package for Errors" button to ensure that you have completed all required data fields. Correct any errors or if none are found, save the application package.
- The "Save & Submit" button will become active, click on the "Save & Submit" button to begin the application submission process.
- You will be taken to the applicant login page to enter your Grants.gov username and password. Follow all onscreen instructions for submission.

OMB Number: 4040-0004
Expiration Date: 03/31/2012

Application for Federal Assistance SF-424

* 1 Type of Submission:	* 2 Type of Application:	* If Revision, select appropriate letter(s):
☐ Preapplication	☒ New	
☒ Application	☐ Continuation	* Other (Specify):
☐ Changed/Corrected Application	☐ Revision	

* 3 Date Received	4. Applicant Identifier:
Completed by Grants.gov upon submission.	

5a. Federal Entity Identifier:	5b. Federal Award Identifier:

State Use Only:

6 Date Received by State	7 State Application Identifier:

8. APPLICANT INFORMATION:

* a Legal Name:	North Carolina Department of Insurance
* b Employer/Taxpayer Identification Number (EIN/TIN):	56-1401519
* c. Organizational DUNS:	0618161330000

d. Address:

* Street1:	1201 Mail Service Center
Street2:	
* City:	Raleigh
County/Parish:	
* State:	NC: North Carolina
Province:	
* Country:	USA: UNITED STATES
* Zip / Postal Code:	27699-1201

e. Organizational Unit:

Department Name:	Division Name:
Technical Services Group	

f. Name and contact information of person to be contacted on matters involving this application:

Prefix:	Mr.	* First Name:	Ernest
Middle Name:			
* Last Name:	Nickerson		
Suffix:			

Title:	Senior Deputy Commissioner
Organizational Affiliation:	
* Telephone Number:	919-807-6870
Fax Number:	919-807-6858
* Email:	ernest.nickerson@ncdoi.gov

Application for Federal Assistance SF-424

*** 9. Type of Applicant 1: Select Applicant Type:**

A: State Government

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

*** 10. Name of Federal Agency:**

Ofc of Consumer Information & Insurance Oversight

11. Catalog of Federal Domestic Assistance Number:

93.511

CFDA Title:

Affordable Care Act (ACA) Grants to States for Health Insurance Premium Review

*** 12. Funding Opportunity Number:**

RFA-FD-10-999

* Title:

"Grants to States for Health Insurance Premium Review-Cycle I" Office of Consumer Information and Insurance Oversight (OCIIO)

13. Competition Identification Number:

ADOBE-FORMS-B

Title:

14. Areas Affected by Project (Cities, Counties, States, etc.):

Add Attachment | Delete Attachment | View Attachment

*** 15. Descriptive Title of Applicant's Project:**

Premium Review Grant

Attach supporting documents as specified in agency instructions.

Add Attachments | Delete Attachments | View Attachments

Application for Federal Assistance SF-424

16. Congressional Districts Of:

* a. Applicant: NC-002 | b. Program/Project: NC-all

Attach an additional list of Program/Project Congressional Districts if needed.

Add Attachment | Delete Attachment | View Attachment

17. Proposed Project:

* a Start Date: 08/09/2010 | * b. End Date: 09/30/2011

18. Estimated Funding ($):

* a Federal	1,000,000.00
* b Applicant	0.00
* c State	341,775.00
* d Local	0.00
* e Other	0.00
* f. Program Income	0.00
* g TOTAL	1,341,775.00

*** 19. Is Application Subject to Review By State Under Executive Order 12372 Process?**

- ☐ a. This application was made available to the State under the Executive Order 12372 Process for review on
- ☐ b. Program is subject to E.O. 12372 but has not been selected by the State for review.
- ☒ c. Program is not covered by E.O. 12372.

