CHAPTER 16 - ACTUARIAL SERVICES DIVISION

SECTION .0100 - FIRE AND CASUALTY STATISTICAL DATA

11 NCAC 16 .0101 APPLICABILITY

The following Rules describe statistical data that shall be submitted to the Actuarial Services Division.

(1) 11 NCAC 16 .0103 shall apply to all companies that write North Carolina nonfleet private passenger automobile insurance and to all statistical organizations that collect data relating to that line of insurance.

(2) 11 NCAC 16 .0105 shall apply to all companies that provide professional liability insurance to more than two percent of the insured physicians and surgeons in North Carolina.

(3) 11 NCAC 16 .0106 shall apply to all companies that write North Carolina credit property insurance.

(4) 11 NCAC 16 .0107 shall apply to all companies that write North Carolina nonfiling insurance.

History Note: *Authority G.S. 58-2-40(1); 58-2-190;*
Eff. December 1, 1990;
Amended Eff. July 1, 2011;
Readopted Eff. October 1, 2018.

11 NCAC 16 .0102 LOSS RESERVES

History Note: *Authority G.S. 58-2-40; 58-2-190;*
Eff. December 1, 1990;
Amended Eff. August 1, 1991;
Repealed Eff. July 1, 2011.

11 NCAC 16 .0103 NONFLEET PRIVATE PASSENGER AUTOMOBILE INSURANCE

All companies writing North Carolina nonfleet private passenger automobile insurance shall collect the statistical data described in this Rule and shall report such data to their statistical agent. The statistical agents shall thereupon provide the data on a combined basis to the Actuarial Services Division.

(1) Premium, Exposure, Loss, and Claim Experience. Provide written and earned exposures, written and earned premiums, number of paid and incurred claims, and paid and incurred total limit losses biannually for each of the latest six accident or calendar half-years in the following detail:
   (a) by coverage as follows: bodily injury, property damage, medical payments, uninsured motorist, underinsured motorist, comprehensive, or collision;
   (b) by type of exposure as follows: voluntary, or involuntary;
   (c) by territory;
   (d) by class;
   (e) by basic or increased limit or deductible; and
   (f) by cause or type of loss for comprehensive coverage.

(2) Loss and Premium Experience by Zip Code. Provide data by zip code annually in the following detail:
   (a) calendar year written premium for all coverages combined;
   (b) accident year incurred losses and incurred claims valued at 15 months for bodily injury and property damage coverages;
   (c) calendar year incurred losses and incurred claims for comprehensive and collision coverages;
   (d) calendar year voluntary written exposures separately for bodily injury and property damage, comprehensive, and collision;
   (e) calendar year involuntary written exposures for bodily injury and property damage;
   (f) calendar year substandard written exposures for comprehensive and collision; and
   (g) calendar year written exposures for bodily and property damage by class.

(3) Loss Trend Experience. Provide earned exposures, earned premiums, number of paid or incurred claims, paid or incurred losses, loss frequency, and loss severity for each of the latest 16 three-month and twelve-month calendar periods ending quarterly in the following detail:

(a) for bodily injury coverage:
  (i) basic limits and total limits paid trends including allocated loss adjustment expense;
  (ii) basic limits and total limits paid trends excluding allocated loss adjustment expense;
  (iii) basic limits and total limits incurred trends including allocated loss adjustment expense; and
  (iv) basic limits and total limits incurred trends excluding allocated loss adjustment expense.
(b) for property damage coverage, the same trends required for bodily injury.
(c) for medical payments coverage, total limits paid trend excluding allocated loss adjustment expense.
(d) for uninsured motorist bodily injury coverage:
  (i) total limits paid trend excluding allocated loss adjustment expense; and
  (ii) total limits incurred trend excluding allocated loss adjustment expense.
(e) for comprehensive coverage:
  (i) paid trend excluding allocated loss adjustment expense for exposures with no deductible;
  (ii) paid trend excluding allocated loss adjustment expense separately for exposures with deductibles of fifty dollars ($50.00), one hundred dollars ($100.00), two hundred dollars ($200.00), two hundred fifty dollars ($250.00), five hundred dollars ($500.00), and one thousand dollars ($1000.00); and
  (iii) paid trend excluding allocated loss adjustment expense for all exposures not otherwise included.
(f) for collision coverage:
  (i) paid trend excluding allocated loss adjustment expense separately for exposures with deductibles of fifty dollars ($50.00), one hundred dollars ($100.00), two hundred dollars ($200.00), two hundred fifty dollars ($250.00), five hundred dollars ($500.00), and one thousand dollars ($1000.00); and
  (ii) paid trend excluding allocated loss adjustment expense for all exposures not otherwise included.

