APPLICATION FOR HMO CERTIFICATE OF AUTHORITY

North Carolina Department of Insurance
Life and Health Division
1201 Mail Service Center
Raleigh, NC 27699-1201
(919) 733-5060

Revised August 2009

ABOUT THE HMO CERTIFICATE OF AUTHORITY PROCESS

The North Carolina Department of Insurance (Department) is the only agency in North Carolina responsible for the regulation of Health Maintenance Organizations. Many separate Divisions within the Department play a role in the ongoing regulation. In some instances, more than one Division will be involved in a particular regulatory issue, but in other instances, you may deal with only one Division.

Life and Health Division: (919) 733-5060
This Division is responsible for coordinating the review of Certificate of Authority modification applications and making the final recommendation as to whether or not the Commissioner should grant requested modifications, review of member forms and benefit design, including the Master Group Contract, Evidence or Certificate of Coverage, Benefit Riders, Enrollment Forms, Change Forms and marketing, premium rates, and advertising materials.

Actuarial Services Division: (919) 733- 3284
This division is responsible for reviewing premium rate setting methodologies and rating assumptions. Review will also rely upon financial condition and Financial Feasibility Plan.

Financial Evaluation Division: (919) 733-5631
This division is responsible for reviewing the financial solvency issues, including the Financial Feasibility Plan, Insolvency Protection Plan and Financial Statements. Also responsible for determining levels of working capital and reserves appropriate to the application submitted.

Pre-Application Meeting

If the applicant has not scheduled and/or already participated in a pre-application meeting with the NCDOI you must contact the Life and Health Division to schedule an informational meeting to review the licensure process and requirements. This meeting is essential for the successful completion of the application. This meeting is most productive when scheduled once you have begun to complete the application, but well prior to submission, in order that you may have prepared specific and informed questions. The application may be impacted by the answers received during the meeting.

MINIMUM FINANCIAL REQUIREMENTS

The following is a summary of minimum financial requirements for starting an HMO in North Carolina. Please note all requirements are **minimums**. Determinations regarding appropriate levels of working capital and reserves are made on a case by case basis and are dictated to a large degree by the three-year plan presented in the application.

MINIMUM FINANCIAL REQUIREMENTS	FULL SERVICE HMO	SINGLE SERVICE HMO	STATUTORY REFERENCE
Working Capital	$ 1,500,000	$100,000	NCGS 58-67-20
Deposit	$ 500,000	$ 25,000	NCGS 58-67-25
Reserves (after one year of operation)	gross annual collections from membership	Same as Full Service HMO	NCGS 58-67-40
Net Worth	$1,000,000	$ 50,000	NCGS 58-67-110

INSTRUCTIONS FOR FILING AN APPLICATION FOR NORTH CAROLINA HMO CERTIFICATE OF AUTHORITY

In an effort to reduce the processing time for the issuance of a HMO certificate of authority, the North Carolina Department of Insurance (NCDOI) has prepared these guidelines which may be used to assist the applicant in completion of an HMO application.

The application references North Carolina statutes and regulations, which must be met by the applicant in order to receive an HMO certificate of authority. Please be advised this list is not all-inclusive and it recommended the applicant contact the publisher for a complete reference of applicable statutes and regulations.

General Statutes of North Carolina - Insurance, Chapters 58 and 58A - The Michie Company
(800) 446-3410
North Carolina Regulations - National Insurance Law Service
(800) 423-5910

GENERAL FILING REQUIREMENTS

The North Carolina Department of Insurance (NCDOI) has prepared this guideline and checklist to help applicants prepare their applications in a manner that promotes prompt and thorough review by the NCDOI. **This guideline is not all-inclusive.** Each Exhibit or sections submitted to the NCDOI must be accompanied by the appropriate supporting documentation, in the order requested. All forms should be filled out completely unless otherwise stated. The NCDOI will not accept an incomplete application. The application cannot be amended once submitted, except for specific changes requested by the NCDOI.

The application and all of its contents will become public information immediately upon submission. The NCDOI is authorized to protect only legitimate trade secrets from public view. The NCDOI approves trade secret, confidential information on a section by section basis, rather than entire documents. Therefore, written information must be submitted that identifies the specific areas to be classified as confidential. In order to have material classified as trade secret and thereby confidentially maintained by the Department, an applicant must:

1. Indicate clearly the specific information to be treated as a trade secret;
2. Submit a written memorandum to the Life and Health Division explaining why this information qualifies as a trade secret pursuant to North Carolina General Statute (NCGS) Chapter 24, Article 66, Section 152 and Article 132 Section 1.2. This information must include specific explanations as to how and why the area meets the definition of trade secret and not a restatment of the definition itself (e.g. how economic value could be obtained)

The explanation and the indicated materials will be reviewed by the Life and Health Division and legal counsel to determine if it meets the criteria as outlined in NCGS 24-66-152 and 132-1.2. The applicant will be notified of the decision rendered.

Historically, little information included in the application has been determined to qualify as a trade secret.

The application must be prepared as follows:

- One original copy must be submitted
- Filing fee of $500.00 must accompany the application
- The application may be filed electronically in portable document format
- A cover letter must be submitted with the application
- Bookmark and/or label the 19 separate exhibits describing the contents of the application
- Identical items should be cross-referenced, rather than duplicated throughout the document
- The original copy has all signed documents with original signature. (electronic signature accepted)

APPLICATION REVIEW PROCESS

The application will be distributed to each of the above listed Divisions. The public copy materials will be available on-line, for public review. Once received by each Division, the application will be assigned to a particular analyst in each Division.

Within the Life and Health Division, an application will be assigned to an Examination Team, which will then become the primary point of contact for routine matters relating to the review. This Examination Team will be permanently assigned to that Company, assuring continuity during the licensure process and for ongoing regulatory and examination purposes once licensed.

The Life and Health Division and the Actuarial Services Division will concurrently review applications. The applicant will receive correspondence from each Division and at this point responses should be addressed directly to the particular Division regarding its questions and concerns. The Financial Evaluation Division conducts a preliminary review of the application, however this review cannot be completed until rating methodologies and projections are secured and finalized by the Actuarial Services Division.