*** 20. Is the Applicant Delinquent On Any Federal Debt? (If "Yes," provide explanation in attachment.)**

☐ Yes ☒ No

If "Yes", provide explanation and attach

Add Attachment | Delete Attachment | View Attachment

21. "By signing this application, I certify (1) to the statements contained in the list of certifications"* and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances"* and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 218, Section 1001)

☒ "* I AGREE

"* The list of certifications and assurances, or an internet site where you may obtain this list, is contained in the announcement or agency specific instructions

Authorized Representative:

Prefix	Mr.
* First Name	Louis
Middle Name	
* Last Name	Belo
Suffix	
* Title	Chief Deputy Comissioner
* Telephone Number	919-733-0433
Fax Number	
* Email	louis.belo@ncdoi.gov
* Signature of Authorized Representative:	Completed by Grants.gov upon submission
* Date Signed	Completed by Grants.gov upon submission 7/7/2010

OMB Number: 4040-0003
Expiration Date: 7/30/2011

Key Contacts Form

*** Applicant Organization Name:**

North Carolina Department of Insurance

Enter the individual's role on the project (e.g., project manager, fiscal contact).

*** Contact 1 Project Role:** Project Manager

Prefix:	Mr.
* First Name:	Ernest
Middle Name:	
* Last Name:	Nickerson
Suffix:	
Title:	Senior Deputy Commissioner

Organizational Affiliation:

* Street1:	1201 Mail Service Center
Street2:	
* City:	Raleigh
County:	
* State:	NC: North Carolina
Province:	
* Country:	USA: UNITED STATES
* Zip / Postal Code:	27699
* Telephone Number:	919-807-6870
Fax:	919-807-6858
* Email:	ernest.nickerson@ncdoi.gov

Delete Entry

Next Person

OMB Number: 4040-0010
Expiration Date: 08/31/2011

Project/Performance Site Location(s)

Project/Performance Site Primary Location ☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name: North Carolina Department of Insurance

DUNS Number:

* Street1: 1201 Mail Service Center

Street2:

* City: Raleigh County: Wake

* State: NC: North Carolina

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: 27699-1201 * Project/ Performance Site Congressional District: NC-all

Project/Performance Site Location 1 ☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization

Organization Name:

DUNS Number:

* Street1:

Street2:

* City: County:

* State:

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: * Project/ Performance Site Congressional District:

Additional Location(s) Add Attachment Delete Attachment View Attachment

ATTACHMENTS FORM

Instructions: On this form, you will attach the various files that make up your grant application. Please consult with the appropriate Agency Guidelines for more information about each needed file. Please remember that any files you attach must be in the document format and named as specified in the Guidelines.

Important: Please attach your files in the proper sequence. See the appropriate Agency Guidelines for details.

1) Please attach Attachment 1		Add Attachment	Delete Attachment	View Attachment
2) Please attach Attachment 2		Add Attachment	Delete Attachment	View Attachment
3) Please attach Attachment 3		Add Attachment	Delete Attachment	View Attachment
4) Please attach Attachment 4		Add Attachment	Delete Attachment	View Attachment
5) Please attach Attachment 5		Add Attachment	Delete Attachment	View Attachment
6) Please attach Attachment 6		Add Attachment	Delete Attachment	View Attachment
7) Please attach Attachment 7		Add Attachment	Delete Attachment	View Attachment
8) Please attach Attachment 8		Add Attachment	Delete Attachment	View Attachment
9) Please attach Attachment 9		Add Attachment	Delete Attachment	View Attachment
10) Please attach Attachment 10		Add Attachment	Delete Attachment	View Attachment
11) Please attach Attachment 11		Add Attachment	Delete Attachment	View Attachment
12) Please attach Attachment 12		Add Attachment	Delete Attachment	View Attachment
13) Please attach Attachment 13		Add Attachment	Delete Attachment	View Attachment
14) Please attach Attachment 14		Add Attachment	Delete Attachment	View Attachment
15) Please attach Attachment 15		Add Attachment	Delete Attachment	View Attachment

OMB Number: 0980-0204
Expiration Date: 12/31/2009

Objective Work Plan

Project:

Premium Review Grant

* Year: * Funding Agency Goal:

* Objective:

* Results or Benefits Expected:

* Activities	* Position Responsible	* Time Period Begin	* Time Period End	* Non-Salary Personnel Hours

OMB Number: 0960-0204
Expiration Date: 12/31/2009

Objective Work Plan

* Activities	* Position Responsible	* Time Period Begin	* Time Period End	* Non-Salary Personnel Hours

* Criteria for Evaluating Results or Benefits Expected:

OMB Number: 0980-0204
Expiration Date: 12/31/2009

Objective Work Plan

You may attach up to 17 additional Objective Work Plan forms here. To extract, fill and attach each additional form, follow these steps:

- Select the "Select to Extract the Objective Work Plan Attachment" button below.

