1997

SENATE PENSIONS & RETIREMENT & INSURANCE COMMITTEE

MINUTES

PENSIONS & RETIREMENT/ INSURANCE COMMITTEE

Tommy Jenkins, Chairman

Bob Martin
Vice Chair

Eric Reeves
Vice Chair

Larry Shaw
Vice Chair

Donald Kincaid
Vice Chair

James McDaniel
Ranking Minority Member

Fountain Odom

Aaron Plyler

Luther Jordan

Allen Wellon

Eleanor Kinnaird

R. C. Soles

Robert Carpenter

Robert Shaw

Hugh Webster

Don East

John Carrington

David Weinstein

NORTH CAROLINA GENERAL ASSEMBLY

COMMITTEE SUMMARY REPORT

1997-98 Regular Session — SENATE: PENSIONS & RETIREMENT & INSURANCE — Valid Through 4-NOV-1997

BILL	INTRODUCER	SHORT TITLE	LATEST ACTION ON BILL	IN DATE	OUT DATE
H 5	ALDRIDGE	HEALTH COVERAGE/DIABETES	*R -CH. SL 97-0225	05-06-97	06-05-97
H 312=	GOODWIN	UPDATE MORTALITY TABLES	*R -CH. SL 97-0133	04-28-97	05-15-97
H 391=	JARRELL	HIGH POINT FIREMEN'S PENSION	R -CH. SL 97-0067	04-21-97	05-15-97
H 434	DOCKHAM	FEDERAL HEALTH INSURANCE CHANGES	*R -CH. SL 97-0259	05-06-97	06-12-97
H 452	REDWINE	BEACH PLAN AMENDMENTS	*R -CH. SL 97-0498	04-28-97	06-25-97
H 522=	BUCHANAN	STATE FIRE AND RESCUE COMMISSION	R -CH. SL 97-0116	04-28-97	05-15-97
H 926	BRAWLEY	PREFERRED PROVIDER CONTRACTS	S -REF TO COM ON PENSIONS	05-06-97	
H1024=	HURLEY	FOREIGN INSURER LICENSING	*R -CH. SL 97-0179	04-29-97	05-22-97
H1052	MILLER G	EXCLUDE EXCESS COVERAGE/COVENANTS	*R -CH. SL 97-0396	04-30-97	07-03-97
H1062	BERRY	CHILD SUPPORT/HEALTH COVERAGE	*S -REF TO COM ON PENSIONS	05-06-97	
H1115	BOYD-MCINTYRE	CHURCH INSURANCE COVERAGE	*R -CH. SL 97-0438	05-06-97	07-30-97
S 6	WINNER	REVISE SCHOOL CALENDAR	*S -RE-REF COM ON APPROPR	03-06-97	04-03-97
S 118	PERDUE	ACCIDENT PREVEN. COURSE REDUCTION	*S -RE-REF COM ON APPROPR	02-17-97	04-24-97
S 128=	ODOM	NO INS. POINTS/15 MPH OVER LIMIT	*S -RE-REF COM ON JUDIC	02-17-97	04-29-97
S 190	WARREN	INCREASE PENSION BENEFITS-2	S -RE-REF COM ON APPROPR	02-19-97	04-10-97
S 234	KINCAID	INCREASE AMTS FOR INSURANCE POINTS	*R -CH. SL 97-0332	02-24-97	03-13-97
S 235=	MARTIN R	INCREASE PENSION BENEFITS-3	*S -RE-REF COM ON APPROPR	02-25-97	04-03-97
S 254=	ODOM	GENETIC INFO/NO DISCRIMINATION	*R -CH. SL 97-0350	02-27-97	04-03-97
S 273	FORRESTER	MASTECTOMY/HOSPITAL STAY	*R -CH. SL 97-0440	03-03-97	03-12-97
S 297=	GULLEY W	AMEND CHARTER SCHOOL LAWS	*R -CH. SL 97-0430	04-03-97	04-28-97
S 299	MARTIN R	LONG-TERM CARE BENEFITS	*R -CH. SL 97-0468	03-05-97	04-10-97
S 301=	MARTIN W	HIGH POINT FIREMEN'S PENSION	S -REF TO COM ON PENSIONS	03-05-97	
S 345=	REEVES	UPDATE MORTALITY TABLES	S -RE-REF COM ON PENSIONS	03-10-97	04-24-97
S 345=	REEVES	UPDATE MORTALITY TABLES	S -RE-REF COM ON PENSIONS	05-19-97	
S 350	SOLES	SUPPLEMENTAL INSURANCE BENEFITS	*H -REF TO COM ON HR	03-10-97	03-27-97
S 400=	WINNER	MENTAL HEALTH PARITY	*H -ASSIGNED TO INS-HLTH	03-17-97	04-28-97
S 420=	MARTIN W	STATE FIRE AND RESCUE COMMISSION	S -REF TO COM ON PENSIONS	03-18-97	
S 434	FORRESTER	NATIONAL GUARD HEALTH BENEFITS	*S -RE-REF COM ON RULES &	03-20-97	04-24-97
S 435	FORRESTER	PHYSICIAN-PATIENT COMMUNICATIONS	S -REF TO COM ON PENSIONS	03-20-97	
S 455=	HOYLE	IMPROVE HMO SERVICES	*R -CH. SL 97-0474	03-24-97	04-29-97

NOTES- = AFTER BILL NUMBER SHOWS THAT BILL IS IDENTICAL, AS INTRODUCED, TO ANOTHER BILL.
* AFTER NUMBERS INDICATES THAT TEXT OF BILL WAS ALTERED BY ACTION ON THE BILL.
BOLDED LINE INDICATES BILL INDEXED AS AFFECTING APPROPRIATIONS.

NORTH CAROLINA GENERAL ASSEMBLY

COMMITTEE SUMMARY REPORT

1997-98 Regular Session — SENATE: PENSIONS & RETIREMENT & INSURANCE — Valid Through 4-NOV-1997

BILL	INTRODUCER	SHORT TITLE	LATEST ACTION ON BILL	IN DATE	OUT DATE
S 538	BALLANCE	PROF. FIREFIGHTERS' RETIREMENT	*S -RE-REF COM ON APPROPR	03-27-97	04-28-97
S 609	MILLER B	INSURANCE AUDIT RECOMMENDATIONS	S -RE-REF COM ON APPROPR	04-01-97	04-10-97
S 611	MILLER B	INSURANCE FRONTING	*H -REF TO COM ON RULES	04-01-97	04-30-97
S 612	MILLER B	INSURER FINANCIAL OPERATIONS	*H -REF TO COM ON RULES	04-01-97	04-10-97
S 613	MILLER B	INSURANCE COMPANY AUDITS AND EXAMS	*H -REF TO COM ON RULES	04-01-97	04-30-97
S 614	MILLER B	INSURANCE LICENSING AMENDMENTS	H -REF TO COM ON RULES	04-01-97	04-21-97
S 673	ODOM	AMEND LEO RETIREMENT DEFINITION	*R -CH. SL 97-0144	04-02-97	04-28-97
S 677	CONDER	REPEAL ALBEMARLE FIREMEN'S PENSION	R -CH. SL 97-0052	04-03-97	04-17-97
S 713	REEVES	RALEIGH FIREMEN'S SUPP RETIREMENT	R -CH. SL 97-0460	04-07-97	04-17-97
S 714	FORRESTER	RECONSTRUCTIVE SURGERY/COVERAGE-2	*R -CH. SL 97-0312	04-07-97	04-29-97
S 747	JENKINS	1997 RETIREMENT BENEFITS ACT	S -RE-REF COM ON APPROPR	04-07-97	04-10-97
S 778	WARREN	FIRE MARSHALL RETIREMENT	*S -RE-REF COM ON APPROPR	04-10-97	07-01-97
S 785	MARTIN W	DIRECT PAYMENT SUNSETS OFF	R -CH. SL 97-0197	04-10-97	04-23-97
S 796	MARTIN R	AREOLA RECONSTRUCTION COVERAGE	S -REF TO COM ON PENSIONS	04-10-97	
S 797	MILLER B	HEALTH & LIFE INSURANCE AMENDMENTS	H -REF TO COM ON RULES	04-10-97	04-30-97
S 843	JENKINS	INSURANCE TECHNICAL CHANGES	*S -RE-REF COM ON PENSIONS	04-15-97	04-29-97
S 843	JENKINS	INSURANCE TECHNICAL CHANGES	*S -RE-REF COM ON PENSIONS	08-28-97	
S 881	WINNER	COVERAGE FOR EMERGENCY SERVICES	S -REF TO COM ON PENSIONS	04-15-97	
S 944	RAND	BARBER EXAMINERS RETIREMENT	S -REF TO COM ON PENSIONS	04-17-97	
S 964=	MILLER B	FOREIGN INSURER LICENSING	S -REF TO COM ON PENSIONS	04-17-97	
S 975	KINCAID	WORKERS' COMP SELF-INSURANCE	*R -CH. SL 97-0362	04-21-97	04-23-97
S1029	MILLER B	INSOLVENT INSURER REVENUE BONDS	*S -RE-REF COM ON FINANCE	04-21-97	05-22-97
S1036	KERR	INSURANCE GUARANTY ASSOC. AMENDMENTS	S -REF TO COM ON PENSIONS	04-21-97	

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BOLDED LINE INDICATES BILL INDEXED AS AFFECTING APPROPRIATIONS.

Pension & Retirement/ Insurance Committee
February 26,1997
10:00
1124 LB
Sen. Jenkins, Chairman

AGENDA

Overview of the Retirement Systems and other Benefit Programs administered by the NC General Assembly

Deputy State Treasurer Dennis Ducker

Minutes
Pensions & Retirement Committee

The Pensions & Retirement Committee met Wednesday, February 26,1997 at 10:00 in Room 1124 of the Legislative Building. Chairman Tommy Jenkins presided. There were fourteen senators in attendance.