Applicants are requested to respond within 60 days of receiving correspondence from any Division. All Divisions should be copied on the response. If the response is not received within this time frame, the application may be closed.

The entire application will be approved at one time. Approval for use of all submitted items is granted through receipt of a Certificate of Authority. Rates, member forms, provider contracts, etc. are not separately approved prior to the date the applicant receives its Certificate of Authority. Applicants may not contract with employer groups prior to receiving its Certificate of Authority.

PRE-LICENSURE SITE VISIT

The Life and Health Division as part of the licensure process will conduct a site visit. This site visit occurs rather late in the application process, once it has been determined that the submission is a viable application. This site visit usually takes one to two days, depending on the scope and location of Company operations. During the site visit, the Division attempts to accomplish a number of goals, including:

1. Providing an update on the Certificate of Authority application review progress.

2. Meeting key individuals that will be involved in the development and management of the proposed HMO, including individuals involved in administration, health systems development, medical management programs and claims administration.

3. Obtaining detailed information regarding the proposed operation of the HMO, including the provision of legal services, risk management program, provider relations, member services, network adequacy, claims administration, utilization management, quality management, credentialing, etc. This typically takes the form of presentations conducted by key personnel from each operational area of the proposed HMO.

4. Observing a demonstration of the automated management and information systems, including claims administration and reporting capabilities.

5. Discussing issues and questions about the application.

APPLICATION FOR HMO CERTIFICATE OF AUTHORITY

Life and Division
North Carolina Department of Insurance
1201 Mail Service Center
Raleigh, NC 27699-1201

Assigned to:	Date Received:
	Returned:
Qualified and accepted:	Application Fee Received:
	Date Distributed to Divisions:

APPLICANT INFORMATION

Applicant's Name**:** _____

Applicant's Address:_____

Domestic or Foreign Application:_____

If Foreign Company, please provide Federal Tax Identification Number _____

If Foreign Company, please provide the NAIC Code Number_____

List all Affiliate Companies (if applicable): _____
_____

Counsel Name, Address, Phone Number:_____
_____

Name of Contact Person Responsible for Application, Address, Phone Number:
_____
_____

Proposed Date of Initial HMO Operations:_____
(Date)

Is it the applicant's intention to apply for Federal HMO qualification after receiving a NC Certificate of Authority? **(circle yes or no)**

Is it the applicant's intention to serve Medicare after receiving a NC Certificate of Authority? **(circle yes or no)**

Is it the applicant's intention to serve Medicaid after receiving a NC Certificate of Authority? **(circle yes or no)**

Is it the applicant's intention to serve the small group market after receiving a NC Certificate of Authority? If yes, do not include small group filing with this application, as applicant must first receive its certificate of authority. **(circle yes or no)**

APPLICATION CHECKLIST FOR CERTIFICATE OF AUTHORITY FOR HEALTH MAINTENANCE ORGANIZATIONS

_____
(Company Name)

is herewith submitting the following in support of its application for a Certificate of Authority to operate a Health Maintenance Organization pursuant to Chapter 58, Article 67 of the North Carolina General Statutes.

I. **Application Forms:** Date Certified

Application to do business in North Carolina (HMO/APP/BUS)	_____
Application for HMO Licensure (HMO/APP/LIC)	_____
Biographical Affidavit (HMO/BIO)	_____
(Complete one form per officer and board member)	_____
Power of Attorney for Sale of Securities (HMO/POA/SEC)	_____
Power of Attorney for Legal Representation (HMO/POA/LGL)	_____

II. **Material Specified in NCGS 58-67-10 and 58-67-11:**

(1) Basic organizational document	_____
(2) Bylaws, rules, regulations, etc.	_____
(3) Names, addresses and positions of officers and board members	_____
(4) Provider contracts and administrative contracts	_____
(5) Description of HMO operations	_____
(6) Evidence of Coverage	_____
(7) Group Contracts	_____
(8) Financial Statements	_____
(9) Financial Feasibility Plan including three years financial forecasts	_____
(10) Power of Attorney (HMO/POA/LGL above)	_____
(11) Description of Service Area	_____
(12) Description of insolvency protection provisions	_____
(13) Description of grievance procedures	_____
(14) Description of claims system	_____
(15) Description of provider credentialing plan	_____
(16) Description of utilization review program	_____
(17) Description of quality assurance program	_____
(18) Description of provider availability standards	_____
(19) Description of provider accessibility standards	_____

III. **$500.00 Application Fee Specified in NCGS 58-67-160** _____

_____ _____
Signature of Preparer Date

STATE OF NORTH CAROLINA POWER OF ATTORNEY

COUNTY OF WAKE

Know All Men By These Presents, that _____ ("the Company"), as partial consideration for a certificate of authority to do business in North Carolina, irrevocably appoints for itself, its heirs, assigns and successors, the Insurance Commissioner of the State of North Carolina ("the Commissioner") as its true and lawful attorney in North Carolina, upon whom all processes of law against the Company in any action, cause, or legal proceeding of any sort whatsoever may be served, subject to and in accordance with the laws of North Carolina. The Company further agrees that all such lawful processes against it which are served upon the Commissioner shall be deemed valid personal service upon the Company and shall be of the same force and validity as if personally served upon the Company.

In Witness Whereof, _____ has hereto affixed its corporate seal, attested to by the official signatures of the President and Secretary thereof, at _____, this _____ day of _____, _____.

County Of _____ _____
State Of _____ PRESIDENT

_____
NOTARY PUBLIC
Commission Expires:_____

(Seal)

County Of _____ _____
State Of _____ SECRETARY

_____
NOTARY PUBLIC
Commission Expires:_____

(Seal)

STATE OF NORTH CAROLINA POWER OF ATTORNEY

COUNTY OF WAKE

Know All Men By These Presents, that _____ ("the Company") hereby irrevocably appoints for itself, its heirs, assigns and successors, the Insurance Commissioner of the State of North Carolina ("the Commissioner"), in the name of and on behalf of said Company, its true and lawful attorney to sell and transfer any securities or assets currently on deposit or to be deposited in the future by said Company with the Commissioner, said sale or transfer being made by the Commissioner for any purpose which the Commissioner in his discretion deems necessary, including but not limited to the payment of any liability or liabilities of the Company.