- Save the file using a descriptive name to help you remember the content of the supplemental form that you are creating. When assigning a name to the file, please remember to give it the extension ".pdf" (for example, "Objective_1.pdf"). If you do not name your file with the ".pdf" extension you will be unable to open it later, using Adobe Reader.

- Use the "Open Form" tool on Adobe Reader to open the new form you just saved.

- Enter your additional Objective information in this supplemental form, similar to the Objective Work Plan form that you see in the main body of your application.

- When you have completed entering information in the supplemental form, save and close it.

- Return to this page and attach the saved supplemental form you just filled in, to one of the blocks provided on this "attachments" form.

Important: Attach additional Objective Work Plan forms, using the blocks below. Please remember that the files you attach must be Objective Work Plan PDF forms that were previously extracted using the process outlined above. Attaching any other type of file may result in the inability to submit your application to Grants.gov. Note: It is important to attach completed forms only. Attach ONLY PDF (.pdf) forms where ALL required fields are filled out. Incomplete or missing data will cause your application to be rejected.

Select to extract the Objective Work Plan Attachment

1) Please attach Attachment 1		Add Attachment	Delete Attachment	View Attachment
2) Please attach Attachment 2		Add Attachment	Delete Attachment	View Attachment
3) Please attach Attachment 3		Add Attachment	Delete Attachment	View Attachment
4) Please attach Attachment 4		Add Attachment	Delete Attachment	View Attachment
5) Please attach Attachment 5		Add Attachment	Delete Attachment	View Attachment
6) Please attach Attachment 6		Add Attachment	Delete Attachment	View Attachment
7) Please attach Attachment 7		Add Attachment	Delete Attachment	View Attachment
8) Please attach Attachment 8		Add Attachment	Delete Attachment	View Attachment
9) Please attach Attachment 9		Add Attachment	Delete Attachment	View Attachment
10) Please attach Attachment 10		Add Attachment	Delete Attachment	View Attachment
11) Please attach Attachment 11		Add Attachment	Delete Attachment	View Attachment
12) Please attach Attachment 12		Add Attachment	Delete Attachment	View Attachment
13) Please attach Attachment 13		Add Attachment	Delete Attachment	View Attachment
14) Please attach Attachment 14		Add Attachment	Delete Attachment	View Attachment
15) Please attach Attachment 15		Add Attachment	Delete Attachment	View Attachment
16) Please attach Attachment 16		Add Attachment	Delete Attachment	View Attachment
17) Please attach Attachment 17		Add Attachment	Delete Attachment	View Attachment

OMB Number: 4040-0003
Expiration Date: 09/30/2011

Project Abstract

The Project Abstract must not exceed one page and must contain a summary of the proposed activity suitable for dissemination to the public. It should be a self-contained description of the project and should contain a statement of objectives and methods to be employed. It should be informative to other persons working in the same or related fields and insofar as possible understandable to a technically literate lay reader. This Abstract must not include any proprietary/confidential information.

* Please click the add attachment button to complete this entry.

Add Attachment | Delete Attachment | View Attachment

Project Narrative File(s)

* Mandatory Project Narrative File Filename:

Add Mandatory Project Narrative File | Delete Mandatory Project Narrative File | View Mandatory Project Narrative File

To add more Project Narrative File attachments, please use the attachment buttons below.

Add Optional Project Narrative File | Delete Optional Project Narrative File | View Optional Project Narrative File

Budget Narrative File(s)

* Mandatory Budget Narrative Filename:

Add Mandatory Budget Narrative | Delete Mandatory Budget Narrative | View Mandatory Budget Narrative

To add more Budget Narrative attachments, please use the attachment buttons below.