(4) Liability Loss Development Experience. Provide loss and earned exposure data for fiscal accident years ending June 30 and December 31 at annual evaluation dates from 15 to 63 months for at least ten years in the following detail:
(a) for bodily injury and property damage coverages, separately detail the coverages for voluntary business and for business ceded to the North Carolina Reinsurance Facility and also provide the total for both types of business:
  (i) basic limits paid losses;
  (ii) basic limits incurred losses;
  (iii) total limits paid losses;
  (iv) total limits incurred losses;
  (v) paid claims;
  (vi) incurred claims;
  (vii) earned premium for the corresponding calendar year; and
  (viii) earned exposures for the corresponding calendar year.
(b) for medical payments coverage, separately detail the coverages for voluntary business and for business ceded to the North Carolina Reinsurance Facility and also provide the total for both types of business:
  (i) total limits paid losses;
  (ii) total limits incurred losses;
  (iii) paid claims;
  (iv) incurred claims;
  (v) earned premium for the corresponding calendar year; and
  (vi) earned exposures for the corresponding calendar year.
(c) for uninsured and underinsured motorist coverage:
  (i) total limits paid losses;

(ii) total limits incurred losses;
(iii) paid claims;
(iv) incurred claims;
(v) estimated (actual if available) earned premium for the corresponding calendar year; and
(vi) estimated (actual if available) earned exposures for the corresponding calendar year.

(5) Physical Damage Age and Symbol Trend Experience. Provide the average age and symbol value for each of the latest twenty half-year periods ending June 30 and December 31 for the following coverages:
(a) full coverage comprehensive;
(b) comprehensive coverage with a fifty dollar ($50.00) deductible;
(c) comprehensive coverage with a one hundred dollar ($100.00) deductible;
(d) collision coverage with a one hundred dollar ($100.00) deductible;
(e) collision coverage with a two hundred fifty dollar ($250.00) deductible; and
(f) collision coverage with a five hundred dollar ($500.00) deductible.

History Note: *Authority G.S. 58-2-40; 58-2-190;*
Eff. December 1, 1990;
Readopted Eff. October 1, 2018.

11 NCAC 16 .0104 PROFESSIONAL LIABILITY INSURANCE

History Note: *Authority G.S. 58-2-170; 58-2-190;*
Eff. December 1, 1990;
Repealed Eff. July 1, 2011.

11 NCAC 16 .0105 PHYSICIANS AND SURGEONS PROFESSIONAL LIABILITY INSURANCE
Companies that insure more than two percent of the insured physicians and surgeons in North Carolina shall submit the following data upon request, evaluated as of December 31 to the Actuarial Services Division:

(1) number of insured doctors by speciality;
(2) basic limits losses and ultimate claims for the most recent ten accident or report years;
(3) class one frequency, basic limits severity, and basic limits pure premium for the most recent ten accident or report years;
(4) exposure distributions separately by class, by maturity, and by increased limits factor for the most recent ten calendar years; and
(5) percentage of claims closed with neither a loss payment nor an allocated loss adjustment payment and the percentage of claims closed with only an allocated loss adjustment payment for the most recent ten calendar and for the most recent ten accident or report years.

History Note: *Authority G.S. 58-2-40(1); 58-2-190; 58-41-50(e)(14);*
Eff. December 1, 1990;
Readopted Eff. October 1, 2018.

11 NCAC 16 .0106 CREDIT PROPERTY INSURANCE
Each writer of North Carolina credit property insurance shall submit the data described in this Rule upon request to the Actuarial Services Division.

(1) North Carolina premium, loss, and expense:
(a) written premium;
(b) earned premium;
(c) paid losses and claims;
(d) incurred losses and claims;
(e) paid loss adjustment expense;
(f) incurred loss adjustment expense;
(g) incurred commissions and brokerage expenses;
(h) incurred other acquisition costs;

(i) incurred premium taxes;
(j) other incurred expenses;
(k) incurred loss and loss adjustment expense ratio;
(l) incurred loss, loss adjustment expense, and other underwriting expense ratio;
(m) dividends paid;
(n) retrospective rate credits paid; and
(o) commissions paid.

(2) Investment income on loss, loss expense, and unearned premium reserves:
(a) loss reserve at the beginning of the year;
(b) loss reserve at the end of the year;
(c) loss expense reserve at the beginning of the year;
(d) loss expense reserve at the end of the year;
(e) unearned premium reserve at the beginning of the year;
(f) unearned premium reserve at the end of the year; and
(g) investment income earned on loss, loss expense, and unearned premium reserves.

(3) Nonrefundable fees collected.
(a) total number of transactions;
(b) transactions involving insured values less than two hundred fifty dollars ($250.00);
(c) transactions involving insured values of two hundred fifty dollars ($250.00) or more but less than five hundred dollars ($500.00); and
(d) transactions involving insured values of five hundred dollars ($500.00) or more.

(4) Insured values:
(a) insured values for single interest insurance at the beginning of the year;
(b) insured values for single interest insurance at the end of the year;
(c) insured values for dual interest insurance at the beginning of the year; and
(d) insured values for dual interest insurance at the end of the year.

(5) Supplementary information:
(a) identification of the Page 14 Annual Statement line under which the experience is reported; and
(b) explanations of any change in the amounts reported in Subparagraphs (1)(a), (1)(k) and (1)(l) of this Rule that is greater than 50 percent of the previous calendar year's value.

History Note: *Authority G.S. 58-2-40; 58-57-90(b);*
Eff. December 1, 1990;
Amended Eff. September 1, 1991;
Readopted Eff. March 21, 2019.