Deputy State Treasurer and Director, Dennis Ducker gave an overview of the retirement systems and other benefit programs that are administered under the direction of the General Assembly. See attached document.

The meeting was adjourned.

Senator Tommy Jenkins, chairman

Katy Haynes, clerk

DEPARTMENT OF STATE TREASURER

Retirement Systems Division

Presentation to the Senate Committee on Pensions & Retirement and Insurance

February 26, 1997

GENERAL

Legislative Purposes

- Recruit and keep a good public workforce
- Reward career public sector employment
- Protection in cases of disability and death
- Provide deferred income after retirement

Retirement Benefits

- "Defined Benefit Plans"
- Based on Formula/Service/Salary/Age
- Not related to contributions or contribution rates

Retirement Funding

- Trust funds for exclusive purpose
- Long-term promises recognized
- Reserves to guarantee benefits
- Prefunding future payments
- Costs funded by taxpayers served
- Combined member and employer contributions
- Level contributions as a percentage of payroll

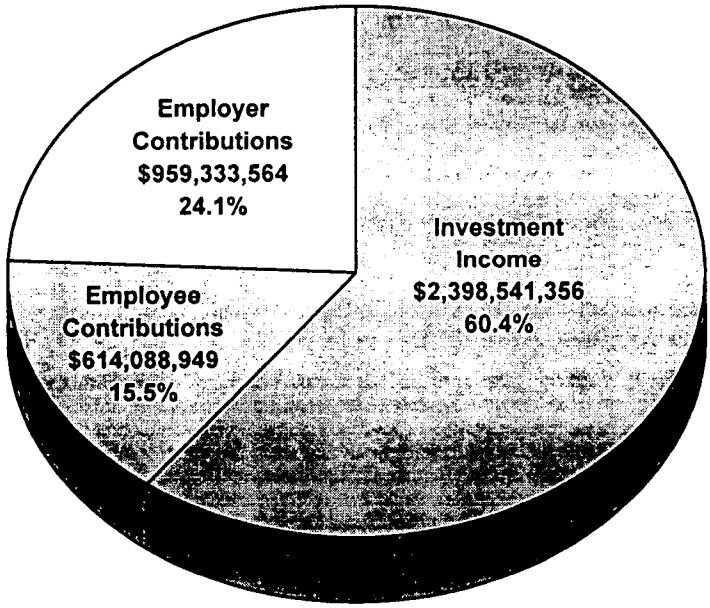
BENEFIT PROGRAMS ADMINISTERED

- Teachers' and State Employees' Retirement System
- Local Governmental Employees' Retirement System
- Consolidated Judicial Retirement System
- Legislative Retirement System and Legislative Fund
- Firemen's and Rescue Squad Workers' Pension Fund
- Supplemental Retirement Income Plan [401 (K)]
- Disability Income Plan / Teachers and State Employees
- Public Employee Benefit Trust
    - Death Benefit for Teachers and State Employees
    - Death Benefit for Local Governmental Employees
    - Death Benefit for Legislators
    - Death Benefit for Retirees
    - Separate Insurance Plan for Law Enforcement
- National Guard Pension Plan
- Registers of Deeds Supplemental Pension Plan

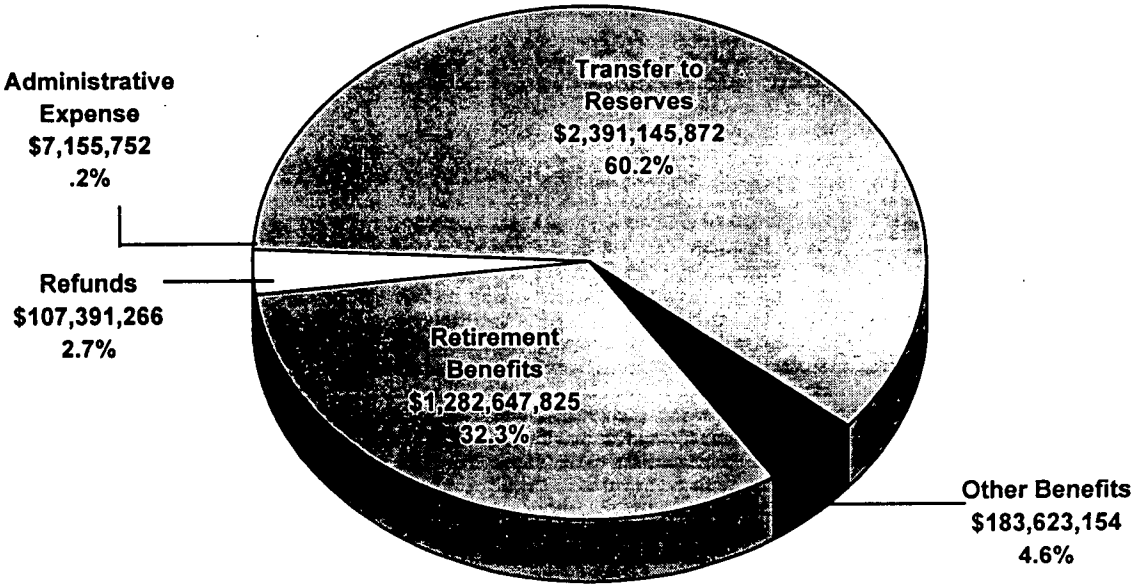
DEPARTMENT OF STATE TREASURER
RETIREMENT SYSTEMS DIVISION

Twelve Months Ended December 31, 1996
(Unaudited)

Sources of Funds



Applications of Funds



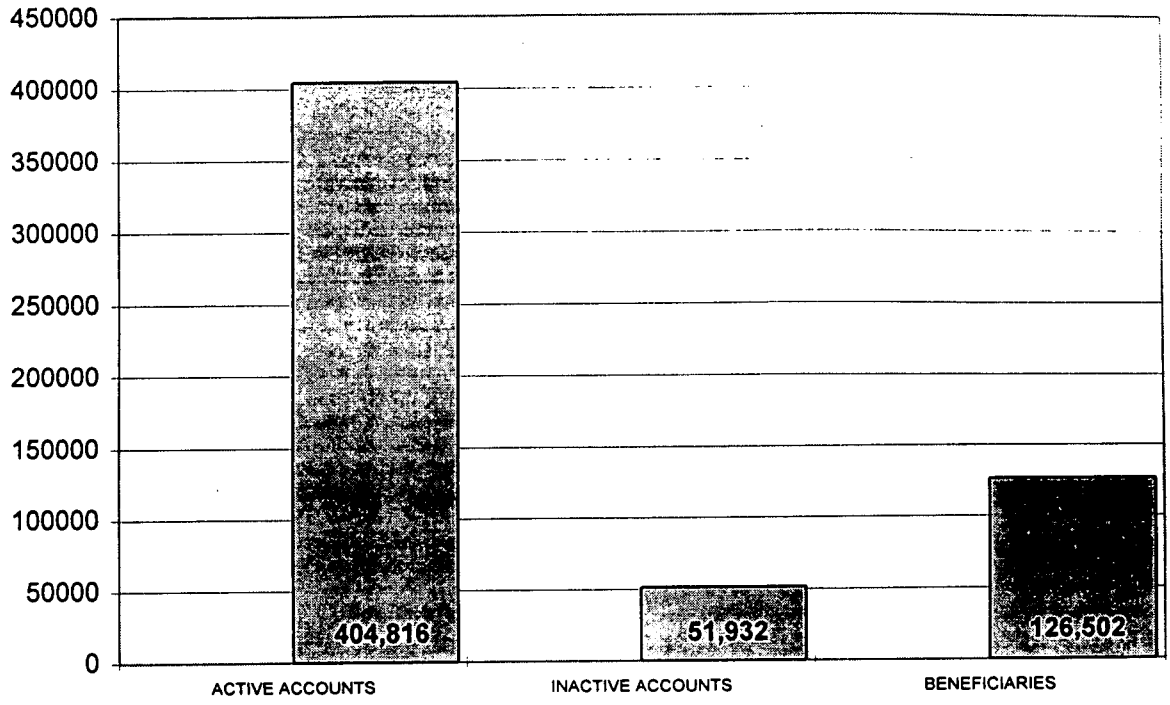
DEPARTMENT OF STATE TREASURER
RETIREMENT SYSTEMS DIVISION

Financial Highlights
Year Ended December 31, 1996
(Unaudited)

