

CIGNA HealthCare of North Carolina, Inc.

Raleigh, North Carolina

Report on Limited-Scope Examination

As of December 31, 2013

CIGNA HealthCare of North Carolina, Inc.

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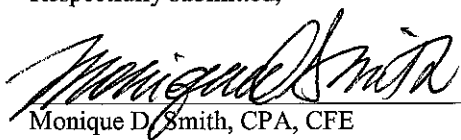
Honorable Wayne Goodwin
Commissioner of Insurance
State of North Carolina
Raleigh, North Carolina

Sir:

Pursuant to your instructions and in accordance with Section (“§”) 58-67-100 of the General Statutes of North Carolina (“GS”), the North Carolina Department of Insurance (“Department”) conducted a limited-scope examination of **CIGNA HealthCare of North Carolina, Inc.** (“Company”) as of December 31, 2013. The Department’s last full-scope examination was as of December 31, 2010. This limited-scope examination was performed to address specific areas based on the Department’s review and analysis of the Company’s 2013 Annual Statement (“AS”).

This examination was performed in accordance with auditing standards established by the Department. The purpose of this examination was to review specific aspects of the Company’s 2013 AS as specified in the Scope of the Examination on page 4. The scope of this examination was not comprehensive, but included a limited review of the Company’s practices and procedures, its corporate and accounting records, details of certain transactions, and an evaluation of certain assets and liabilities reported as of December 31, 2013. This report is not intended to communicate all matters of importance for an understanding of the Company’s financial condition as of December 31, 2013. Therefore, the findings and conclusions contained within this report are based solely on the work performed on the specific areas of concern and are provided in the Summary of Examination Objectives and Findings on page 5.

Respectfully submitted,



Monique D. Smith, CPA, CFE
Chief Financial Examiner
North Carolina Department of Insurance

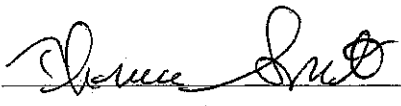
August 29, 2014

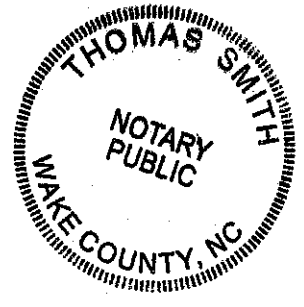
STATE OF NORTH CAROLINA
COUNTY OF WAKE

Ke Xu, Assistant Chief Financial Examiner, North Carolina Department of Insurance, being first, duly sworn, deposes and says that this report on examination, subscribed by her, is true and correct to the best of her knowledge and belief.

Signature:  Date: 10/6/2014
Ke Xu

Sworn and subscribed before me this 6 day of October, 2014.

Notary Public Signature:  Notary Public Seal:



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1. Company Background

The Company is a Health Maintenance Organization (“HMO”) that commenced operations on April 18, 1986. The Company is licensed to write health care insurance in all counties in the state of North Carolina and provides health care services to a defined, enrolled population for a predetermined, prepaid monthly fee.

The Company provides health care services including basic hospital services, primary and specialty care physician services, outpatient services, emergency room treatment, laboratory and diagnostic services, mental health and substance abuse treatments (through Cigna Behavior Health, Inc.), and preventive health and well-baby care. The Company contracts with health care professionals and hospitals in-network for the delivery of health care.

The Company is a member of an insurance holding company group. The Company is a wholly owned subsidiary of Healthsource, Inc., which is a wholly-owned subsidiary of Cigna Health Corporation (“CHC”), which is an indirect wholly-owned subsidiary of Cigna Corporation, a Delaware corporation and the ultimate controlling entity.

The Company has no employees and utilizes the personnel services of CHC. Pursuant to the terms of a management services agreement, effective January 1, 1994, CHC provides services such as sales support, underwriting, personnel services, claims processing, system services, tax planning, membership services, treasury, corporate training, administrative services, payroll, legal, and marketing. In return, the Company pays a fixed monthly fee on a per-member, per-month basis. The Company also has a Line of Credit agreement with CHC to ensure the Company will meet its operational cash obligations while earning additional investment income.