11 NCAC 16 .0107 NONFILING INSURANCE

Writers of North Carolina nonfiling insurance shall submit the following information upon request to the Actuarial Services Division:

(1) written premium;
(2) earned premium;
(3) earned exposures;
(4) incurred losses;
(5) number of incurred claims; and
(6) incurred expenses.

History Note: *Authority G.S. 53-177; 58-2-40(1);*
Eff. December 1, 1990;
Readopted Eff. March 21, 2019.

11 NCAC 16 .0108 SINGLE OR DUAL INTEREST AUTOMOBILE PHYSICAL DAMAGE INSURANCE

Writers of North Carolina Single or Dual Interest Automobile Physical Damage Insurance shall submit the following data described in this Rule upon request to the Actuarial Services Division.

(1) North Carolina premium, loss, and expense:

(a) written premium and car year exposures;
(b) earned premium and car year exposures;
(c) paid losses and claims;
(d) incurred losses and claims;
(e) paid loss adjustment expense;
(f) incurred loss adjustment expense;
(g) incurred commissions and brokerage expenses;
(h) incurred other acquisition costs;
(i) incurred premium taxes;
(j) other incurred expenses;
(k) incurred loss and loss adjustment expense ratio;
(l) incurred loss, loss adjustment expense and other underwriting expense ratio; and
(m) policyholder dividends paid.

(2) Investment income on loss, loss expense, and unearned premium reserves:
(a) loss reserve at the beginning of the year;
(b) loss reserve at the end of the year;
(c) loss expense reserve at the beginning of the year;
(d) loss expense reserve at the end of the year;
(e) unearned premium reserve at the beginning of the year;
(f) unearned premium reserve at the end of the year; and
(g) investment unearned income earned on loss, loss expense, and unearned premium reserves.

(3) Insured values:
(a) insured values for single interest insurance at the beginning of the year;
(b) insured values for single interest insurance at the end of the year;
(c) insured values for dual interest insurance at the beginning of the year; and
(d) insured values for dual interest insurance at the end of the year.

(4) Supplementary information: identification of the Annual Statement line of business under which the experience is reported on the state page of the NAIC Annual Statement.

History Note: *Authority G.S. 58-2-40; 58-57-100;*
Eff. September 1, 1991;
Readopted Eff. October 1, 2018.

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 non-cancelable 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 (NAIC) 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 forms 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;
Readopted Eff. October 1, 2018.

11 NCAC 16 .0202 ACCIDENT AND HEALTH INSURANCE RENEWABILITY DEFINITIONS

With respect to all individual accident and health insurance in this State, the following renewability definitions or substantively similar wording as the Commissioner approves shall be used:

(1) Conditionally Renewable - Renewal may be declined for stated reasons, except for the deterioration of health of an individual insured, provided that the declination applies to all insureds in this state insured under the same policy or rider.

(2) Guaranteed Renewable - Renewal may not be declined by an insurance company for any reason, but the insurance company may revise rates on a class basis.

(3) Non-cancelable - Renewal may not be declined nor may rates be revised by an insurance company.

History Note: *Authority G.S. 58-2-40; 58-51-95; 58-63-15(7)b.;*
Eff. March 1, 1992;
Readopted Eff. October 1, 2018.

11 NCAC 16 .0203 CONDITIONALLY RENEWABLE STATED REASON PROHIBITED

For policies or riders permitting the adjustment of premiums for which the insurer retains the right to nonrenew, no insurer shall exercise a right not to renew for the following reason or any synonymous reason:

"The insurer is prevented by any law, or any regulation, or any ruling of a government agency from using a table of premium rates that the insurer has certified as being reasonable in relation to the benefits provided under the policy."

History Note: *Authority G.S. 58-2-40; 58-51-20;*
Eff. March 1, 1992;
Readopted Eff. October 1, 2018.

11 NCAC 16 .0204 OPTIONALLY RENEWABLE PROHIBITED

No policy of accident, health, or accident and health insurance shall contain a provision that permits the insurer to refuse to renew the coverage of an individual insured based upon the deterioration of health of an individual insured or based upon the claim experience of an individual insured. As used in this Rule, "policy" shall include an endorsement, rider, or any amendment to a policy.

History Note: *Authority G.S. 58-2-40; 58-51-95; 58-63-15(7)b;*
Eff. March 1, 1992;
Readopted Eff. October 1, 2018.

11 NCAC 16 .0205 DATA REQUIREMENTS FOR RATE REVISION SUBMISSION

(a) With respect to any individual accident and health insurance policy governed by G.S. 58, Articles 1 through 64, 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 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 by the Division. 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 "Additional Data Requirements" subsection shall include:

(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; such as guaranteed renewable;

(6) the type of coverage provided by each policy form; such as medical expense;

(7) identification of the type of rating methodology; such as issue age, attained age, or community rate;

(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 date;

(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 divided 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 that 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 that 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 that experience is recorded;

(20) a count of the number of incurred claims for each calendar year of data provided. The count shall be calculated by adding 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, shall 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 shall 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; and

(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 shall not be 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;
Readopted Eff. October 1, 2018.