In Witness Whereof, _____ has hereto affixed its corporate seal, attested to by the official signatures of the President and Secretary thereof, at _____, this _____ day of _____, _____.

County Of _____ _____
State Of _____ PRESIDENT

_____
NOTARY PUBLIC
Commission Expires:_____

(Seal)

County Of _____ _____
State Of _____ SECRETARY

_____
NOTARY PUBLIC
Commission Expires:_____

(Seal)

STATE OF NORTH CAROLINA
DEPARTMENT OF INSURANCE
BIOGRAPHICAL AFFIDAVIT
FOR
HEALTH MAINTENANCE ORGANIZATION (HMO)

Full Name and Address of HMO: _____

_____

In connection with the above-named HMO, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer fully any question.) IF ANSWER IS "NO" OR "NONE", SO STATE.

1. Affiant's Full Name: _____

2. Have you ever used an alias, an assumed name, another name or had your name changed? _____

   If yes, give the reason for the change: _____

   _____

3. Date and Place of Birth: _____

4. Residence Address: _____

   _____

5. Business Address: _____

   _____

   Business Telephone: (_____) _____

6. List places of residence for the last ten (10) years, starting with your current address:

   _____

   _____

   _____

   _____

7. Present or Proposed Position with the Applicant HMO:

   _____

8. List complete employment record (up to and including present jobs, positions, directorates or officerships) for the past ten (10) years:

Dates Employer and Address Title

_____

_____

_____

_____

_____

9a. Have you ever been in a position which required a fidelity bond?: _____

If any claim was made on the bond, provide details:

_____

b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond cancelled or revoked? Were any claims made or attempted to be made?

_____

_____

10. Education (Provide dates, names, locations, degrees and field of study):

College _____

_____

Graduate Studies _____

_____

Other _____

_____

11. Experience in the field of HMOs, managed care or experience in the areas of fully insured and self-insured administration:

_____

_____

12. Memberships in Professional Societies and Associations:

_____

_____

13. Professional, occupational and vocational licenses issued by any public or governmental licensing agency or regulatory authority which you presently hold or have held in the past. (Provide dates, issuer of license and reason for termination.)

_____

_____

14a. Companies subject to the jurisdiction of an insurance commissioner which you control directly or indirectly or in which you own legally or beneficially 10% or more of the outstanding stock (in voting power):

_____

_____

b. If any of the stock is pledged or hypothecated in any way, provide details:

_____

15. Will you or members of your immediate family subscribe to or own, beneficially or of record, shares of stock of the applicant HMO or its affiliate? If yes, list.

_____

_____

16. Have you ever been refused a professional, occupational or vocational license by any public or governmental licensing agency or regulatory authority, or has any such license held by you ever been suspended or revoked? If yes, provide details.

_____

_____

_____

17. Have you ever been adjudged bankrupt? _____

18. Have you ever been convicted or had a sentence imposed or suspended or been pardoned for conviction of or pleaded guilty or nolo contendere to an indictment charging any crime

involving fraud, dishonesty or moral turpitude, or charging violation of any corporate securities statute or any insurance law, or have you been a subject of any disciplinary proceedings of any federal or state regulatory agency? If yes, provide details.

_____

_____

_____

19. Have you ever been an officer, director, manager, trustee or controlling stockholder of any company which, while you occupied any such position or capacity with respect to it, became insolvent or was placed under supervision or in receivership, rehabilitation, liquidation or conservatorship? If yes, provide details.

_____

_____

_____

20. Has the certificate of authority or license to do business of any insurance company of which you were an officer or director or key management person ever been suspended or revoked while you occupied such position? If yes, provide details.

_____

_____

_____

21. Are you a citizen of any country other than the United States? If yes, what country? _____

I HEREBY CERTIFY, under penalty of perjury, that the foregoing answers, statements, and information are true and correct.

I, the undersigned affiant, under penalty of perjury, do declare that I have carefully examined each of the questions asked in this BIOGRAPHICAL AFFIDAVIT and each of my responses thereto, and do solemnly swear or affirm that all of my responses, information, exhibits and documentary evidence submitted in support thereof are true and correct.

_____
(Typed Name)

_____ _____
(Signature) (Date)

County of _____

State of _____

BEFORE ME this day personally appeared _____
who, being duly sworn, deposes and says that he/she executed the above BIOGRAPHICAL AFFIDAVIT and that the answers, statements and information contained in this statement are true and correct.

Sworn to and subscribed before me this _____ day of

_____, 19,__.

_____
Notary Seal Notary Public

My Commission Expires: _____

TO: Life and Health Division
North Carolina Department of Insurance
1201 Mail Service Center
Raleigh, NC 27699-1201

FORM MAY BE DUPLICATED WITHOUT MODIFICATION

APPLICATION FORMS

- Complete all application forms in full
- Application forms should not be executed if the applicant is applying to be licensed as a **domestic** HMO and therefore, is not incorporated. Such forms should be executed at the time the Company becomes incorporated.
- Applicants will receive information during the licensure process regarding the process and timing for incorporating and capitalizing the Company. The draft Articles of Incorporation may be submitted to the Secretary of State by the Financial Evaluation Division when the application is near approval. Detailed instructions for capitalizing the Company will be sent with the Certificate of Authority.

EXHIBITS

The following exhibits are required pursuant to NCGS 58-67-10 and 58-67-11. The exhibits should be clearly labeled as Exhibit 1, 2, 3 etc. Any attachments to the Exhibit should be labeled 1a, 1b, 1c etc., and referenced accordingly.

EXHIBIT 1: BASIC ORGANIZATIONAL DOCUMENT

- Articles of Incorporation, bylaws and other organizational documents should be filed with the application if a company is to be a North Carolina Corporation. All filings for incorporation will be made with the Department of Insurance. The Department may make filings with the Secretary of State.

- This exhibit should contain all basic organizational documents including any amendments to the articles of incorporation or associations, partnership agreement, or other applicable documents and articles of amendments from the Secretary of State.

- In order to secure executed contracts with providers the Company may incorporate as a general business corporation while the application is pending.