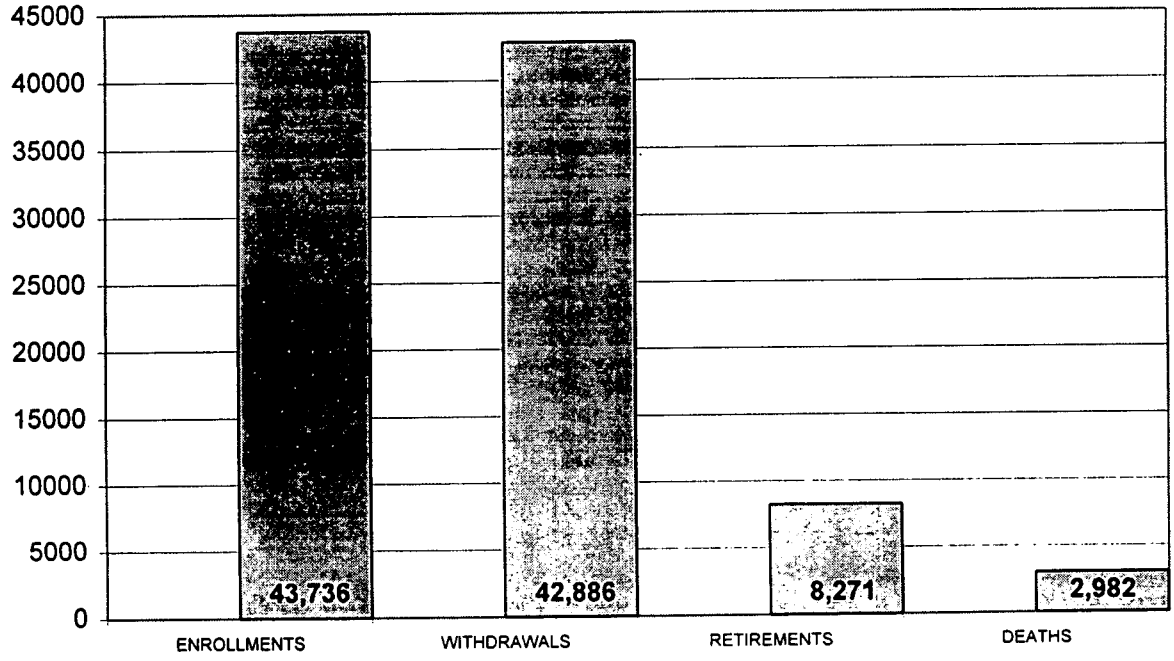
	TSERS	LGERS	CJRS	LRS	FRSWPF (3)	OTHER	TOTAL
Beginning Balance	$22,178,591,785	$5,411,167,465	$164,358,605	$12,883,019	$110,195,711	$431,894,688	$28,309,091,273
Investment Income	1,883,073,012	461,554,897	13,870,587	1,069,344	10,722,943	28,250,573	2,398,541,356
Employee Contributions (1)	438,269,112	163,812,749	2,431,675	313,833	2,955,106	6,306,474	614,088,949
Employer Contributions (2)	583,646,832	147,303,471	7,702,193	793,783	11,735,187	208,152,098	959,333,564
Total Receipts	2,904,988,956	772,671,117	24,004,455	2,176,960	25,413,236	242,709,145	3,971,963,869
Retirement Benefits	1,042,160,775	216,777,574	9,869,243	740,439	10,940,235	2,159,559	1,282,647,825
Other Benefits						183,623,154	183,623,154
Refunds	64,455,176	41,774,145	77,424	2,260	1,082,261	0	107,391,266
Administrative Expense	4,309,231	1,565,023	18,552	4,243	321,572	937,131	7,155,752
Total Disbursements	1,110,925,182	260,116,742	9,965,219	746,942	12,344,068	186,719,844	1,580,817,997
Transfer To Reserves	1,794,063,774	512,554,375	14,039,236	1,430,018	13,069,168	55,989,301	2,391,145,872
Ending Balance	$23,972,655,559	$5,923,721,840	$178,397,841	$14,313,037	$123,264,879	$487,883,989	$30,700,237,145
Footnotes:							
(1) Contribution Rate	6.00%	6.00%	6.00%	7.00%	$120 Yr		
(2) Contribution Rate	8.15%	5.24% (4)	20.65%	21.27%	430 Yr		
(3) Year Ended June 30, 1996							
(4) Average							

DEPARTMENT OF STATE TREASURER
RETIREMENT SYSTEMS DIVISION

Accounts as of December 31, 1996



Account Activity for the
Twelve Month Period Ended December 31, 1996



DEPARTMENT OF STATE TREASURER
RETIREMENT SYSTEMS DIVISION

Membership Activity Summary
Year Ended December 31, 1996

	TSERS	LGERS	FRSWPF(1)	CJRS	LRS	TOTAL
Beginning Active Members	256,904	101,341	28,099	438	167	386,949
Beginning Beneficiaries	85,036	22,825	6,613	330	163	114,967
New Members	28,325	13,057	2,338	12	4	43,736
Retirements	5,953	1,892	408	13	5	8,271
Withdrawals (2)	7,675	5,191	3,790	3	2	16,661
Deaths - Active	699	205	32	0	1	937
Deaths - Beneficiaries	2,199	585	182	9	7	2,982
Ending Active Members	270,902	107,110	26,207	434	163	404,816
Ending Beneficiaries (3)	88,790	24,132	6,839	334	161	120,256

(1) Data for the year ended June 30, 1996
(2) An additional 26,225 inactive accounts were transferred to pension accumulation funds.
(3) An additional 6,246 beneficiaries are in receipt of monthly benefits from the National Guard Pension Fund, Legislative Retirement Fund, Register of Deeds Supplemental Pension Fund, Disability Income Plan of North Carolina.

DEPARTMENT OF STATE TREASURER
RETIREMENT SYSTEMS DIVISION

FUNDED RATIOS
Year Ended December 31, 1995
(Dollars in Thousands)

Retirement System	Actuarial Liabilities	Assets	Unfunded Liabilities	Percentage Funded
Teachers' and State Employees'	$22,663,750	$ 22,178,592	$ 485,158	97.9%
Local Governmental Employees'	5,472,970	5,411,167	61,803	98.9%
Firemen's and Rescue Squad Workers' *	160,233	123,265	36,968	76.9%
Consolidated Judicial	175,127	164,359	10,768	93.8%
Legislative	12,685	12,883	(198)	101.6%

* Data for the year ended June 30,1996

CONTRIBUTION RATES
Year Ended June 30, 1997

Retirement System	Member Contribution	Employer Contribution
Teachers' and State Employees'	6%	8.15%
Local Governmental Employees'	6%	5.24%*
Fireman's and Rescue Squad Workers'	$120 a year	$450 a year
Consolidated Judicial	6%	20.65%
Legislative	7%	22.58%

* Average

Final
January, 1997

SUMMARY OF ACTUARIAL GAINS AND LOSSES[1] FOR PRESENTATION TO THE 1997 GENERAL ASSEMBLY

Retirement System	Present Value Gain or (Loss)[2]	Alternatives: Employer Contributions	Alternatives: Unfunded Accrued Liability Period	Alternatives: Enhance Benefits
Teachers' and State Employees'	$409,257,000	Decrease Unfunded Rate[3] by 0.94% for a Savings to the General Fund of $51,653,000 and to the Highway Fund of $4,192,000	N/A[4]	Increases Equal to 0.94% of Members Covered Payroll
Local Governmental Employees'	$ 81,732,000	Decrease Normal Rate[5] by 0.30% for a Savings to Employers of $9,000,000	N/A	Increases Equal to 0.30% of Members Covered Payroll
Consolidated Judicial	$ 2,271,000	Decrease Unfunded Rate[6] by 0.87% for a Savings to the General Fund of $339,000	Decrease Liquidation from 9 Years to 7 Years from December 31, 1995	Increases Equal to 0.87% of Members Covered Payroll
Disability Income Plan	($ 33,666,000)[7]	N/A	N/A	N/A

FOOTNOTES:

[1]Gains and losses are a result of the actuarial valuation of assets and liabilities for the year ended December 31, 1995.

[2]Amounts are the present value of future employer contributions.

[3]The total employer contribution rate for 1996-97 is 8.15%. The estimated payrolls are $5,495,000,000 for the General Fund and $446,000,000 for the Highway Fund.

[4]The liquidation period for unfunded accrued liabilities is frozen at nine years for the 1995-97 biennium.

[5]The current normal employer contribution rates are 4.63% for General Employees and 5.10% for Law Enforcement Officers. The total estimated payroll is $3,000,000,000.

[6]The total employer contribution rate for 1996-97 is 20.65%. The estimated payroll is $39,000,000.

[7]The employer contribution rate for 1996-97 is 0.52%. The total estimated General Fund payroll is $5,865,000,000 and the estimated Highway Fund payroll is $446,000,000.

Preliminary
January, 1997

GASB 25/27 ASSETS AT MARKET-RELATED VALUE
SUMMARY OF ACTUARIAL GAINS[1]
FOR PRESENTATION TO THE 1997 GENERAL ASSEMBLY

		Alternatives		
Retirement System	**Present Value[2]**	**Employer Contributions**	**Unfunded Accrued Liability Period**	**Enhance Benefits**
Teachers' and State Employees'	$927,500,000	Decrease Unfunded Rate[3] by 2.13% for a Savings to the General Fund of $117,044,000 and to the Highway Fund of $9,500,000	N/A	Increases Equal to 2.13% of Members Covered Payroll
Local Governmental Employees'	$ 219,700,000	Decrease Normal Rate[4] by 0.81% for a Savings to Employers of $24,300,000	N/A	Increases Equal to 0.81% of Members Covered Payroll
Consolidated Judicial	$ 6,700,000	Decrease Unfunded Rate[5] by 2.57% for a Savings to the General Fund of $1,002,000	Decrease Liquidation from 9 Years to 4 Years from December 31, 1995	Increases Equal to 2.57% of Members Covered Payroll

FOOTNOTES:

[1]Gains would be the result of the recognition of an actuarial (market-related) valuation of assets for the year ended December 31, 1995, under Governmental Accounting Standards Board Statements Number 25 and 27.

[2]Amounts are the present value of future employer contributions.

[3]The total employer contribution rate for 1996-97 is 8.15%. The estimated payrolls are $5,495,000,000 for the General Fund and $446,000,000 for the Highway Fund.

[4]The current normal employer contribution rates are 4.63% for General Employees and 5.10% for Law Enforcement Officers. The total estimated payroll is $3,000,000,000.

[5]The total employer contribution rate for 1996-97 is 20.65%. The estimated payroll is $39,000,000.

Fran update 2/26/97

General Stats

- 25 deaths
- 52 NC counties under federal disaster declaration (= + 60% of NC citizens) (8 counties added on 9/18: Buncombe, Caswell, Hertford, [redacted]de, Martin, Pitt, Randolph, Scotland; Rockingham added later)
- [redacted]ategory 3 storm, cut a 150 mile wide swath across state; 1996 = 5 federal disaster declarations in NC
- 30,275 damaged homes, total costs $2.24 billion; 16,500 of which were destroyed or have major damage (4,000 Wake County homes have major damage)
- 891 businesses damaged at a total cost of $50 million
- 150 miles of coastline damaged
- largest power outage from a natural disaster in US history;1.7 million power customers were without power on Friday 9/6; as of Saturday 9/14 98% of customers had power restored; 7,300 linesmen from 20 states worked on restoring power
- 3,000 National Guardsmen, 3,000 DOT workers and 2,000 inmates assisted in Fran recovery removing debris; more than 8 million cubic yards of debris removed at a cost of $200 million
- people in 52 federal disaster counties who lost their jobs because of Hurricane Fran are eligible for emergency unemployment benefits. According to the Employment Security Commission, unemployment must be a direct result of the disaster.