11 NCAC 16 .0206 CLASS DEFINITION RESTRICTION

With respect to individual accident and health insurance policies for which the adjustment of premium rates is allowed by law, the insurer shall not establish, for rate revision purposes, a class within a policy form or group of policy forms so as to eliminate the possibility of new entrants into the class. This Rule shall not preclude actuarially justified apportionments of aggregate rate revisions on either open or closed blocks of business between classes established at the time the policy form or group of policy forms were approved by the Commissioner.

History Note: *Authority G.S. 58-2-40(1); 58-51-95; 58-63-15(7)b;*
Eff. June 1, 1992;
Readopted Eff. October 1, 2018.

11 NCAC 16 .0207 COMMON BLOCK

(a) As used in this Rule, "Common Block" means a grouping of similar policy form types for which the pooling of experience is actuarially justified and for which the rate revisions are based upon the common experience. A Common Block may include both open and closed policy form types.
(b) If a company establishes a Common Block for compliance with G.S. 58-51-95(h), with respect to all future rate revision filings, the company shall request a common uniform rate revision to apply to all policy forms in the Common Block and shall not request an apportionment by form. If policy forms are grouped into a Common Block, they shall remain grouped for future rate filings. Actuarially justified apportionments of the common rate increase, due to differences in benefits between forms, shall be allowed.
(c) If a company establishes a Common Block for compliance with G.S. 58-51-95(h), the Closed Block portion of policy forms that make up the Common Block shall comply with G.S. 58-3-275.

History Note: *Authority G.S. 58-2-40; 58-3-275; 58-51-95; 58-63-15(7)b;*
Eff. July 1, 2006;
Readopted Eff. October 1, 2018.

11 NCAC 16 .0208 ANNUAL ACTUARIAL CERTIFICATIONS FOR LONG-TERM CARE FORMS

For actuarial certifications required by G.S. 58-51-95(i):

(1) The actuarial certification shall be made by an individual who is either a Fellow or an Associate of the Society of Actuaries, a Fellow or an Associate of the Casualty Actuarial Society, or a member of the American Academy of Actuaries.
(2) For a policy form which becomes closed, but for that no corrective action is currently required, or for other situations for which no corrective action is currently required, the actuary shall, in lieu of the plan of corrective action required by G.S. 58-51-95(i)(2), provide a certification that the actuary has reviewed the historical experience for the policy form and that, in the actuary's opinion, a rate revision is not currently justified.

History Note: *Authority G.S. 58-2-40; 58-2-171; 58-3-275; 58-51-95; 58-63-15(7)b;*
Eff. July 1, 2006;
Readopted Eff. October 1, 2018.

SECTION .0300 - SMALL EMPLOYER GROUP HEALTH INSURANCE; FOR CALENDAR YEAR 1994 ACTUARIAL CERTIFICATION

11 NCAC 16 .0301 DEFINITIONS AND SCOPE
11 NCAC 16 .0302 RESTRICTIONS ON PREMIUM RATES
11 NCAC 16 .0303 ANNUAL FILING

History Note: *Filed as a Temporary Adoption Eff. January 25, 1993 for a Period of 180 Days or Until the Permanent Rule Becomes Effective, Whichever is Sooner;*
Authority G.S. 58-2-40; 58-50-130(b);
Eff. May 3, 1993;
Amended Eff. January 1, 1994; October 1, 1993;
Repealed Eff. April 1, 2001.

SECTION .0400 - CREDIT LIFE ACCIDENT AND HEALTH RATE DEVIATION

11 NCAC 16 .0401 DEFINITIONS

As used in this Section:

(1) "Class of Business" means one of the following determined by the source of the business:
  (a) Credit Unions;
  (b) Commercial Banks and Savings and Loan Associations;
  (c) Finance Companies;
  (d) Motor Vehicle Dealers;
  (e) Other Sales Finance; or
  (f) All Others.

(2) "Account" means the aggregate credit life insurance, credit accident and health insurance, or credit unemployment insurance coverage for a single plan of insurance and for a single class of business written through a single creditor, whether coverage is written on a group or individual basis.

(3) "Case" means either a "Single Account Case" or a "Multiple Account Case" as follows:
  (a) "Single Account Case" means an account that is at least 25% credible or, at the option of the insurer, any higher percentage as determined by the Credibility Formula as defined in Item (6) of this Rule; and
  (b) "Multiple Account Case" means two or more accounts of the same plan of insurance and class of business having similar underwriting characteristics, excluding single account cases defined in Sub-item (3)(a) of this Rule, and that when combined, are at least as credible as the minimum level of credibility elected in Sub-item (3)(a) of this Rule.

(4) "Plan of Insurance" means:
  (a) decreasing term credit life insurance on single or joint lives;
  (b) level term credit life insurance on single or joint lives;
  (c) credit accident and health insurance on single or joint lives, with single premiums that vary by waiting period and retroactive or nonretroactive benefits; and
  (d) credit Unemployment insurance on single or joint lives.

(5) "Credibility Factor" means the degree to which the past experience of a case is expected to occur in the future.

(6) "Credibility Formula" means the following process used to calculate the credibility factor:
  (a) determine the incurred claim count during the experience period;
  (b) divide Sub-item (6)(a) of this Rule by 1082;
  (c) take the square root of Sub-item (6)(b) of this Rule; and
  (d) the credibility factor is the lesser of the number one and the results of Sub-item (6)(c) of this Rule.