- When the Company nears licensure the Articles of Incorporation must be amended and should state that the primary purpose of the company is to function as a Health Maintenance Organization.

- At the time that the applicant is incorporated during the application process, the applicant must obtain a federal tax identification number and provide the Department with that number.

EXHIBIT 2: BYLAWS, RULES, REGULATIONS, ETC.

This exhibit typically includes bylaws or rules and regulations or similar documents regulating the conduct of the internal affairs of the applicant. The documents should be certified copies.

EXHIBIT 3: NAMES, ADDRESSES AND POSITIONS OF OFFICERS AND BOARD

- This exhibit should list the names, addresses, and official positions of persons who are to be responsible for the conduct of the affairs of the applicant, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers in the case of a corporation, and the partners or members in the case of a partnership or association. **Label Exhibit 3a**

- A biographical affidavit has been supplied in Section I. Application Forms must be completed and signed for each officer, director and person responsible for operation of the plan. All questions must be answered and if the question is not applicable, or the answer is none, please so indicate. **Label Exhibit 3b**

- The list of Officers and Board members should be consistent with the Company's proposed Bylaws, including number of board members and number and title of officers.

- Throughout the process, provide the Department with updates, including applicable biographical affidavits, as officers and board members change or are added.

EXHIBIT 4: PROVIDER CONTRACTS / ADMINISTRATIVE CONTRACTS

This exhibit must contain a copy of any contract form made or to be made between any class of providers and the HMO and a copy of any contract form made or to be made between third party administrators, marketing consultants, or persons listed in Exhibit 3.

Any management or administrative agreements entered into pursuant to NCGS-58-67-30 must be submitted for review and approval prior to use. Such contracts should clearly outline the obligations of both parties including the services to be provided to the HMO and the fee to be paid by the HMO. Services to be provided to the HMO should be outlined in terms of operational areas, support staff, etc. Prior to issuance of a license, the Department must receive executed copies of any management or administrative agreement.

- Review the regulations provided with this exhibit (Title 11 NCAC 20.0200) which outline the provisions which must be included in all provider contracts
- Review the regulations provided with this exhibit which outline the provisions which must be included in all intermediary contracts
- Provider contracts must be secured prior to the Department granting a Certificate of Authority. Attached is a detailed memorandum, which details the approval requirements the applicant must meet prior to securing contracts with providers. **The Life and Health Division will notify the applicant when approval has been authorized to execute contracts with providers.**
- When approval has been granted to execute contracts with providers, the applicant must provide monthly updates to the Department on diskette, of progress made.

Please also note the following:

- Mandatory, binding arbitration for members is prohibited by NCGS 58-3-35. Therefore, binding arbitration for members should not be referenced in provider contracts.
- Because the Department strongly discourages HMOs from practicing subrogation, provider contracts should not reference it either.
- HMOs are discouraged from filing for bankruptcy under federal code in North Carolina, pursuant to NCGS 58-67-5 (f) which defines an HMO as a domestic insurance company for purposes of USC 11, the federal bankruptcy code. This statute places HMOs under the jurisdiction of the Commissioner of Insurance. In addition, NCGS 58-67-145 outlines provisions for rehabilitation, liquidation or conservation of HMOs. Therefore, provider contracts should reference the more general term “insolvency,” rather than bankruptcy.
- Contracts should be in the true, legal name of the Company, as provided by NCGS 58-3-50.
- No language that has the potential to be interpreted as limiting physician actions or communications with members that is consistent with their professional or ethical responsibilities will be permitted. In addition, program requirements for credentialing, utilization management, etc. may not contain such provisions.
- If provider administrative manuals or provider handbooks are referenced within and made a part of the provider contracts, these documents must be submitted for review.
- All exhibits and addendums referenced in the contracts should be submitted for review.

EXHIBIT 5: DESCRIPTION OF HMO OPERATIONS

This exhibit should contain a detailed description of how the applicant intends to operate its HMO. The description should include, but is not limited to the following information:

- General background information on the applicant and/or parent (where applicable) if licensed as an insurer in other states
- If the applicant is filing as a domestic North Carolina HMO, it is the Department's preference that it establish a home office in North Carolina upon licensure and must maintain its financial and accounting records in North Carolina. All correspondence from the Department will be addressed to that North Carolina office.
- A description of proposed operations including claims processing and payment, utilization management, quality management, enrollment and billing, customer service, provider relations, etc.
- The city and state where each operation will be performed (e.g. location of affiliate or branch office what will perform claims processing)
- Affiliates and/or intermediaries who will perform operations on behalf of the applicant if known
- The type of HMO the applicant will operate (e.g. group, staff, IPA)
- The products to be offered (e.g. triple option, point of service, vision, dental)
- Management Information Systems to be employed and location of these systems
- Submit a description of the marketing strategies to be implemented
- Types of markets the applicant will concentrate on (i.e., large, small group etc.)

ORGANIZATIONAL CHARTS

- Include in this exhibit separate corporate organizational charts which clearly identify the relationships between the applicant and any affiliates.

- Include a chart(s) showing the internal organizational structure of the applicant's management [Officers] and administrative staff [Day-to-Day CEO, Medical Director (when hired) CFO, VPs, Secretary, etc.].

- If the applicant intends to establish the HMO as a domestic North Carolina corporation and will be more than 10 percent owned by any person or Company, it will meet the definition of a holding company and will have to comply with the provisions of Articles 18 and 19 of the North Carolina General Statutes, Chapter 58. Such application for holding company must be submitted within 30 days after having received a license.

EXHIBITS 6 and EXHIBIT 7 EVIDENCE OF COVERAGE AND MASTER GROUP CONTRACT

The Evidence of Coverage(s) must be provided in this section that are to be issued to enrollees and any group agreement which is to issued to employers, unions, trustees, or other organizations.

Documents that are part of the Evidence of Coverage may include: certificate issued to each enrolled subscriber of a group, group and non-group applications for coverage, non-group agreement, group subscriber enrollment form, riders, endorsements, amendments and any form that is attached or made part of the evidence of coverage.

Please provide the form number, which has been assigned to each member form submitted. If the type of form is not applicable to your plan to be offered please state n/a in the form number box.