Insurance/Loss Stats

- FEMA estimates $4.5 Billion in damage (total).
- In the first week after Fran hit on Sept. 5 DOI received +3,200 calls; between 9/5/96 and 12/31/96, DOI received more than 46,600 calls
- DOI has received approximately 575 written complaints so far. Of the 140 complaints that were closed in December and January, five insurance companies had 10 or more complaints: NCJUA with 20, Farm Bureau 14, State Farm 13, NC Grange 11, and First Mutual 10. Unsatisfactory settlement/offer, denial of claim, and delay of settlement were the leading causes for complaints.
- DOI personnel staffed and provided information at 20 Disaster Relief Centers throughout eastern and central parts of the state
- expecting $1.6 Billion total insured losses from Fran; Property Claim Services so far estimates $1.31 Billion in insured losses paid in [redacted]orth Carolina from 425,000 claims; of those claims 50,000 were auto, totaling $70 Million, an average of $1,400 per claim; PCS [redacted]imates less than 3% of NC claims still outstanding
- [redacted]st. 4,500 claims adjusters working in NC
- $2 billion in agricultural and timber losses; CP&L expecting $72 Million in losses
- DHR issued $42.4 million in emergency food stamps to 157,000 low-income families affected by Fran (to families who don't normally receive stamps and to those who lost food during storm)
- as of 1/17/97 federal assistance for damage totaled $561 million in grants, low-interest loans to small businesses and other payments. More than 70,000 people have applied for help from FEMA or other agencies. Checks totaling $36.2 million had been issued to 24,300 applicants for housing assistance, and grants of $20.4 million have been awarded to 9,400 people who had no insurance or serious needs. FEMA has announced a $1.5 million grant to state for crisis counseling program for storm victims.
- as of 11/12/96 the federal SBA had loaned Triangle homeowners and business owners almost $10 million. Wake County has received more than $6 million. Other counties include: Chatham, $151,000; Durham, $502,000; Franklin, $298,000; Harnett, $666,000; Johnston, $1,349,000; and Orange, $738,000. FEMA has awarded Wake County more than $3 million in housing grants.
- more than 3,500 tree removal requests were referred to the Corps of Engineers. Folks with trees threatening their homes—call 1-888-TREE-OFF
- Red Cross officials expect to spend at least $7 million in North Carolina for Fran relief

Storm Comparisons

- Hazel-1954, category four, 14 deaths, NC losses = $136 Million (total)
- Hugo-1989, category four, 7 deaths, NC losses = $1Billion (total); $650 Million insured losses paid in NC from 240,000 claims, 215 DOI complaint files
- [redacted]ertha-1996, category two? ,$100 Million in insured losses paid in North Carolina from 55,000 claims, 25 DOI complaint files

—NCDOI—

[redacted]ources: EOC update 9/14/96; the insider 9/19/96, 9/20/96, 11/20/96, 1/17/97; Triangle Business Journal 9/20/96; Governor's Office; NC Disaster Recovery Task Force; FEMA; News and Observer 9/20/96, 9/21/96, 10/4/96, 10/27/96, 11/12/96, 12/4/96, 1/5/97; Property Claim Services

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VISITORS SIGN-IN SHEET

MENTAL HEALTH STUDY COMMISSION

Pension & Retirement 2-26-97

NAME	AGENCY	ADDRESS
1. Robert Paschal	Young, Moore	
2. Alan Miles	Barkley & Dixon LLP	
3. Richard Hatch	AARP	
4. Starla N. McKenney	DOI	
5. Dasheil Provus	DOI	
6. Brian Washington	NCAE	
7. Adam Searing	NC Health Access Coalition	
8. David Ferrell	Hafer, McNamara, Caldwell et al	
9. Chris Manning	Jordan, Price, Wall, Gray et al	
0. [illegible]	[illegible]	
1. [illegible]	Moore & Van Allen	
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5. Danielle Chavis (page)		
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Pension & Retirement/ Insurance Committee
March 5, 1997
10:00
1124 LB
Sen. Jenkins, Chairman

AGENDA

Commissioner of Labor Jim Long

Minutes

Pensions & Retirement/ Insurance Committee

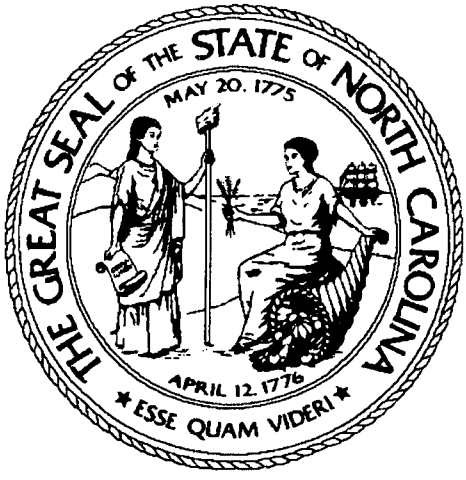
The Pensions & Retirement / Insurance Committee met Wednesday, March 5, 1997 at 10:00 in room 1124 of the Legislative Building. Chairman Jenkins presided. There were sixteen Senators present.

Commissioner of Insurance Jim Long gave an overview. He presented two documents; HMOs in North Carolina and the 1995-96 Biennial Report of the NC Department of Insurance. A period of questions and answers followed.

The meeting was adjourned.

Sen. Tommy Jenkins, Chairman

Katy Haynes, Clerk



1995-1996 Biennial Report
N.C. Department of Insurance

Jim Long
Insurance Commissioner

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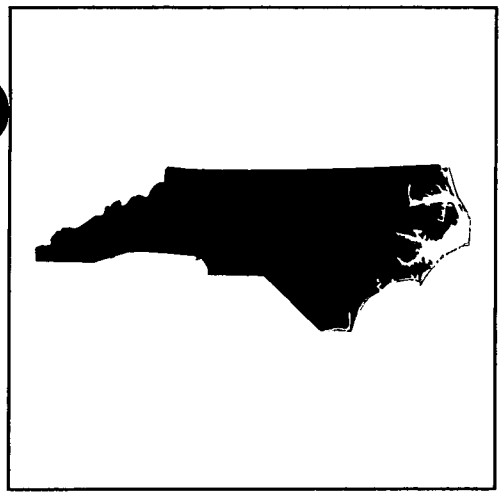
Department of Insurance Mission Statement

The North Carolina Department of Insurance serves the citizens of North Carolina through consumer protection and education, safety training and promotion, and regulation of specified activities and industries.

This is accomplished by:

- Assuring an optimum marketplace in which consumers can readily purchase fairly-priced insurance products from sound, responsive entities;
- Educating the public in loss prevention, safety awareness and developing life safety standards;
- Maintaining a well-managed, fiscally-responsible organization staffed by knowledgeable, courteous, professional employees.

At all times, the affairs of the department are conducted in an open, ethical manner and in the best interests of the public.



Ensuring Safety and Equity for North Carolinians



Insurance Commissioner Jim Long

The Department of Insurance continued to be a strong advocate for North Carolina consumers during the 1995-96 biennium on issues ranging from auto rates to fire safety.

Department staff worked long and hard to keep auto insurance rates reasonable. North Carolinians currently pay the lowest auto insurance rates of any state east of the Mississippi River, and yet still enjoy a thriving market of financially-sound insurance companies eager to do business in our state.

In December 1996, the North Carolina Court of Appeals issued its decision on the 1994 auto insurance rate filing—a decision which unanimously confirmed the commissioner's authority to set rates and supported his ratemaking approach. By the close of 1996, it was unknown whether the industry would pursue further appeals. If the Court of Appeals' decision becomes final, the commissioner will order consumer refunds totaling millions of dollars.

The department continued to work to lower insurance rates through traffic safety and injury-prevention programs. The department and Commissioner Long played a pivotal role in the success of the *Click It or Ticket* and *Booze It & Lose It* programs.

Over the past two years, the *Click It or Ticket* program has reduced fatalities and serious injuries by 12 percent, resulting in a savings of $164 million in health care costs. Also, in two recent rate filings from the auto insurance industry, savings of more than $33 million in auto insurance premiums were attributed to *Click It or Ticket*.

The *Booze It & Lose It* program is having similar success. Numbers gathered at North Carolina checkpoints indicate that we've cut late night drunk driving in half and reduced DWI-related fatalities by 20 percent. Together, these programs are saving lives, preventing injuries, and helping reduce the high medical costs of auto crashes.

The department's in-house safety programs also have been very busy during the biennium. The Buckle Up Kids program is active in 57 counties and has distributed more than 2,100 child safety seats through local fire/rescue agencies. The Learn Not to Burn program provides fire safety education to more than 90,000 fourth graders annually. A new program was added in 1996—the NC SAFE KIDS coalition is one of 250 local and state groups dedicated to childhood injury prevention.

The department has been a leader in anti-fraud efforts since establishing the first investigations bureau within an insurance department in 1945. In 1996, the Investigations Division helped to obtain a $187 million settlement in the largest criminal health care fraud case in North Carolina history. The case against this medical laboratory was investigated jointly by state and federal law enforcement agencies and was the third-largest criminal health care fraud case in the nation.