(7) "Earned Premium at Current Approved Rate" means North Carolina earned premium, during the experience period, restated as though the current North Carolina approved rate had been charged.

(8) "Incurred Losses" means North Carolina incurred losses during the experience period including the increase in provision for incurred losses, whether reported or not, from the beginning to the end of the period.

(9) "Expense Ratio" means the ratio of the insurer's operating expenses for a class of business and plan of insurance to its earned premium for that class of business and plan of insurance.

(10) "Operating Expenses" means any combination of the following expenses:
- (a) commissions;
- (b) other acquisition;
- (c) general Administration;
- (d) taxes, licenses, and fees; and
- (e) profit and contingency margin.

(11) "Benchmark Loss Ratio" means the percentage of premium that is expected to be used to pay losses. It is calculated by subtracting the expense loss ratio from the number one.

(12) "Rate Adjustment Factor" means the result of the calculations in 11 NCAC 16 .0403(15).

(13) "Experience Period" means the period of time for which experience is reported, but not for a period longer than the most recent three years.

(14) "Incurred Claim Count" means the number of North Carolina claims incurred for the case during the experience period. This means the total number of claims reported during the experience period, whether paid or in the process of payment, plus any claims incurred but not reported at the end of the experience period less the number of claims incurred but not reported at the beginning of the experience period. If a debtor has been issued more than one certificate for the same plan of insurance, then only one claim shall be counted. If a debtor receives credit disability or credit unemployment benefits, then only the initial claim payment for that period of disability or period of unemployment is counted.

(15) "Incurred Loss Ratio at Current Approved Rate" means the ratio of incurred losses, as defined in Item (8) of this Rule, to earned premium at current North Carolina approved rate, as defined in Item (7) of this Rule.

(16) "Class of Business Incurred Loss Ratio at Current Approved Rate" means the ratio of incurred losses, as defined in Item (8) of this Rule, to earned premium at current North Carolina approved rate, as defined in Item (7) of this Rule, for the class of business and plan of insurance associated with the case.

(17) "Qualified Actuary" means an individual who is a member of the American Academy of Actuaries, an Associate or Fellow of the Society of Actuaries, or an Associate or Fellow of the Casualty Actuarial Society.

(18) "Maximum Approved Rate" means the current North Carolina approved rate for the case multiplied by the prima facie rate adjustment factor as defined in Item (12) of this Rule.

History Note: *Authority G.S. 58-2-40; 58-57-35(a); 58-57-70;*
Eff. January 1, 1994;
Readopted Eff. October 1, 2018.

11 NCAC 16 .0402 GENERAL SUBMISSION REQUIREMENTS

(a) All rate deviation requests, including the data required by Rule .0403 of this Section, shall be submitted to the Life and Health Division. All rate deviation requests shall be submitted no later than March 31, of each calendar year to become effective during the calendar year of submission.

(b) All experience used in the calculation of the rate deviation shall only be North Carolina experience.

(c) All rate deviations shall be submitted, in accordance with this Rule, to the Life and Health Division each succeeding year for reevaluation.

(d) All rate deviation calculations shall be performed by or under the supervision of a qualified actuary.

(e) The following information shall be submitted in regards to the qualified actuary:
- (1) the name of the qualified actuary;
- (2) the professional designations of the qualified actuary, e.g. A.S.A., F.S.A., ACAS, FCAS, or M.A.A.A.;
- (3) the name and address of the company or actuarial consulting firm employing the qualified actuary; and
- (4) the telephone number, including extension, of the qualified actuary.

(f) The qualified actuary shall include in the credit rate deviation request a written statement certifying the following:

(1) that the qualified actuary has reviewed Rules .0401 through .0403 of this Section;

(2) that the qualified actuary certifies that all submitted calculations and data preparation are in conformity with Rules .0401 through .0403 of this Section; and
(3) that all data submitted are accurate and in conformity with Rule .0401 of this Section.

History Note: *Authority G.S. 58-2-40; 58-57-35(a); 58-57-70;*
Eff. January 1, 1994;
Readopted Eff. October 1, 2018.

11 NCAC 16 .0403 CALCULATION PROCEDURE AND DATA REQUIREMENTS FOR RATE DEVIATIONS

An insurer requesting a rate deviation shall submit to the Department of Insurance the following information, the results of each calculation as follows, and the corresponding data required to perform each calculation in accordance with this Rule, identified for each case for which the insurer is requesting a rate deviation:

(1) identification of the class of business and plan of insurance associated with the case;
(2) identification of the single or multiple account case and, for a multiple account case, identification of each case;
(3) for the case, calculate the incurred loss ratio at the current North Carolina approved rate as defined in Rule .0401(15) of this Section;
(4) for the case, calculate the credibility factor using the credibility formula as defined in 11 NCAC 16 .0401(6);
(5) multiply Item (3) of this Rule by Item (4) of this Rule;
(6) for the class of business, calculate the class of business incurred loss ratio at current North Carolina approved rate as defined in 11 NCAC 16. 0401(16);
(7) for the class of business, calculate the credibility factor using the credibility formula as defined in 11 NCAC 16.0401(6);
(8) multiply Item (7) of this Rule by the quantity one minus Item (4) of this Rule, as in the following formula: Item (7) of this Rule x [1 - Item (4) of this Rule];
(9) multiply Item (6) of this Rule by Item (8) of this Rule;
(10) multiply the quantity one minus Item (4) of this Rule by the quantity one minus Item (7) of this Rule, as in the following formula: [1 - Item (4) of this Rule] x [1 - Item (7) of this Rule];
(11) multiply .60 by Item (10) of this Rule;
(12) add Items (5), (9) and (11) of this Rule;
(13) calculate the expense ratio as defined in 11 NCAC 16. 0401(9);
(14) calculate the benchmark loss ratio as defined in 11 NCAC 16. 0401(11);
(15) the rate adjustment factor is equal to Item (12) of this Rule divided by Item (14) of this Rule; however, if the rate adjustment factor is greater than or equal to 0.95 and less than or equal to 1.05, then the rate adjustment factor shall be set equal to the number one; and
(16) the maximum approved rate in effect for a period of 12 months is equal to the current North Carolina approved rate for the case multiplied by Item (15) of this Rule.

History Note *Authority G.S. 58-2-40; 58-57-35(a); 58-57-70;*
Eff. January 1, 1994;
Amended Eff. October 1, 2008;
Readopted Eff. October 1, 2018.

SECTION .0500 - CREDIT UNEMPLOYMENT MINIMUM LOSS RATIO STANDARD

11 NCAC 16 .0501 MINIMUM INCURRED LOSS RATIO

The premium rates charged for credit unemployment insurance shall be reasonable in relation to the benefits provided as indicated by a minimum annual incurred loss ratio of 60%.

History Note: *Authority G.S. 58-2-40; 58-57-110(a);*
Eff. January 1, 1994;
Amended Eff. November 11, 2011;
Readopted Eff. October 1, 2018.

11 NCAC 16 .0502 DEFINITIONS

As used in this Section:

(1) "Earned Premium" means North Carolina credit unemployment earned premium, during the experience period, restated as though the current North Carolina credit unemployment rate had been charged.

(2) "Incurred Claims" means North Carolina credit unemployment incurred losses during the experience period.

(3) "Experience Period" means the period of time for which experience is reported, but not for a period longer than the most recent three years.

(4) "Incurred Claim Count" means the number of North Carolina credit unemployment claims incurred during the experience period. This means the total number of claims reported during the experience period, whether paid or in the process of payment, plus any claims incurred but not reported at the end of the experience period less the number of claims incurred but not reported at the beginning of the experience period. Only the initial claim payment for that period of unemployment shall be counted.

(5) "Credibility Factor" means the degree to which the past experience is expected to occur in the future.

(6) "Credibility Formula" means the following process used to calculate the credibility factor:

(a) determine the incurred claim count during the experience period;

(b) divide Sub-item (6)(a) of this Rule by 1082;

(c) take the square root of Sub-item (6)(b) of this Rule; and

(d) the credibility factor is the lesser of the number one and the results of Sub-item (6)(c) of this Rule.

(7) "Qualified Actuary" means an individual who is a member of the American Academy of Actuaries, an Associate or Fellow of the Society of Actuaries, or an Associate or Fellow of the Causality Actuarial Society.

(8) "Incurred Loss Ratio at Current Credit Unemployment Rate" means the ratio of incurred losses, as defined in Item (2) of this Rule, to earned premium, as defined in Item (1) of this Rule.

History Note: *Authority G.S. 58-2-40; 58-57-70; 58-57-110(a);*
Eff. January 1, 1994;
Readopted Eff. October 1, 2018.

11 NCAC 16 .0503 GENERAL SUBMISSION REQUIREMENTS

(a) All credit unemployment minimum incurred loss ratio compliance demonstrations shall be submitted to the Life and Health Division upon request.

(b) All experience used in the demonstration of compliance shall be only North Carolina experience.

(c) All compliance demonstrations shall be submitted, in accordance with this Rule, to the Life and Health Division each succeeding year for reevaluation.

(d) The following information shall be submitted in regards to the qualified actuary:

(1) the name of the qualified actuary;

(2) the professional designations of the qualified actuary;

(3) the name and address of the company or actuarial consulting firm employing the qualified actuary; and

(4) the telephone number, including extension, of the qualified actuary.

(e) The qualified actuary shall include in the credit unemployment rate request a written statement certifying the following:

(1) that the qualified actuary has reviewed Rules .0501 through .0504 of this Section;

(2) that the qualified actuary certifies that all submitted calculations and data preparation are in conformity with Rules .0501 through .0504 of this Section; and

(3) that all data submitted are accurate and in conformity with Rule .0502 of this Section.

History Note: *Authority G.S. 58-2-40; 58-57-70; 58-57-110(a);*
Eff. January 1, 1994;
Amended Eff. November 1, 2011;
Readopted Eff. October 1, 2018.