TYPE OF FORM	FORM NUMBER(S)
Group Agreement	
Subscriber Certificate	
Non-Group Agreement	
Group Application	
Non-Group Application	
Group Subscriber Enrollment Form	
Riders	
Endorsements	
Amendments	
Letters of Agreement	
Other	

General Form Information

Questions relating to **rates, policy forms, advertising filings, etc.** should be directed to the Life and Health Division.

Each filing is assigned to an Analyst for review within 24 hours of its receipt in the Life and Health Division. Assignments are made daily.

The receptionist of the Life and Health Division maintains a list of analysts and their respective filings. Applicants are asked to deal directly with the analyst on all questions relating to a particular filing.

Please use restraint in making inquiries regarding the status of your filing. We realize it is important to you and will respond as promptly as possible, within an administratively established schedule. To expedite all inquiries regarding the status of a filing, please know the form number of your filing and/or the six digit Life and Health Division tracking number.

If applicants wish to be assured their filing has been received, they may enclose a stamped, self-addressed postcard with their filing. The postcard should identify the form number of your filing. The postcard will be returned on the date of receipt.

The flesch readability score should be provided for all policy filings. (NCGS 58-38-30).

To receive an approval communication of the filing after a Company is licensed, benefit forms should be submitted in accordance with Title 11 of the North Carolina Administrative Code (NCAC) Chapter 12, Section 0329. A vaild E-Mail Address is required.

The form number must be on the lower left corner of all forms. The form number must be unique to that form and must include a prefix or suffix if needed. (NCGS 58-51-5(a)(6).

After a Company is licensed, all future rate filings must be approved. [NCGS 58-67-50(b)(1)].

When contracting for PPO or TPA services, the filing letter must state the full name of the organization and its date of registration/licensing with the Life and Health Division (NCGS 58-56-51). If the insurer is not contracting with an outside entity, the filing letter must include an appropriate explanation.

An application or enrollment form used in the business of insurance in North Carolina must be filed for approval. (NCGS 58-3-150(a), NCGS 58-50-5 and 11 NCAC 12.0326)

To assist you in answering questions about filing requirements, visit the Life and Health Division home page at: http://www.ncdoi.com/lh/lh_home.asp

FORM COMPLIANCE

The following list of North Carolina General Statutes and North Carolina Regulations has been compiled to assist you in drafting your member forms. The applicant may review the aforementioned books or the internet for a more comprehensive list.

NCGS 58-3-50 - settlement through arbitration cannot be more restrictive than permitted by law. The right to pursue legal action through the courts cannot be eliminated.

NCGS 58-3-121 - bones and joints of the jaw or face must be covered as any bone or joint in the body. The dollar minimum for non-surgical treatment is $3500.00

NCGS 58-3-150 - all policy forms, contracts, certificates and applications must be filed with and approved by the Commissioner prior to use.

NCGS 58-3-150(b) - out of state trust or association business issued or issued for delivery to residents of this State must be filed with and approved by the Commissioner prior to issue.

NCGS 58-3-168- mandated coverage for post mastectomy inpatient care.

NCGS 58-3-169 -maternity coverage shall provide for a 48-hour hospital stay following vaginal delivery and 96 hours following cesarean section.

NCGS 58-3-170 - maternity coverage shall provide benefits on the same basis as any physical illness (if available under the health benefit plan).

NCGS 58-3-172 - written notification of denied claims to members and providers.

NCGS 58-3-190 - coverage required for emergency care.

NCGS 58-3-191 - managed care reporting and disclosure requirements.

NCGS 58-3-200 - miscellaneous insurance and managed care coverage and network provisions.

NCGS 58-38-20 - speaks to contacts and format requirements. 11 NCAC 12.0329 speaks to the minimum form filing procedures. Address all form and rate submissions to the Life and Health Division. Provide a highlighted side by side comparison of form revisions. All forms must include a form number positioned at the lower left-hand corner of the form.

NCGS 58-38-30 - flesch readability score must meet or exceed 50.

NCGS 58-50-5 - agent's certification statement.

NCGS 58-50-45 - fiduciary notice required.

NCGS 58-50-61 - requirements for utilization review and grievances.

NCGS 58-50-62 - required standards for insurer grievances procedures.

NCGS 58-50-115 - identifies plans subject to Small Group Health Reform (employer groups of 1-50).

NCGS 58-51-15(a)(2)(b)- maximum pre-existing waiting period up to 12 months for individual and association plan. Credit for time accrued under previous coverage applies to the new plan.

NCGS 58-51-30 - newborn infants and foster children mandate.

NCGS 58-51-37 - pharmacy of choice requires that all willing pharmacies be given the opportunity to participate as contract providers.

NCGS 58-51-38 - requires health benefit plan to allow each female plan participant or beneficiary age 13 or older direct access to participating obstetrician/gynecologist without prior referral.

NCGS 58-51-115 - defines health benefit plan and prohibits taking eligibility for Medicaid into consideration when issuing private health coverage.

NCGS 58-51-120 - regardless of when the child becomes eligible, no issuer may require enrollment within a certain time frame.

NCGS 58-51-125 - adopted children must be treated as newborns mandate.

NCGS 58-54-10 - Medicare supplement and Medicare Select standards.

NCGS 58-56-51 - third party administrators must be licensed.

NCGS 58-63-15(7) - no discrimination among classes of individuals.

NCGS 58-67-10 - the establishment of health maintenance organizations.

NCGS 58-67-11 - additional HMO application information.

NCGS 58-67-50(b)(1) - no schedule of premium shall be used until the demonstration is filed with and approved by the Commissioner.

NCGS 58-67-50(b)(2) - premium rates for an individual plan must be guaranteed for one year and at least forty-five days written notice must be given prior to a rate increase.

NCGS 58-67-70 - chemical dependency minimum benefit offering.

NCGS 58-67-74 - mandated coverage for certain treatment of diabetes.

NCGS 58-67-75 - no discrimination against mentally ill or chemically dependent and mandates certain level of benefits for mental illness coverage for groups with more than 50 employees.

NCGS 58-67-76 - mandated mammogram and pap smear coverage.

NCGS 58-67-77 - mandated prostate-specific antigen test.