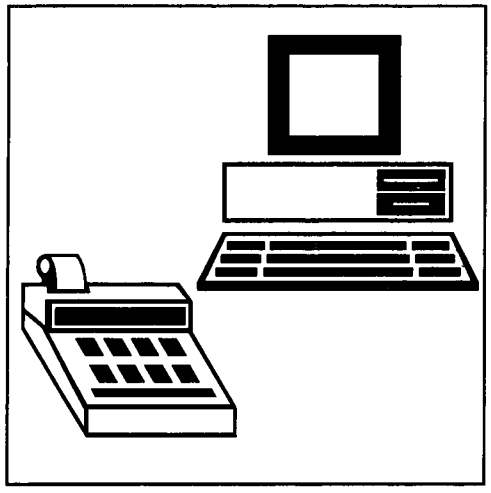
Investigators from the Special Services Division also concluded two record-breaking cases this biennium. A $250,000 fine levied against one collection agency is the largest ever assessed by the division. The owner of another collection agency pled guilty to 45 counts of embezzlement totaling nearly $400,000. He is currently serving a 21-year active sentence—the longest sentence ever ordered by the courts as a result of a criminal investigation conducted by the division. One of the division's investigators received the Governor's Award for Excellence in 1995, in part for his work on this case.

The 1995-96 biennium marked a period of great change in the health insurance industry. New federal legislation and the growth of managed care pose challenges for regulators and consumers.

The Life and Health Division has prepared legislation which brings North Carolina law into compliance with the federal Health Insurance Portability and Accountability Act of 1996, sponsored by Senators Kassebaum and Kennedy. The act requires states to conform their statutes to the new law or risk federal management of health insurance. The legislation prepared by the division is expected to be introduced during the 1997 session of the General Assembly.

The Managed Care and Health Benefits Division has developed a status report on health maintenance organizations in North Carolina. The report provides a snapshot of the current HMO industry in the state and a detailed analysis of HMO activity in 1995. The report is intended to give legislators, regulators and citizens a better understanding of the health care environment in North Carolina.

The following report explains in detail how each group, division, and unit within the department contributes to the overall mission of the NC Department of Insurance.



Company Services Group

The Company Services Group consists of five divisions: Financial Evaluation, Actuarial Services, Information Systems, Administrative Supervision, and Estate Operations.

The Financial Evaluation Division monitors the solvency of insurance companies; reviews admission of out-of-state, domestic, and surplus lines companies seeking to do business in the state; and audits domestic and foreign insurance organizations.

The Actuarial Services Division assists in the review of rate, form, and statistical filings. The division also conducts actuarial studies for financial evaluation work and is involved in special projects and studies.

The Information Systems Division manages the department's information technological resources, which include data processing, word processing, office automation, data communications and voice communications.

The Administrative Supervision Division monitors the financial condition and operations of domestic insurance companies to determine whether a troubled entity can be prevented from going into formal delinquency proceedings by returning the insurer to sound financial condition and good business practices.

The Estate Operations Division works closely with the Administrative Supervision Division to evaluate the necessity of instituting formal delinquency proceedings and to provide guidance to troubled insurers after leaving administrative supervision.

Financial Evaluation Division

The Financial Evaluation Division is comprised of the Company Admissions Section, Financial Compliance Section, Field Audit Section, Self-Insured Workers Compensation Section, and the Continuing Care Retirement Communities Section. The division regulates managing general agents and accredited reinsurers, and ensures compliance with many new solvency-related laws.

The division is currently working toward accomplishing the following goals and objectives:

- Continue to respond to the National Association of Insurance Commissioners Interim Annual Review in order to enable the department to maintain its accreditation, which was just re-awarded for five years, by this national regulatory oversight board.
- Finalize additional financial solvency laws necessary to maintain the department's accreditation with the National Association of Insurance Commissioners for introduction in the 1997 Legislative Session
- Evaluate the adequacy and appropriateness of other insurance laws administered by the division prior to the 1997 Legislative Session.
- Re-engineer the Field Audit Section.

Company Admissions Section

The primary responsibility of this section is the review and evaluation of the financial condition of insurance companies applying for initial licensing, eligibility or registration to transact insurance business in North Carolina.

It is important that insurance entities meeting or exceeding the minimum requirements be licensed or authorized so that adequate markets and competition are available to North Carolina insurance consumers. It is equally important that each entity not meeting the minimum requirements be denied a license or certificate of authority in order to protect North Carolina insurance consumers from potential insurance problems.

In 1995-1996 insurance companies continued to demonstrate considerable interest in companies seeking authority to transact business in North Carolina. During the last two years, 95 new applications were received.

A total of 76 insurance entities were qualified and received initial certificates of authority during the biennium, including the formation of one new North Carolina domestic insurance company.

This section has been responsible since 1985 for the initial review of insurance companies applying for eligibility for the placement of surplus lines business. A list of eligible companies is produced and distributed to North Carolina surplus lines brokers monthly. The surplus lines market represents insurance products that are not readily available to consumers through licensed companies. The statutory requirements for surplus lines eligibility were strengthened during 1991, 1992, and 1993.

During 1995-1996, this section received and reviewed 17 filings for surplus lines eligibility. Thirteen new companies were found to qualify and were added to the list. There were 23 companies deleted or withdrawn from the list during this period. The Financial Compliance Section is responsible for the financial surveillance of surplus lines companies after they initially qualify for eligibility.

Since early 1993, this section has been responsible for reviewing applications for accredited reinsurer status in North Carolina. During 1995-1996, 14 such filings were received. Ten companies were found to satisfy the requirements and were listed as accredited reinsurers in this jurisdiction. The Financial Compliance Section is responsible for the continued financial surveillance of accredited reinsurers.

Since late 1986, this section has been responsible for conducting the financial review of risk retention groups filing for initial registration. It has also been responsible for making the initial determination that purchasing groups satisfy the requirements for registration. These entities operate under the authority of the Federal Risk Retention Act and North Carolina Insurance Statutes governing liability risk retention. The federal act permits risk retention groups and purchasing groups to provide certain types of liability insurance coverages to their members if the group is properly licensed in at least one state and files certain minimal financial information with each state in which it desires to do business.

The department has required as much information as allowed under the federal act in order to evaluate the merits of risk retention group filings and to protect North Carolina citizens to the maximum extent possible. North Carolina statutes require a purchasing group to purchase its coverages from an insurance company that is either licensed or eligible for surplus lines business in this state.

During the biennium, a total of seven filings for initial registration were received from risk retention groups and 62 initial filings were received from purchasing groups. Fourteen risk retention groups and 51 purchasing groups received initial registration during the period. The Financial Compliance Section is responsible for the continued surveillance of these entities after registration.

Financial Compliance Section

The primary responsibility of this section is to monitor the solvency of all insurance organizations licensed and/or authorized by the department. The section has the following responsibilities:

Process and review company licenses, corporate changes and corporate filings: Includes the review of renewal license applications of insurance organizations and the review, processing and approval of corporate changes of insurance organizations. Corporate changes include: acquisitions, mergers, dissolutions, reinsurance arrangements, charter changes, bylaw changes, holding company filings, and requests for sale of securities.

Monitor financial condition of insurance organizations: Accomplished by reviewing the operations and financial condition of each organization through the financial analysis of annual and interim financial statements and other financial data. The primary responsibility of the section is to determine the financial health of each insurance organization and take necessary and appropriate steps to safeguard the interests of the citizens of North Carolina. This financial analysis process utilizes the database and programs of the National Association of Insurance Commissioners.

Maintain security deposits from insurance organizations: Includes the collection of and maintenance of all security deposits made by insurance organizations for the protection of North Carolina policyholders. The actual funds are maintained by United Carolina Bank under a safekeeping arrangement and total approximately $400 million at present. Most of the functions of the collateral securities program are computerized which allows quicker response on transactions and better monitoring of the quality of securities on deposit.

Performance Indicators	
1995-96	
Insurance organizations regulated	1,738
Financial statements analyzed	11,897
Reports on examination reviewed	1,008
Insurer licenses suspended	2
Insurer licenses revoked	6
Administrative actions	33
Deposits obtained as a result of financial inquiries	$10,000,000
Securities on deposit for policyholder protection	$400,000,000
Requests for authority to sell securities	357
Certificates of good standing, deposit, etc. processed	2,500

Field Audit Section

The primary responsibility of the Field Audit Section is to protect the interests of policyholders by ascertaining the financial strength of regulated insurance entities through on-site verification of financial data reported to the department. This function is conducted principally at the home office of insurance companies. Practices and procedures developed by this section, the Financial Evaluation Division, and the National Association of Insurance Commissioners (NAIC) provide the framework for the examinations conducted. This department was instrumental in directing the NAIC to incorporate North Carolina's in-house procedures into the NAIC Financial Examiners' Handbook. These procedures were adopted by the NAIC in 1994 and became required procedures in all states in 1996.

From January 1995 through December 1996, the Field Audit staff examined 61 domestic companies. Beginning in 1996, the section assumed responsibility for the field examinations of self-insured workers compensation groups.

EDP audit software sub-licensed from the NAIC is used to supplement other examination procedures. Both mainframe and personal computer versions of this software are utilized. Beginning in 1997, the section will explore implementation and training with new audit software that is currently under review by the NAIC.

Other automation includes the use of personal computers and various software packages. The previous objective to provide each examiner with a computer for use in the examination process has been met. However, with technological advances and the development of more sophisticated

software applications, much of the hardware had to be updated during 1996. The section believes upgrading of hardware will continue to be a challenge in the coming years as technology changes.

Electronic communication with the office and the NAIC is an important part of the examination process. The field examiners' personal computers are equipped with modems so they may connect to the department's and the NAIC's LAN file server. Field examiners can now gain access to financial information of insurance entities and provide information gained through the examination process.

Self-Insured Workers Compensation Section

This section reviews and evaluates applications of all entities that self-insure for liability under the Workers Compensation Act for initial licensing and ongoing solvency analysis. These entities are composed of "individuals" (single employers that retain their liability) and "groups" (two or more employers that pool their liabilities).