11 NCAC 16 .0504 CALCULATION PROCEDURE AND DEMONSTRATION OF COMPLIANCE

Each credit unemployment insurer shall submit to the Department of Insurance the results of each calculation as follows and the corresponding data required to perform each calculation in accordance with this Rule:

(1) calculate the incurred loss ratio at current credit unemployment rate as defined in 11 NCAC 16 .0502(8);
(2) calculate the credibility factor using the credibility formula as defined in 11 NCAC 16 .0502(6);
(3) multiply Item (1) of this Rule by Item (2) of this Rule;
(4) multiply .60 by the quantity one minus Item (2) of this Rule;
(5) add Items (3) and (4) of this Rule; and
(6) divide Item (5) of this Rule by .60. Compliance with 11 NCAC 16 .0501 shall be satisfied if this quotient is equal to or greater than one. If this quotient is less than one, then in order to satisfy 11 NCAC 16 .0501 the insurer shall decrease the current credit unemployment rate until the quotient is equal to or greater than one.

History Note: *Authority G.S. 58-2-40; 58-57-70; 58-57-110(a);*
Eff. January 1, 1994;
Readopted Eff. October 1, 2018.

SECTION .0600 - HEALTH MAINTENANCE ORGANIZATION FILINGS AND STANDARDS

11 NCAC 16 .0601 DEFINITIONS

(a) The definitions contained in G.S. 58-67-5 shall apply in this Section.
(b) As used in this Section:

(1) "Adjusted community rating" means a rating method that allows an HMO to prospectively establish premium rates based upon the expected revenue requirements for individual groups and to take into account a group's historical utilization, intensity, or cost experience.
(2) "Capitated" means covered health care services are provided by an HMO, medical group, or institution based on a prepaid fixed amount per enrollee regardless of the actual value of those services.
(3) "Community rating" means a general method of establishing premiums for financing health care in which an individual's rate is based on the actual or anticipated average cost of health services used by all HMO members in a specified service area.
(4) "Community rating by class" means a modification of community rating whereby individual groups may have different rates depending on the composition by age, gender, number of family members covered, geographic area, or industry.
(5) "Contingency reserve" means the unassigned funds held over and above any known or estimated liabilities of an HMO for the protection of its enrollees against the insolvency of the HMO.
(6) "Contract type" means a classification of the members into categories, usually based on enrolled dependent status, such as subscriber only, subscriber with one dependent, and subscriber with two or more dependents.
(7) "Credibility rating" means a rating method that establishes premium rates based upon the assignment of a level of credibility to an HMO group's historical utilization, intensity, or cost experience.
(8) "Fee-for-service" means payment for health care services is made on a retrospective basis based on the actual value of those services.
(9) "Full-service HMO" means an HMO that provides a comprehensive range of medical services, including hospital and physician services.
(10) "HMO expansion request" means all materials submitted for the purpose of obtaining authority to operate an HMO in a new or expanded geographic area in this State.
(11) "HMO model type" means a classification that describes the manner in which physicians are affiliated with the HMO and the contractual and payment arrangements with hospitals, and includes types such as group, network, staff, independent practice association, and point-of-service.
(12) "HMO rate filing" means an initial HMO rate filing, an HMO expansion request, or an HMO rate revision filing.

(13) "HMO rate revision filing" means all materials submitted for the purpose of making a revision to an existing schedule of premiums.
(14) "Incurred loss ratio" means the ratio of total medical expenses, including the change in claim reserves to total earned premium revenues.
(15) "Initial HMO rate filing" means all materials submitted for the purpose of obtaining a certificate of authority to operate an HMO in this State.
(16) "Single-service HMO" means an HMO that undertakes to provide or arrange for the delivery of a single or limited type of health care service to a defined population on a prepaid basis.

History Note: *Authority G.S. 58-67-50(b); 58-67-150;*
Eff. April 1, 1995;
Readopted Eff. October 1, 2018.

11 NCAC 16 .0602 HMO GENERAL FILING REQUIREMENTS

(a) All schedules of premiums for enrollee coverage for health care services and all 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 shall indicate whether the filing is an original or amended filing. All data requirements prescribed by this Section shall 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 their 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) As used in Paragraph (b) of this Rule, "qualified actuary" means an individual who is a member of the American Academy of Actuaries, an Associate or Fellow of the Society of Actuaries, or an Associate or Fellow of the Casualty Actuarial Society, 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;
Readopted Eff. October 1, 2018.

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; and
(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;
Readopted Eff. October 1, 2018.

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; and
(2) a three-year financial projection, provided by the Department's Actuarial Services Division, 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; or
(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 that 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 that 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 that 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 that affect the premium rates. Identification of specific hospitals or physician groups shall not be required; and
(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;
Readopted Eff. October 1, 2018.

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; and
(2) a three-year financial projection, provided by the Department's Actuarial Services Division, 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;

Readopted Eff. October 1, 2018.

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 all 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 all trend factors 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; and

(8) 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, provided by the Department Actuarial Services Division, 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;
Readopted Eff. October 1, 2018.

11 NCAC 16 .0607 HMO INCURRED LOSS RATIO STANDARDS

(a) The following shall 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 that 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; or

(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 list of each of the specific components that 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 that make up the total retention loading;

(C) a brief explanation as to why any of the components that 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 all special fee negotiations or contract arrangements that affect the premium rates. Identification of specific hospitals or physician groups shall not be required; and

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

(b) The following shall 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; or
   (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 list of each of the specific components that 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 that make up the total retention loading;
   (C) a brief explanation as to why any of the components that 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 that affect the premium rates. Identification of specific hospitals or physician groups shall not be required; and
   (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;
Readopted Eff. October 1, 2018.