NCGS 58-67-78 - whether or not the drug is proven effective for the type of cancer prescribed, if it is an approved drug for cancer it must be covered.

NCGS 58-67-79 - mandated coverage for reconstructive breast surgery following mastectomy.

NCGS 58-67-100 - conducting examinations as often as deemed necessary by the Commissioner.

NCGS 58-67-130 - replacing insurer must cover all validly covered under the plan being replaced.

NCGS 58-67-140 - the suspension or revocation of an HMO license.

NCGS 58-68-30 - requirements for increased portability through limitation on pre-existing condition exclusions for group health benefit plans.

NCGS 58-68-35 - prohibits discrimination against individual participants and beneficiaries based on health status.

NCGS 58-68-40 - mandates guaranteed availability of coverage for employees in the small group employer market.

NCGS 58-68-45 - mandates guaranteed renewability of coverage for employees in the group market.

NCGS 58-68-50 - mandates disclosure of information by health insurers in the small group market.

NCGS 58-68-60 - mandates availability of individual health insurance coverage to certain individuals with prior group coverage.

NCGS 90-21.22A - provisions for medical review committees acting within the scope of the functions of the committee.

11 NCAC 4.0319 - claim status report to members for claims not processed after 45 days after receipt of the initial claim by the insurer.

11 NCAC 20.0602 - written notifications required to be submitted to the Life and Health Division by the HMO.

EXHIBIT 8: FINANCIAL STATEMENTS

This exhibit should include the applicant's most recent financial statements and the financial statements of all controlling entities. If audited financial statements are available for the applicant or its controlling entities, a copy of each should be provided with the application. Please be advised of the following:

- Other jurisdictions where the Company and/or its affiliates operate should be identified. A Certificate of Good Standing from other jurisdictions in which the Company operates should be presented.

- The working capital requirements of NCGS 58-67-5(j) are in addition to the statutory deposit required by NCGS 58-67-25.

- If the applicant is filing as a foreign HMO, it must demonstrate compliance with 11 NCAC 11.0308 and must present statutory annual financial statement filings made with the state of domicile for the three years preceding the date of the application.

EXHIBIT 9: FINANCIAL FEASIBILITY PLAN

This exhibit should include a financial feasibility plan, which includes detailed enrollment projections, the methodology for determining premium rates to be charged during the first 12 months of operations certified by an actuary or a recognized actuarial consultant, a projection of balance sheets, cash flow statements, showing any capital expenditures, purchase and sale of investments and deposits with the State, and income and expense statements anticipated from the start of operations until the organization has had net income for at least one year; and a statement as to sources of working capital as well as any other sources of funding. Please be advised of the following:

- The application should state the Company's initial source of capital and the method of capitalization. The Company will be required to provide documentation that the initial capital as required by the Department has been received prior to the issuance of their license.

- A copy of the financial projection worksheet (PROJ_36.WK4), required by NCAC 16.0604, is available on diskette through the Actuarial Services Division. All projections must be on a statutory basis and include detailed assumptions. The forecasts are to be prepared on a monthly basis and **include year-end totals** for the Financial Evaluation Divisions. Please note that there are separate income statements for large group, small group, Medicare and Medicaid business. All applicable sections of the worksheet must be completed, including the contingency reserve as specified by NCGS 58-67-40. A hard copy of the projections should be presented with the filing.

- The financial statements and projections filed must be on a statutory accounting basis based upon North Carolina law.

RATE COMPLIANCE

The application must include detailed rate development for all proposed benefit packages. It is important to note that once the Actuarial Services Division has approved the rates, the large group rates are "locked in" for at least the first 12 months of operation with membership enrollment. Small group rates may be changed subject to NCGS 58-50-130, but no schedule of premiums may be used by a licensed HMO until it has been filed with and approved by the Department.

Please note the following points specifically related to rates:

- All HMOs are required to specify the number of months that a rate will be guaranteed and all special cases must be identified in a manner consistent with 11 NCAC 16.0606(2).

- In regard to extended rate guarantees, no HMO may issue a rate guarantee in excess of 12 months unless the rating methodology is filed with and approved by the Commissioner. The rate guarantee period must not exceed the term of any provider contract on which the rate is dependent and in no case may exceed 24 months.

- In regard to renewal rate caps, no HMO may guarantee a rate cap or specify a predetermined formula for a rate revision to a group for a future benefit period (beyond the current contract period). An anticipated rate cap may be stated but the HMO must specify that the rate is contingent upon the HMOs approved rating methodology and upon approval by the Commissioner. An HMO shall not state an anticipated rate cap for future benefit periods, which extend beyond approved financial projections.

- HMOs shall file actuarial data certified by an actuary and established in accordance with actuarial principles that are not excessive, inadequate or unfairly discriminatory.

- By law, the Commissioner must conduct an appropriate data analysis of all HMO rate submissions. Once the company has been licensed as an HMO, the Commissioner shall take action on the submission of all rate filings within 45 days of receipt, in accordance with NCGS 58-67-50. **Rates are not subject to this "deemer" provision in cases in which the filer has not yet been issued an HMO Certificate of Authority.**

- Please note that approved rates shall only be applicable to that period of time forward of the date of approval.

- An actuarial demonstration must accompany any form filing wherein a premium is charged. If the rate schedule for the product has received the Commissioner's prior approval, the filer must clarify and provide evidence of such approval.

- The Office of the Commissioner shall not tolerate any infraction of the law and shall vigorously pursue any HMO who violates the laws of this State. The penalty for implementing an unapproved rate shall result in fine and possible revocation of license. The Commissioner shall hold a public hearing on all such violations and impose the highest penalty allowed by law.

- The Actuarial Services Division acts as a consultant to the Department's Life and Health Division with respect to rates. If anytime during the process you need assistance, please contact the Life and Health Division first, unless contacted directly by the Actuarial Services Division.

EXHIBIT 10: POWER OF ATTORNEY FORM HMO/POA/LGL)

This exhibit must contain the power of attorney form provided with the application. The form should be duly executed by the applicant if not domiciled in this State, appointing the Commissioner and his successors in office, and duly authorized deputies, as the true and lawful attorney of such applicant in and for this State upon whom all lawful process in any legal action or proceeding against the HMO on a cause of action arising in this State may be served.