2. Appointed Actuary

Appointed Actuary

All HMOs are required to file annual statements in accordance with the appropriate National Association of Insurance Commissioners (“NAIC”) Annual Statement Instructions Handbook, pursuant to GS § 58-67-55 and § 58-2-165(c). The Annual Statement Instructions require the statement of the appointed actuary setting forth an opinion relating to claim reserves and any other actuarial items included on or attached to the annual statement. Actuarial opinions regarding the Company’s reserves for claims unpaid and unpaid claim adjustment expenses were issued by an appointed actuary for the examination period. The appointed actuary evaluated the data of the claims unpaid and unpaid claim adjustment expenses provided by the Company for reasonableness and consistency. According to the actuarial opinion, the Company’s reserves for claims unpaid and unpaid claim adjustment expenses met the requirements of the insurance laws of North Carolina; were consistent with reserves computed in accordance with accepted actuarial standards and principles; and made a reasonable provision for all claims unpaid and unpaid claim adjustment expenses obligations of the Company.

3. Scope of the Examination

The scope of this examination was limited to the following areas relative to the 2013 AS:

- a) Premiums
- b) Reserves
- c) Related party transactions

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4. Examination Procedures

The examination procedures performed during this examination included the following:

- 1) detailed reviews and verification of supporting documentation for balances reported;
- 2) substantive testing of underlying data and transactions;
- 3) detailed review of the Company's underwriting;
- 4) an actuarial review of the Company's reserves by the Department's Actuarial Services Division; and
- 5) other examination procedures deemed necessary to meet the established objectives.

5. Summary of Examination Objectives and Findings

a) Premiums

- 1) **Examination Objective:** Verify the accuracy and completeness of the written premium as of December 31, 2013.

Findings

There were no adverse findings in relation to premiums written totaling \$16,185,049, as reported in the Company's 2013 AS Underwriting and Investment Exhibit.

- 2) **Examination Objective:** To verify underwriting decisions were made by the appropriate person, complied with underwriting guidelines and appropriate pricing.

Findings

No adverse findings were noted during our review of the Company's underwriting decisions.

- 3) **Examination Objective:** Perform an independent calculation/estimate of the Company's premium deficiency reserve ("PDR").

Findings

An independent review was performed on the Company's PDR of \$0, noting no adverse findings.

- 4) **Examination Objective:** Test the accuracy of the premium accounts by verifying aging categories to invoices and collection documentation.

Findings

Examiners selected a sample of premium receivables to ensure that they were accurately calculated and aged. Examiners identified no significant adjustments or adverse findings regarding the accuracy and aging of the Company's uncollected premiums totaling \$539,802 reported in the Statement of Assets of the Company's 2013 AS.

- 5) **Examination Objective:** To review the Company's aging detail to determine whether any premiums are over 90 days past due and if applicable, verify that those premium receivables are non-admitted in accordance with Statement of Statutory Accounting Principle ("SSAP") No. 6.

Findings

We noted no adverse findings during our review of premium receivables over 90 days past due and non-admitted totaling \$13,505 as reported in the Statement of Assets of the Company's 2013 AS.

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b) Reserves

- 1) Examination Objective:** Review reserving assumptions and methodologies for reasonableness, appropriateness and accuracy.

Findings

It was determined that the reserving assumptions and methodologies used by the Company were reasonable, appropriate and accurate.

- 2) Examination Objective:** Perform an independent estimate of the reserves to determine their adequacy.

Findings

We noted no adverse findings during our review of the Company's claims unpaid, unpaid claims adjustment expense and aggregate health policy reserves totaling \$886,118, \$13,884 and \$583,012, respectively, at December 31, 2013.

c) Related party transactions

- 1) Examination Objective:** Verify calculations of expense allocations for compliance with terms of the management services agreement.

Findings

We noted no adverse findings during our review of the Company's amounts due to affiliates totaling \$67,881, as reported in the Company's Statement of Liabilities, Capital and Surplus and total fees incurred of \$1,936,174, as reported in Note No. 10 of the Company's 2013 AS.

- 2) Examination Objective:** Verify payments made to affiliates after year-end are properly recorded per the terms of the agreement.

Findings

No adverse findings were noted based on our review.

- 3) Examination Objective:** If any related party amounts have been offset, verify the Company has a legal right to offset per the terms of the agreement and whether the required conditions necessary to permit the offset meet the requirements of SSAP No. 64.

Findings

Examiners reviewed related party account activity for the month of December 2013 and verified account activity was recorded in accordance with the terms of the management services agreement and met the requirements of SSAP No. 64.

6. Subsequent Events

Effective January 2014, the Cigna organization plans to utilize the Company as part of its overall growth strategy related to Medicare Advantage products, and as its vehicle to further expand its Medicare Advantage business within the State of North Carolina. In connection with this expansion, the Company has entered into certain affiliated agreements, effective January 1, 2014, with the Department's approval.

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Appendix A – Report Distribution

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