In the fall of 1995, the legislature passed significant legislation affecting groups. This legislation provided the department with additional authority to evaluate the financial condition of groups through additional filing requirements, examination by the Field Audit Section, and other oversight responsibilities.

Currently, there are 380 individuals and 29 groups. These entities generated $18.3 million in premium tax revenue in 1996.

Continuing Care Retirement Communities Section

The Continuing Care Retirement Communities Section is charged with the responsibility of registration, disclosure, contract, and financial monitoring requirements for continuing care facilities in North Carolina. This section serves to provide for the financial oversight and licensing of continuing care facilities as well as providing additional safeguards for facility residents and prospective residents.

This authority, which became effective on January 1, 1990, applies only to facilities that furnish lodging or independent living combined with health-related services under a contract for the life of the individual, or for a period in excess of one year. Current laws provide for: disclosure of all material facts and financial data, departmental authority to intervene in the event of insolvency or the imminent danger of financial impairment, departmental authority to audit the financial records of facilities, and the establishment of a nine-member Advisory Committee to advise the Commissioner of Insurance on matters related to these facilities.

Facility filings sent to this section include a disclosure statement, certified financial statements, forecast projections, listings of services and fees, and residency agreements or contracts. Facility filings are evaluated for statutory compliance, financial stability, operating trends, and consistency between disclosure statements and residency agreements.

The first filing was received on January 29, 1990. As of December 31, 1996, 43 continuing care facilities have been issued permanent licenses. These 44 facilities are serving some 13,000 North Carolina residents.

Actuarial Services Division

Life and Health Section

This division's review of rate change requests has saved consumers covered under individual accident and health insurance policies approximately $1.6 million in 1994, approximately $3.5 million in 1995, and approximately $1.2 million in 1996. An additional $285,537 in savings will result from rate compromises that become effective in 1997. Since the division's review of the rates began, consumers have realized savings of approximately $29.7 million as of December 1996.

During the biennium, Actuarial Services collected data and evaluated the impact of mandated reductions in the credit life insurance prima facie rates. The results of lowering the credit life insurance prima facie rates show a modest increase in the incurred loss ratio as of the end of 1995. It is expected that the incurred loss ratio will continue to increase with further reductions in prima facie rates.

Actuarial Services annually reviews the Medicare supplement insurance refund calculations submitted by insurance carriers. All carriers were correctly performing the calculations and no refunds were made for calendar year 1995. Actuarial Services also continues to review Small Employer Group actuarial rate certifications to assure compliance with the Small Employer Group Health Reform Act.

Actuarial Services continues to assist other divisions in regard to all aspects of actuarial science. As an example, Actuarial Services has assisted the Consumer Services Division with consumer complaints on rate increases (small employer group rate increases) and with questions concerning the recently adopted policy illustration regulation; the Financial Evaluation Division with shepherding Actuarial Guideline XXX through the rules adoption procedure; the Field Audit Division with various reserve and proper accounting of reserve items; the Managed Care Division in regard to the licensing of new HMOs and investigating HMO rate violations which resulted in several HMOs being fined; the Life & Health Division with reviewing unusual life, annuity and health insurance products as well as the review of all individual accident and health insurance and HMO rate revisions; and the State Health Plan with respect to the review of all rates submitted by HMOs.

Actuarial Services also provided the South Carolina Department of Insurance with its evaluation techniques and procedures for reviewing individual accident and health insurance rate revisions, HMO applications for certificate of authority, HMO rate revisions, and MEWA applications and regulations.

Property and Casualty Work

Actuarial Services works closely with the Property and Casualty Division in reviewing rate filings, loss cost filings, form filings and statistical filings. Actuarial Services has been heavily involved in private passenger automobile rate filings, workers compensation filings, self-insured compensations funds, and discussions with the North Carolina Rate Bureau on hurricane models for possible use in homeowners filings. The Actuarial Services Division strives to maintain rates that are not excessive and are not unfairly discriminatory to policyholders, yet adequate so as to provide a reasonable profit to companies and to protect their solvency. From the 1989 private passenger automobile filing, the companies were ordered to refund almost $140 million, including interest, to North

Carolina drivers. In addition, the Actuarial Services Division helped save drivers in North Carolina approximately $400 million from the 1994 filing and about $13 million from the 1995-1996 filing with potential refunds of approximately $900 million from those two filings.

The 1995 workers compensation filings were changed to produce loss costs rather than final rates. The Actuarial Services Division reviewed requests for loss cost decreases of 15.4% in 1995 and 13.7% in 1996. Additionally, as a result of loss costs legislation, the Actuarial Services Division has reviewed more than 100 loss cost filings for individual companies.

Another change in legislation dealt with workers compensation groups. This change strengthened the department's oversight of self-insured workers compensation groups. The Actuarial Services Division has reviewed the rate structure for every one of the self insured groups domiciled in North Carolina. This division has also assisted the Financial Evaluation Division in the financial review of these groups.

As a result of the protracted litigation involved with the 1993 homeowners rate filing the Actuarial Services Division has met several times with the North Carolina Rate Bureau to discuss the feasibility of using hurricane models in rate filings. Much information has been exchanged and much progress has resulted. In addition to these activities, this division has reviewed hundreds of rate filings, loss-cost and loss-cost adoption filings for commercial lines of insurance.

Financial Evaluation Work

Actuarial Services assists various sections of the Financial Evaluation Division. Actuarial analyses are performed on financial projections and proposed rates of companies applying for admission or registration in North Carolina. Loss and loss adjustment expense reserve reviews are also performed to aid in the financial evaluation of domestic insurance companies.

Information Systems Division

The Information Systems Division deals with high-technology issues and equipment, with a goal of using technology effectively to support the department's regulatory function. This activity, known within state government as "information resources management" (IRM), includes voice, image and data processing equipment and software, as well as telecommunications systems such as two-way radios, telephones and facsimile equipment.

Day-to-day responsibilities include programming, operating, planning, and managing five local area network (LAN) servers connected via the state's area network; and providing support for the department's microcomputers. An electronic mail system connects our staff with all other state departments of insurance; NAIC staff in Kansas City, Washington, and New York; other state government agencies; numerous private insurance companies; and Internet addresses worldwide. The division also provides office automation training to department staff.

The Information Systems Division is directly responsible for maintaining four major application systems on the network: consumer complaint tracking and analysis, company licensing, property and casualty rate and forms filings, and life and health rate and form filings. Staff of the division also work with computer programmers at State Information Processing Services (SIPS) to maintain and develop major software systems for our Agent Services and Self-Insured Workers Compensa-

tion units. Other smaller applications include fire incident reporting and an inventory of state property, which is self-insured by the department.

The Information Systems Division also consults with the department's line divisions regarding technology planning. Information Systems is the department's representative on the SIPS Advisory Board, and represents Commissioner Long on the Information Resources Management Commission as required. Similarly, the division exercises approval authority over all acquisitions of information and technology resources such as telephones, radios, computers, software, services, and maintenance contracts.

Under the state's revised IRM management structure as implemented by the 1992 General Assembly, the division will continue to perform the lead role within the department for integrated information technology planning and management. Similarly, within the department, the division provides staff support to a committee of managers of line divisions setting hardware and software standards, and IRM operational policy.

Administrative Supervision Division

The Administrative Supervision Division was formed in early 1992 to increase regulatory scrutiny over potentially-troubled insurance entities domiciled in North Carolina. The primary responsibility of this division is to closely monitor the financial condition and operations of domestic insurance entities deemed to be in a potentially hazardous financial condition. The ultimate goal of this division is to determine whether a troubled insurance entity can be prevented from going into formal delinquency proceedings and returned to sound financial condition and good business practices.

Examples of close monitoring procedures performed by this division include:

- financial analyses of annual and interim financial statements and other financial data, including holding company and affiliated company data;
- initiating, monitoring and enforcing workout plans designed to correct deficiencies causing the hazardous financial condition;
- performance of targeted financial and operational examinations;
- institution of formal administrative supervision proceedings designed to protect insurance company assets through a workout period.

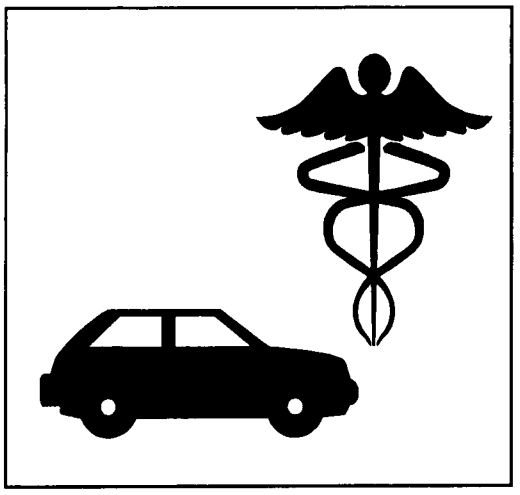
Potentially-troubled insurance companies are transferred to the Administrative Supervision Division via interaction with the Financial Evaluation Division and other divisions of the Department of Insurance.

Estate Operations Division

The Estate Operations Division works closely with the Administrative Supervision Division to evaluate the necessity of instituting formal delinquency proceedings and to provide guidance to troubled insurers after leaving administrative supervision. The unit's ultimate goal is to rehabilitate and/or liquidate troubled and insolvent insurers in order to protect and preserve, to the maximum extent possible, the remaining assets of the insurer for the benefit of the company's policyholders, creditors and the public.

The Estate Operations Division manages the financial and operational affairs of domestic insurance entities placed into receivership. Examples of specific duties performed include:

- marshaling assets, pursuing asset recoveries and liquidating assets of companies in receivership to the maximum benefit of policyholders and other creditors;
- managing the operations of the various departments of the insurer through a runoff period including claims, underwriting, policyholder service, data processing, accounting, and personnel.
- coordinating relationships and issues involving the various state guaranty associations called upon to pay policyholder claims.
- providing litigation support services and coordinating relationships and issues involving federal and state investigative agencies outside of the Department of Insurance.