EXHIBIT 11: SERVICE AREA

This exhibit should include a completed service area form which is provided with this exhibit, indicating by way of a check or x, each county the applicant is proposing to serve. Additionally, a North Carolina Map should be provided which clearly indicates by way of shading or coloring all counties requested. Please be advised:

- HMOs are licensed in North Carolina by county. Please clearly indicate which counties are being requested. Changes in the requested service area after the application has been received will necessitate a new filing.

- A provider network must support each county requested. Signed provider contracts must be submitted to the Department during the review process.

- Failure to demonstrate an adequate network in a given county will result in that county being excluded from the service area. The deletion of counties from the service area is likely to result in a requirement for a revised financial feasibility plan.

- The Life & Health Division will review the availability and accessibility standards included in Exhibit 18 and 19 and determine if the applicant is meeting the standards set, taking into account urban and rural settings, as well as the provider to member ratios established by the applicant.

- Phased-in service areas are not permitted.

- Service area expansion requests cannot be made within the first 12 months of operation.

EXHIBIT 12: INSOLVENCY PROTECTION PROVISIONS

This exhibit must provide the applicant's provisions for protection against insolvency pursuant to of NCGS 58-67-110, 115 and 120.

If a reinsurance agreement is to be used to satisfy the provisions of Article 67 (detailed below), a draft of that agreement must be filed with the application. The reinsurance agreement must be with an insurance company licensed to do business in North Carolina. The applicant must indicate that the reinsurance agreement is filed pursuant to which, if any of the following:

- NCGS 58-67-110(e) - Protection Against Insolvency.
- NCGS 58-67-11(B)(1)(b) - Hold Harmless Agreements or Special Deposit.
- NCGS 58-67-120 - Continuance of Benefits.

Reinsurance agreements require the prior approval of the Department before execution. An executed copy of the agreement must be received prior to issuance of the applicant's license.

- If a guaranty is to be used to meet the provisions of Article 67 (detailed below) a draft of the Agreement, which is in substantial compliance with the Department's model guaranty agreement (available upon request), must be filed with this exhibit. The current financial statements of the guarantor must be filed with the Agreement. The applicant must indicate that the guaranty agreement is filed pursuant to either, or both of the following:

  - NCGS 58-67-110 - Protection Against Insolvency.
  - NCGS 58-67-115(B)(1)(b) - Hold Harmless Agreements or Special Deposit.

Guaranty Agreements require the prior approval of the Department prior to execution. An executed copy of the agreement must be received prior to the issuance of the applicant's license.

EXHIBIT 13: DESCRIPTION OF GRIEVANCE PROCEDURES

A member grievance procedure should be submitted which describes the internal grievance procedures to be utilized for the investigation and resolution of member complaints and grievances as provided for in NCGS 58-50-62.

The applicant may only use one process, which addresses both utilization management appeals of noncertifications and member grievances. If so, the procedures must comply with NCGS 58-50-61 and 58-50-62 for first and second level appeals and/or grievances.

Please submit samples of the following:

- letter to the member and, if applicable, to the member's provider acknowledging receipt of first level and second level grievances;

- written determination letter to member and, if applicable, to the member's provider for first level and second level grievances.

EXHIBIT 14: CLAIMS ADMINISTRATION

A description of the claims administration system should be submitted which clearly demonstrates compliance with provisions of NCGS 58-3-172, 58-63-15 and 11 NCAC 4.0319. The description should include the capabilities of the computer system for processing claims accurately and timely and in accordance with the requirement of the Company's various lines of business, provider payment methodologies, benefit plans and regulatory requirements. This description must also include samples of the claims administration computer system's capability of producing the following:

- an easily understandable explanation of benefits (EOB) form for members
- remittance advice (RA) form for participating providers
- written notification to members and providers of denied claims, if applicable
- written notification to members of the status of claims not paid within 45 calendar days of receipt, including cases where payment to the provider has not been made, which should include the following elements:
    - a statement that the claim has not been paid;
    - an explanation of why the claim has not been paid within the 45 day period;
    - if the reason for the delay is that investigation is not complete, all records have not been obtained, etc., then the report needs to so state;
    - if the insurer needs more information from the insured to process the claim, then it should ask for the same in the claims status report.

EXHIBIT 15: PROVIDER CREDENTIALING PLAN

This exhibit should contain all program documents, which have been developed in accordance with 11 NCAC 20.0400. This may include but not be limited to: provider credentialing plan, credentialing policies, procedures and/or criteria provider/facility credentialing application, tools used to assess provider capabilities such as office assessments, provider profiles etc.

CREDENTIALING PLAN

A provider credentialing plan should be submitted which includes the following:

- Description of the organizational structure and staffing relative to credentialing activities
- Purpose, goals and objectives of the credentialing program
- Role of the Board of Directors, Clinical Director, Quality Management Personnel and any Committee
- Provider selection criteria and credentialing requirements
- Confidentiality of provider information
- Provision whereby Committee members will not review files of providers in which they have a conflict of interest
- Procedures for verification of provider and facility credentials, including, but not limited to (and where applicable):
    - License
    - DEA Certificate
    - Board Certification
    - Medical/Professional education and training, if not board certified
    - Professional liability insurance
    - Malpractice claim history
    - Hospital privileges
    - JCAHO accreditation
    - Medicare/Medicaid program certification
- Procedures for querying recognized monitoring sources, if such sources will be referenced, including but not limited to:
    - National Practitioner Data Bank
    - Medicare/Medicaid sanctions report
    - Federation of State Medical Boards
- Procedures for waiver of credentials in certain situations
- Site Visit to Provider Location if applicable
- Actions to be taken by the Committee
- Procedures for termination and an appeal mechanism for the provider
- Recredentialing policies and procedures which include coordination with:
    - utilization review
    - quality assurance
    - member services
- Procedures for maintaining oversight over any delegated credentialing activities. If responsibility for credentialing activities will not be delegated, this should be stated.

- If credentialing is delegated, need to outline requirements.