SECTION .0700 - HEALTH MAINTENANCE ORGANIZATION CLAIM RESERVE DATA REQUIREMENTS

11 NCAC 16 .0701 DEFINITIONS

As used in this Section:

(1) "Claim reserves" means reserves or liabilities held for claims incurred on or before the valuation date, but unpaid as of the valuation date. Claim reserves include both reported and unreported claims. Claim reserves are established for both accrued and unaccrued benefits.

(2) "Valuation date" means the date at which reserves are estimated.

History Note: *Authority G.S. 58-2-40; 58-67-135(b);*
Eff. February 1, 1995;
Readopted Eff. October 1, 2018.

11 NCAC 16 .0702 CLAIMS

(a) When an HMO has been informed that a claim has been incurred, if the date reported is on or before the valuation date, the claim shall be considered as a reported claim.

(b) When an HMO has not been informed, on or before the valuation date, concerning a claim that has been incurred on or before the valuation date, the claim shall be considered as an unreported claim.

(c) The date on which a claim is determined to be a liability of an HMO is the incurred date. For example: The incurred date for charges for inpatient hospital and physician visits in hospital shall be the date of admission, for outpatient hospital charges shall be the date of service, and for surgical expenses shall be the date of the surgery.

History Note: *Authority G.S. 58-2-40; 58-67-135(b);*
Eff. February 1, 1995;
Readopted Eff. October 1, 2018.

11 NCAC 16 .0703 CLAIM RESERVE FILING REQUIREMENTS

(a) A quarterly claim reserve data filing shall be made by any HMO that has been in operation for more than one full calendar year but less than three full calendar years.

(b) An annual claim reserve data filing shall be made by any HMO that satisfies either of the following conditions:

(1) for the most recent quarterly valuation the net worth less the contingency reserve is less than the statutory minimum stated in G.S. 58-67-110(c) or G.S. 58-67-110(d); or

(2) for the most recent annual valuation the sum of the following exceeds 110 percent of the estimated liability of unpaid claims on December 31 of the previous year:

(A) total of claims paid during the year and incurred in previous years; and

(B) claims unpaid at December 31 of the current year on claims incurred in previous years.

(c) A triennial claim reserve data filing shall be made by all HMOs.

(d) All annual and triennial claim reserve data filings shall be sent to the Actuarial Services Division by March 1 of the reporting year.

(e) All quarterly claim reserve data filings shall be sent to the Actuarial Services Division within 45 days after the end of each calendar quarter.

History Note: *Authority G.S. 58-2-40; 58-67-135(b); 58-67-150;*
Eff. February 1, 1995;
Amended Eff. April 1, 1997;
Readopted Eff. October 1, 2018.

11 NCAC 16 .0704 CLAIM RESERVE DATA AND FORMAT REQUIREMENTS

(a) The data requirements in Paragraph (b) of this Rule shall be recorded for the following types of claims:

(1) inpatient Claims;

(2) physician Claims;

(3) referral Claims; and

(4) other.

(b) For the most recent 24-month period immediately preceding and including the valuation date, the following "monthly" historical data shall be recorded by the month in which the claim or payment was incurred and by the following:

(1) cumulative number of claims reported through the 24-month period;

(2) cumulative number of claims paid through the 24-month period;

(3) cumulative dollar amount of claims paid through the 24-month period; and

(4) cumulative dollar amount of claims incurred through the 24-month period.

(c) The following monthly historical data shall be recorded for the most recent 24-month period immediately preceding and including the valuation date:

(1) earned premiums by calendar month;

(2) total number of enrollees at the beginning and end of each month; and

(3) data on claim amounts greater than or equal to one hundred thousand dollars ($100,000).

History Note: *Authority G.S. 58-2-40; 58-67-135(b); 58-67-150;*
Eff. February 1, 1995;
Amended Eff. December 1, 1995;
Readopted Eff. October 1, 2018.

11 NCAC 16 .0705 CLAIM RESERVE METHODOLOGY AND ACTUARIAL CERTIFICATION

(a) A written description of the claim reserve methodology and a numerical verification of the claim reserves submitted in 11 NCAC 16 .0704(d) shall be included with each annual filing.

(b) Each annual filing shall contain an actuarial certification signed by an actuary stating that the actuary has examined the claim reserves listed in Schedule - H, Section II, and affirms that these claim reserves are calculated in accordance with generally accepted actuarial principles and practices and in the actuary's opinion are adequate.

History Note: *Authority G.S. 58-2-40; 58-67-135(b);*
Eff. February 1, 1995;
Readopted Eff. October 1, 2018.

SECTION .0800 - SMALL EMPLOYER GROUP HEALTH INSURANCE ACTUARIAL CERTIFICATION

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

(a) 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 state either of the following, as applicable:

(A) For a carrier actuary, the opening paragraph shall state:
"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 state:
"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 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 state:
"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, are not being applied individually in the final premium rate charged to an employee, and are 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, are not inadequate, 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 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 shall 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; and

(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;
Readopted Eff. October 1, 2018.