Technical Services Group

Created in September 1988, the Technical Services Group is comprised of the Property and Casualty Division, Market Examinations Division, Life and Health Division, Seniors' Health Insurance Information Program and the Managed Care Division.

The Property and Casualty Division's primary responsibility is the review of rate, rule and policy form filings relating to property and casualty coverages. These filings are made by insurance companies, statutory bureaus and licensed rating organizations.

The Life and Health Division is responsible for the review and approval of rate, rule and policy form filings submitted by life and health insurance companies. Beginning in late 1996, this division began regulating the activities of third party administrators and multiple employer welfare arrangements.

The Market Examinations Division conducts field examinations of the market practices of domestic and foreign insurers and their representatives. Market Examinations has been reorganized and has standardized its review, summary, expense and examination procedures in order to develop meaningful trends.

The primary function of the Seniors' Health Insurance Information Program (SHIIP) is to train adult volunteers to help older adults through the maze of Medicare regulations, Medicare supplement insurance, long-term care insurance and claims procedures. In September 1992, SHIIP completed a six-year drive to expand the program to all 100 counties of North Carolina.

The Managed Care Division was established in 1992 to monitor and regulate the activities of managed care entities including: health maintenance organizations (HMOs), preferred provider organizations (PPOs), utilization review organizations (UROs), managed care indemnity health insurers, multiple employer welfare arrangements (MEWA), and third part administrators (TPAs). The division's emphasis is on how company activities affect consumers in North Carolina. The division accomplishes its work through several types of activities: market practice examinations of companies, review of document filings required of companies, and data collection and analysis.

While each of these functions has existed within the department for a variable number of years, the Technical Services Group was formed to increase their effectiveness, improve communication and enhance coordination, primarily with the actuarial staff and financial analysis examiners, as well as with other divisions within the department.

Property and Casualty Division

This division licenses rating organizations, advisory organizations and joint underwriting associations, and reviews rate, rule and policy form filings made by these entities. The division also collects filing fees for rate and form filings. In addition, this division reviews the rates, rules and forms for the North Carolina Rate Bureau , North Carolina Reinsurance Facility, Beach Plan, Fair Plan and licensed property and casualty insurance companies.

State law permits insurance coverages to be placed with surplus lines companies — those unlicensed in North Carolina — as long as there is compliance with applicable statutes and rules. Surplus lines taxes are the responsibility of specially-licensed agents; this division receives and reviews the tax forms submitted by these agents. In 1995-96, surplus lines premium taxes generated $6,417,124 for the state.

Premium Taxes

	No. of Policies	Premium	Tax Generated
1995	27,659	$83,649,691	$4,182,483
1996*	22,135	$44,692,812	$2,234,642

**Through 9/96*

Rate Deviations

State law allows companies to file rate deviations (discounts) on coverages such as private passenger automobile, homeowners, and dwelling fire under the jurisdiction of the North Carolina Rate Bureau. A typical deviation would be lower auto insurance premiums for autos with anti-locking brakes.

New Rate Deviations

	HO	Dwelling/Fire	Auto	WC	Combined Auto/HO
1995	197	74	139	88	0
1996*	202	71	150	90	1

**Through 9/96*

Consent To Rate

Because some risks cannot be written at standard rates, state law permits companies to charge higher-than-standard rates on individual policies with the written consent of the policyholder. Prior to October 1, 1996, insurance companies were required to submit consent information to the Commissioner of Insurance for approval. However, due to a statute change, this division no longer reviews such information. Each insurance company must now maintain the required information for review during market conduct examinations or specific inquires from this department.

Consent To Rate Requests

	Private Auto	All Others
1995	791,775	3,314
1996*	754,411	2,785

**Through 10/96*

Filings Review

Because this division's primary responsibility is the review of forms, rules and rates, filings must be carefully analyzed. During 1995-1996, a total of 17,923 filings were reviewed.

Forms, Rules and Rates Reviewed

	Companies and Organizations
1995	8,395
1996*	9,528

**Through 12/16/96*

Workers Compensation

Effective September 1, 1995, the method in which workers compensation insurance rates were established changed. The new system provided that the North Carolina Rate Bureau would determine the "loss cost," then each insurance company would determine its "multiplier." *Loss Costs* are based on historical aggregate losses and loss adjustment expenses adjusted through development to their ultimate value and projected through trending to a future point in time. A *multiplier* is an individual company's determination of expenses, other than loss expense and loss adjustment expense, associated with writing workers compensation and employers liability insurance.

Workers Compensation Loss Costs Filings			
	NC Rate Bureau	Residual Market	Individual Company
1995*	1	1	0
1996**	1	1	177

**Effective 9/1/95*
*** Through 11/96*

Workers Compensation Rates 1985-1996				
Filing Year	Rate Requested	Rate Implemented	Statewide Premium	Employer Savings
1985	12.90%	7.50%	$289,077,233	$15,610,171
1986	12.80%	5.80%	$363,134,574	$25,419,420
1987	16.80%	15.90%	$419,796,824	$3,778,171
1988				(no filing)
1989	16.80%	9.00%	$509,210,148	$39,718,392
1990	29.30%	18.90%	$541,485,184	$56,314,459
1991	41.80%	15.80%	$575,129,570	$149,533,688
1992	40.30%	33.00%	$650,405,437	$47,479,597
1993	15.50%	9.30%	$865,000,000*	$53,630,000
1994				(no filing)
NC Rate Bureau Loss Costs Base Rates				
1995	-15.00%	-15.00%	$603,000,000	$92,259,000
1996	-14.00%	-14.00%	$511,000,000	$70,000,000
			Total Savings	**$541,280,898**

Significant Issues

Building Code Effectiveness Grading: North Carolina is one of three states that have approved this rating system for Commercial Property. The Building Code Effectiveness Grading Schedule developed a grade of 1 to 10 for a community based on the adequacy of its building code and the effectiveness of its enforcement of that code. The credits for the grades range from -1% to -15%. The Commissioner of Insurance approved the rate filing effective March 1, 1995.

Auto Rate Filings: The 1995 Auto Rate Filing was withdrawn as a result of problems with the data. Instead of a 1996 filing, the 1995 Filing was amended. Data problems still existed in the 1996 data but most were corrected. At the conclusion of the hearing, the Commissioner of Insurance ordered an overall rate *decrease* of 8.3%. The North Carolina Rate Bureau implemented a rate *increase* of 5.5% over the commissioner's order. The matter is now in litigation.

In December 1996, the North Carolina Court of Appeals issued its decision on the 1994 auto insurance rate filing—a decision which unanimously confirmed the commissioner's authority to set rates and supported his ratemaking approach. By the close of 1996, it was unknown whether the industry would pursue further appeals. If the Court of Appeals' decision becomes final, the commissioner will order consumer refunds totaling millions of dollars.

Private Passenger Auto Rates
1984-1996

Filing Year	Rate Requested	Rate Implemented	Consumer Savings*
1984	3.90%	-0.20%	$23,535,607
1985	20.80%	10.40%	$69,767,852
1986	12.20%	1.00%	$98,010,197
1987	4.10%	1.00%	$36,525,296
1988	6.40%	4.30%	$23,917,914
1989	4.10%	-6.10%	$127,768,278
1990	9.60%	4.00%	$77,400,316
1991	9.60%	4.00%	$83,191,330
1992	-4.20%	-6.10%	$28,537,119
1993	(No filing)		
1994	17.70%	4.40%	$418,072,648
1995/96	6.10%	5.50%	$12,771,921
		Totals	**$999,044,625**

** Difference in total manual premium dollars between filed and implemented rates*

Medical Malpractice: Many companies have been revising physician and surgeon rates this year. The companies have made changes ranging from reclassifications to small overall rate increases. Two new companies have submitted filings for physicians and surgeons professional liability and are pending approval. This market appears to remain very competitive. It also appears that major changes may occur in the hospital professional liability market in 1997. The industry has indicated that a change in the rating basis will probably be filed in the next year. There has also been some interest from the industry in writing capitated stop-loss coverage. Approval is now pending for one company's program. Division staff anticipate more of these filings in 1997.

HO-91 Program: The new homeowners program was approved by the Commissioner of Insurance on April 1, 1996 with an effective date of November 1, 1996. The new program contains the following new coverages and enhancements:

New Coverages

- Other Structures away from the Residence Premises (HO 04 92)
- Refrigerated Property Coverage (HO 04 98)
  $500 limit of coverage
  $100 deductible
- Special Personal Property Coverage for Unit-Owners (HO 17 31)

Coverages Enhancements

- $1,000 Special Limit on grave markers *removed*
- $1,000 Special Limit for electronic apparatus *added*
- $2,500 Additional coverage for landlord's furnishings *added*
- Exclusion for damage resulting from "constant or repeated seepage or leakage over period of weeks, months, or years" *removed*
- Threshold for actual replacement to receive replacement cost settlement *raised* from $1,000 to $2,500
- Up to 10% of Coverage A for Ordinance or Law Coverage

Beach Plan: There were three important changes made during the 1996 legislative session.

- The development of a proposal for a Reserve Fund to pay catastrophic losses as recommended by the Legislative Research Committee.
- Passage of an act to revise the Beach Plan participation formula. The revision to the formula is to encourage companies to write voluntary policies in the Beach area and enable them to write themselves out of the losses of the Beach Plan.
- The addition of business income coverage to the coverages available from the Beach Plan.

North Carolina Insurance Underwriting Association
(Beach Plan)

	Premiums	% of Change	Policies Issued	% of Change
Beach Policies Only				
1995	$14,844,286	9%	18,135	7%
1996	$16,237,766	9%	19,113	5%
Wind and Hail Policies Only				
1995	$6,911,128	52%	7,154	31%
1996	$8,134,454	18%	8,368	17%
Total Beach Plan				
1995	$21,755,414	19%	25,289	13%
1996	$24,372,220	12%	27,481	9%

Life and Health Division

The 1995-1996 biennium has been a period of explosive activity for this division. Activities relating to federal and state health insurance reform, increases in the volume of life and health form and rate filings, and changes to life insurance rules have significantly impacted the workload of the division.