Add Optional Budget Narrative | Delete Optional Budget Narrative | View Optional Budget Narrative

BUDGET INFORMATION - Non-Construction Programs

OMB Approval No. 4040-0006
Expiration Date 07/30/2010

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. Technical Serivces		$	$	$ 1,000,000.00	$ 341,775.00	$ 1,341,775.00
2.						
3.						
4.						
5. Totals		$	$	$ 1,000,000.00	$ 341,775.00	$ 1,341,775.00

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY (1)	(2)	(3)	(4)	Total (5)
	Technical Serivces				
a. Personnel	$ 644,707.00	$	$	$	$ 644,707.00
b. Fringe Benefits	181,841.00				181,841.00
c. Travel	23,452.00				23,452.00
d. Equipment					
e. Supplies					
f. Contractual	150,000.00				150,000.00
g. Construction					
h. Other					
i. Total Direct Charges (sum of 6a-6h)	1,000,000.00				$ 1,000,000.00
j. Indirect Charges					$
k. TOTALS (sum of 6i and 6j)	$ 1,000,000.00	$	$	$	$ 1,000,000.00
7. Program Income	$	$	$	$	$

SECTION C - NON-FEDERAL RESOURCES

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e)TOTALS
8. Technical Services	$	$ 341,775.00	$	$ 341,775.00
9.				
10.				
11.				
12. TOTAL (sum of lines 8-11)	$	$ 341,775.00	$	$ 341,775.00

SECTION D - FORECASTED CASH NEEDS

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	$ 1,000,000.00	$ 250,000.00	$ 250,000.00	$ 250,000.00	$ 250,000.00
14. Non-Federal	$ 341,775.00	85,443.75	85,443.75	85,443.75	85,443.75
15. TOTAL (sum of lines 13 and 14)	$ 1,341,775.00	$ 335,443.75	$ 335,443.75	$ 335,443.75	$ 335,443.75

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT

(a) Grant Program	FUTURE FUNDING PERIODS (YEARS) (b)First	(c) Second	(d) Third	(e) Fourth
16. Technical Services	$ 1,000,000.00	$ 1,170,043.00	$ 1,170,043.00	$ 1,170,043.00
17.				
18.				
19.				
20. TOTAL (sum of lines 16 - 19)	$ 1,000,000.00	$ 1,170,043.00	$ 1,170,043.00	$ 1,170,043.00

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges: 1st year - salary, benefits, contractual, travel

22. Indirect Charges:

23. Remarks:

OMB Approval No.: 4040-0007
Expiration Date: 07/30/2010

ASSURANCES - NON-CONSTRUCTION PROGRAMS

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

NOTE: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant, I certify that the applicant:

1. Has the legal authority to apply for Federal assistance and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project cost) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States and, if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C.§§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee- 3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and, (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally-assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally-assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P L. 91-190) and Executive Order (EO) 11514, (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clean Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (P.L. 93-523); and, (h) protection of endangered species under the Endangered Species Act of 1973, as amended (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U S.C. §§4801 et seq.) which prohibits the use of lead-based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations, and policies governing this program.

* SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	* TITLE
Completed on submission to Grants.gov	Chief Deputy Comissioner
* APPLICANT ORGANIZATION	* DATE SUBMITTED
North Carolina Department of Insurance	Completed on submission to Grants.gov 7/7/2010

Standard Form 424B (Rev. 7-97) Back

DISCLOSURE OF LOBBYING ACTIVITIES

Complete this form to disclose lobbying activities pursuant to 31 U.S.C.1352

Approved by OMB
0348-0046

1. * Type of Federal Action:
- [ ] a contract
- [x] b grant
- [ ] c cooperative agreement
- [ ] d loan
- [ ] e loan guarantee
- [ ] f loan insurance

2. * Status of Federal Action:
- [ ] a bid/offer/application
- [x] b initial award
- [ ] c post-award

3. * Report Type:
- [x] a initial filing
- [ ] b material change

4. Name and Address of Reporting Entity:

[x] Prime [ ] SubAwardee

* Name: North Carolina Department of Insurance

* Street 1: 1201 Mail Service Center | Street 2:

* City: Raleigh | State: NC: North Carolina | Zip: 27699

Congressional District, if known:

5. If Reporting Entity in No.4 is Subawardee, Enter Name and Address of Prime:

6. * Federal Department/Agency:

hhs/OCIIO

7. * Federal Program Name/Description:

Affordable Care Act (ACA) Grants to States for Health Insurance Premium Review

CFDA Number, if applicable: 93.511

8. Federal Action Number, *if known:*

9. Award Amount, *if known:*

$

10. a. Name and Address of Lobbying Registrant:

Prefix: | * First Name: N/A | Middle Name:

* Last Name: N/A | Suffix:

* Street 1: | Street 2:

* City: | State: | Zip:

b. Individual Performing Services (including address if different from No. 10a)

Prefix: | * First Name: N/A | Middle Name:

* Last Name: N/A | Suffix:

* Street 1: | Street 2:

* City: | State: | Zip:

11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when the transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

* Signature: [signature]

*Name: Prefix: Mr. | * First Name: Keith | Middle Name:

* Last Name: Bell | Suffix:

Title: Chief Deputy Commissioner | Telephone No.: 919-733-0433 | Date: 7/1/2010

Authorized for Local Reproduction
Standard Form - LLL (Rev. 7-97)

APPENDIX C - SUMMARY OF PRODUCTS AND ASSOCIATED GOVERNING LAWS

As of 10/1/2009 Insurance Type	Indemnity Department Action	Ind. Medical Underwriting (Y/N)	Underwriting At Renewal (Y/N)	Health Insuring Corp. Department Action
Individual				
Individual	Prior Approval Required 30 Day Deemer	Y	N (ORC 3923.15)	Prior Approval Required 60 Day Deemer
Short Term	Prior Approval Required 30 Day Deemer	Y	Y	N/A
Non-Employer Based				
Association Group Trust (Individual Market) ERISA	Prior Approval Required 30 Day Deemer	Y	Y	N/A
Conversion to Individual Coverage (Basic and Standard)				
Non-FEI :Any Individual Contract Available	Prior Approval Required 30 Day Deemer (Must have Small or Large Group)	Y	N	Prior Approval Required 60 Day Deemer (Must have Small or Large Group)
Basic & Standard: FEI	Prior Approval Required 30 Day Deemer (Must have Small or Large Group)	Y	N	Prior Approval Required 60 Day Deemer (Must have Small or Large Group)
Open Enrollment (Basic and Standard)				
Pre-HIPPA: non-FEI	Prior Approval Required 30 Day Deemer (Must have Individual or Non-Employer Business)	Y	N	Prior Approval Required 60 Day Deemer (no new business on state held OE)
HIPPA: FEI	Prior Approval Required 30 Day Deemer (Must have Individual or Non-Employer Business)	Y	N	Prior Approval Required 60 Day Deemer (Must have Individual or Non-Employer Business)
Group				
Employer Based				
Fully Insured Group:				
Small Employer (Group Policy) (2-50 as defined in ORC 3924.01N)	File and Use (Rates Maintained On File) Small Group Cert Required	Y	+/- 15% Limit	File and Use (Accept or Reject- 30 Day Process Deemer) Small Group Cert Required
Large Employer (51 and greater)	File and Use (Rates Maintained On File)	Y	Y	File and Use (Accept or Reject- 30 Day Process Deemer)
Self Insured HBP: Health Benefit Plan				
MEWA	No Rate Review Regulation Cert Required	N/A	N/A	N/A
Supplemental HIC	N/A	Y	N	Prior Approval Required 60 Day Deemer
Long Term Care (Individual)	Prior Approval Required 30 Day Deemer	Y	N	N/A
Group	File and Use (Rates Maintained On File)	Y	N	
Medicare Supplemental (Group & Individual)	Prior Approval Required 30 Day Deemer	Y N- open enrollment	N	Admin must be actual. And rate and doc must be on file.
Medicaid	N/A	N/A	N/A	Admin must be actual. And rate and doc must be on file.