PROVIDER/FACILITY APPLICATION

Provider and facility applications should be submitted, which include the following:

- Personal information
- Practice information
- Education and training history
- Current license, registration or certification and the names of other states where the applicant is or has been licensed, registered or certified
- DEA registration number and prescribing restrictions, if any
- Specialty board certification or eligibility, if applicable
- Professional and hospital affiliations, if applicable
- Amount of professional liability coverage and any malpractice history
- History of disciplinary actions by medical organizations and regulatory agencies
- Type of affiliation requested
- JCAHO accreditation, for facilities and if applicable
- Medicare and Medicaid certification, if applicable
- Statements regarding:
    - Conflict of interest
    - Mental health/chemical dependency
    - Felony convictions
    - Application is true and correct
- Authorization/Release to obtain information

EXHIBIT 16: QUALITY MANAGEMENT PROGRAM

This exhibit should include all program documents which assure quality of care and health care services managed and provided through the health care plan in accordance with 11 NCAC 20.0500.

QUALITY MANAGEMENT PLAN

A quality management plan should be submitted which includes, but is not limited to the following:

- Description of the structure and organization relative to quality assurance functions
- Role of the Board of Directors, Clinical Director and Quality Management Personnel
- Integration with other HMO functional areas (i.e., utilization review, credentialing, member services, claims, etc.)
- Purpose, goals, objectives, functions of the program
- Specific services to be monitored
- Confidentiality of information
- Provision whereby reviews will not be performed by any individual with a conflict of interest
- Activities/studies/methodologies to be employed
- Procedures for handling quality of care and service complaints, including corrective action plans
- Specific standards to be adopted and monitored
- Procedures for dealing with providers who are frequent and/or flagrant abusers of HMOs quality of care program, including a provider appeal mechanism
- Provision for annual evaluation and update of the program
- Procedures for maintaining oversight over any delegated quality assurance activities. If responsibility for quality assurance activities will not be delegated, this should be stated.

EXHIBIT 17: UTILIZATION MANAGEMENT PROGRAM

A utilization review program document should be submitted which clearly demonstrates compliance with each provision of NCGS 58-50-61 and 58-50-62. In addition, the following should be addressed:

- Selected key definitions that apply to utilization review or utilization management
- Policies and procedures for monitoring and evaluating the performance of third parties with which the insurer contracts to perform utilization review. Mechanisms to ensure compliance with legal requirements for utilization review.
- Scope and content of all delegated and nondelegated functions of the utilization review program which includes: procedures to evaluate medical necessity; data sources and clinical review criteria to be used in decision making; process for conducting appeals of noncertifications; mechanisms to ensure consistent application of criteria and compatible decisions; process of data collection and analytical methods to assess utilization; provisions to assure confidentiality of clinical and patient information in accordance with State and federal law; organizational structure (e.g., utilization review committee, quality assurance, or other committee) that periodically assesses utilization review activities and reports to insurer's governing body; the staff position functionally responsible for day-to-day program management; and methods of data collection and analysis to assess utilization and how that data is used to improve utilization review criteria.
- Operational requirements for the utilization review program
- Responsibilities of insurer and methods to provide for the following: routine assessment of utilization review program; procedures to coordinate the utilization review program with other medical management activity; telephone accessibility for covered persons and their providers to seek required preauthorizations; establishment of telephone accessibility standards, monitoring of actual telephone accessibility and corrective actions as indicated by at least monthly monitoring of average speed of answer and call abandonment rate; policies and procedures for requesting information necessary for utilization review; written procedures for making determinations and notifying covered persons of decisions; and written procedures to address the failure or inability of a provider or covered person to provide all information necessary for the review.
- Policies and procedures for the performance of various types of reviews, including precertification review, concurrent review and retrospective review
- Policies and procedures for the performance of standard and expedited appeals of noncertifications
- sample of noncertification letter to the member and the member's provider
- sample of letter to the member and, if applicable, to the member's provider acknowledging receipt of first level and second level appeals/grievances
- sample of written notification to the member of the second level review meeting date
- sample of written determination letter to member and, if applicable, to the member's provider for first level and second level appeals/grievances
- A clear and comprehensive description of utilization review procedures, including the procedures for appealing noncertifications and a statement of the rights and responsibilities of covered persons, including the voluntary nature of the appeals process, as described in the certificate of coverage and member handbook

EXHIBIT 18: PROVIDER AVAILABILITY STANDARDS

This exhibit should include the provider network and evidence of the ability of that network to provide all health care services to the applicant's prospective enrollees in accordance with 11 NCAC 20.0301 and 20.0304

Provider availability standards must be submitted and should address the following:

- Each network plan carrier must establish a methodology to determine the size and adequacy of the provider network necessary to serve its members. The methodology must provide for the development of performance targets that address the following:
  1. The number and type of primary care physicians, specialty care providers, hospitals, and other provider facilities, as defined by the carrier;
  2. A method to determine when the addition of providers to the network will be necessary based on increases in the membership of the network plan carrier; and
  3. A method for arranging or providing health care services outside of the service area when providers are not available in the service area

EXHIBIT 19: ACCESSIBILITY STANDARDS

This exhibit should include the applicant's provider network and evidence of the ability of that network to provide all health care services to the applicant's prospective enrollees in accordance with 11 NCAC 20.0302, 20.0303 and 20.0304

Provider accessibility standards must be submitted and should address the following:

- Each network plan carrier must establish performance targets for member accessibility to primary and specialty care physician services, hospital-based services, and health care services provided by non-physician providers. Written policies and performance targets must address the following:
  1. Proximity of network providers as measured by such means as driving distance or time a member must travel to obtain primary care, specialty care and hospital services, taking into account local variations in the supply of providers and geographic considerations;
  2. The availability to provide emergency services on a 24-hour, seven day per week basis;
  3. Emergency provisions within and outside of the service area; and
  4. The average or expected waiting time for urgent, routine and specialist appointments.

- HMOs must demonstrate that the services provided would be accessible in each county for which licensure is requested. In order to demonstrate the accessibility of the network, please submit the following:
  - Accessibility standards (i.e., ratio of physicians to members, drive time, distance to providers in terms of mileage, etc.)
  - A chart illustrating provider interest in all requested counties, broken down by county and provider specialty including mental health and ancillary. Hospital interest should also be included.