Health Insurance Issues

Most of the division's efforts have concentrated on health insurance issues. Many of these activities were a result of the public's interest in making health insurance more accessible, and the continued growth of uninsured persons in North Carolina.

Division staff served as a consultant to the NC Health Planning Commission and its successor, the NC Health Care Reform Commission. Staff members assisted the regional health insurance Purchasing Alliances in their efforts to make health insurance available to North Carolina's small businesses. Assistance was provided to the Small Group Carrier Committee as it revised the "standard" and "basic" plans to make them more marketable, and thus increase access to health insurance for small businesses. In response to Senate Bill 652 (enacted by the 1995 legislative session), which analyzed the impact of adjusted community rating on North Carolina and other states, the division researched and drafted a report submitted to the General Assembly.

The division prepared legislation which brings NC law into compliance with the requirements of the recently enacted federal Health Insurance Portability and Accountability Act of 1996, sponsored by Senators Kassebaum and Kennedy. The law makes all group health insurance plans "guaranteed issue," and increases the "portability" of all health insurance plans. The federal legislation requires

states to conform their statutes to the new law or risk federal management of health insurance. The legislation prepared by the division is expected to be introduced during the 1997 session of the General Assembly.

The division has worked closely with the Managed Care and Health Benefits Division in its oversight of managed care in North Carolina. Issues in which the division has been involved include "pharmacy of choice," freedom of access to obstetricians/gynecologists, length of maternity stays, confidentiality of data and trade secrets and the advertising of insurance products.

Much effort was spent in 1996 on issues relating to violations of rate laws by HMOs in North Carolina. It came to the attention of the division that several managed care organizations were using rates which had not been approved by the Commissioner of Insurance, or were offering rate guarantees or rate caps in violation of state statutes. These violations are apparently due to the intense competition for business within the HMO industry. Two cases have been closed. In both, the commissioner imposed monetary penalties on the managed care organizations. Research on other cases is continuing, and they are expected to be resolved in 1997.

Life Insurance Issues

The department adopted a rule governing life insurance illustrations in 1996. The rule, based on the model regulation for life insurance illustrations developed by the National Association of Insurance Commissioners, was effective January 1, 1997. As used in the rule, "illustrations" are presentations or depictions that include non-guaranteed elements of a policy over a period of years. The rule establishes how the various elements of a life insurance policy shall be described, how illustrations of future policy values shall be explained to consumers and how calculations of future policy values shall be projected.

Form and Rate Filings

The 1995-1996 biennium witnessed a steady increase in both the volume and complexity of health insurance form filings. New products, many of which contain innovative and complex provisions, were submitted to the Life and Health Analysts for review as the health insurance industry responded to increasing concern about costs, increasing marketplace competitiveness, the growth of the managed care industry and increasing pressure to provide insurance for the uninsured.

Life and Health Form/Rate Filings

	Forms Filed	Fees Received
1995	6,881	$307,560
1996	7,414	$328,342

Seniors' Health Insurance Information Program

The Seniors' Health Insurance Information Program, known as SHIIP, was established in 1986 by North Carolina Insurance Commissioner Jim Long in response to an increased number of calls, letters and complaints from older North Carolinians confused by their health insurance options.

The activities and duties performed by SHIIP provide a valuable service to the State's senior population. SHIIP's primary objective is to educate the public on seniors' health insurance concentrating on Medicare, Medicare supplements and long-term care insurance. SHIIP educates the public using a three tier approach:

- by training volunteer counselors in all 100 counties of NC to educate and counsel their peers on seniors' health insurance
- by operating a toll-free hotline from the Raleigh SHIIP office, and
- by developing educational materials for use by consumers.

Since its creation SHIIP has trained more than 8,000 senior volunteers who undergo an extensive 24-hour training course to serve as SHIIP counselors. *Currently there are almost 1,500 active SHIIP volunteers covering all 100 counties in the state.* SHIIP Education Specialists conducted 41 training programs in 1995 and 25 in 1996, training a total of 427 volunteers. As a result of these trainings, SHIIP volunteers documented cash savings to clients of $339,204.51 in 1995, and $110,981.00 in 1996. In addition to individual counseling SHIIP received 31,353 calls on the hotline during 1995-96. SHIIP creates a number of consumer publications on a yearly basis including the *Medicare Supplement Comparison Guide* and the *Guide to Long-Term Care Insurance in North Carolina* and serves as a clearinghouse for many Health Care Financing Administration publications.

SHIIP is coordinated in each county through an existing human service agency such as a Council on Aging office, a Senior Center, or a Cooperative Extension office. These agencies serve as sponsors and provide important continuity, an available point of access and are models for interagency cooperation. Currently there are 124 SHIIP sponsors in our state.

SHIIP Achievements:

- receipt of national recognition from the Council of State Governments
- receipt of *Medicare Beneficiary Services Award* from HCFA in 1990
- training and informational workshops for NC Cooperative Extension Service agents on health insurance
- development and distribution of multimedia program called *Medicare Myths* which targets the pre-retirement audience and details five common misconceptions about Medicare and how these misconceptions can be hazardous to pre-retirement planning
- development and statewide distribution of an informational video on long-term care insurance
- development of Employer Group Health Plans and Related Issues Module
- development of direct mailer project targeting all North Carolinians turning age 65 in 1996

Market Examinations Division

The Market Examinations Division was created to monitor insurance company market practices, especially as they affect consumers. The examination methods employed by the division are based on a program developed by the National Association of Insurance Commissioners (NAIC). By agreeing to pilot the NAIC program, North Carolina became the first state in the nation to conduct market examinations along the lines promulgated by the NAIC.

The division is staffed by a deputy commissioner, a management support person, 13 field examiners and two clerical support persons. The division monitors the activities of foreign and domestic insurance carriers operating in North Carolina.

The division is divided into four regular examination teams, each capable of responding to special problems or concerns related to company practices.

Examinations are conducted on a regular rotation so that all companies domiciled in North Carolina will be examined on a four-year cycle and dominant foreign companies on a five-year cycle. A company's size usually dictates the number of analysts required for an examination. Most companies require no fewer than three analysts to conduct a thorough, effective examination.

Upon completion of the examination, and after a report has been submitted to the Commissioner of Insurance, the company is required to take action on all areas of concern referenced in the report.

Examinations are divided into three categories: general, focus and market segment. The three types of examinations require distinct protocols to ensure that companies are treated fairly and without prejudice or unfair discrimination.

Market Conduct Examinations

Year	General	Focus	Market Segment
1994	6	36	14
1995	16	13	5

Managed Care and Health Benefits Division

The Managed Care and Health Benefits Division was established in 1992 to monitor and regulate the activities of managed care entities including: health maintenance organizations (HMOs); preferred provider organizations (PPOs); utilization review organizations (UROs); managed care indemnity health insurers; multiple employer welfare arrangements (MEWA); and third party administrators (TPAs). The division's emphasis is on how company activities affect consumers in North Carolina.

In contrast to traditional indemnity health insurance, through which insureds obtain covered services from health care providers of their choice and with little consideration of plan requirements, managed care plans determine many of the specifics of the delivery of care, such as the types of

providers available, selection of individual providers, and programs and policies that insureds and their treating physician must follow as a condition of receiving coverage.

As a result of the additional company and enrollee obligations present in the contractual relationship under a managed care plan, special regulatory concerns, in addition to traditional concerns relating to fair marketing practices, fair policyholder treatment, and financial capability, are warranted. These concerns relate primarily to the provider networks utilized by managed care plans, and their programs and policies designed to promote effective care and eliminate unnecessary care. Misapplication of these tools and techniques could result in insureds not getting coverage for the services promised under their policy, either through outright denial of coverage or through systematic barriers to care.

The division accomplishes its work through several types of activities: market practice examinations of companies, review of document filings required of companies, and data collection and analysis. These activities are discussed below.

The division's examination program has focused entirely on HMOs, with a few exceptions in earlier years. This focus is due to the fact that HMOs employ the highest level of policies and techniques to "manage care," thus having the greatest potential impact on consumers, as well as due to the need to utilize staff to perform statutorily prescribed examination duties. The examination program provides for examination of each HMO on at least a triennial basis, as required by law, and includes review of operational areas of a company, including management and control, provider network development, utilization management programs, quality assurance activities, third-party contracting arrangements, marketing, member services, claims payment, and underwriting practices. Examinations last between two and nine weeks, depending on their type and areas covered. General examinations entail comprehensive review of policies, procedures and practices in major operational areas of the company. Compliance examinations are designed to ascertain whether the company has taken corrective action to address problems found during the previous general examination.

The division is also responsible for reviewing filings for an HMO certificate of authority. These reviews are conducted in consultation with other divisions in the department, including actuarial and financial staff, and include review of applicant companies' planned operations, as well as an on-site pre-licensure examination. When resources permit, a licensure follow-up examination is conducted approximately 12 months after a new HMO has been licensed. The purpose of follow-up examinations is to ensure that actual operations are in accordance with that proposed in the licensure application, as well as to review company policies and procedures relating to areas addressed in law or regulations.

HMO Examinations and Licensure Summary

Year	Licensed HMOs	General Exams	Compliance Exams	Pre-Licensur Exams	Follow-Up Exams	Total Exams
1994	18	1	1	6	0	8
1995	22	5	4	10	7	26
1996	27	6	4	2	1	13

In-house review is performed on form health care provider contracts used by HMOs and managed care indemnity health insurers and annual registration filings from PPOs and UROs. Review of these filings permits evaluation of company practices and compliance as indicated by their written policies and procedures, data reporting, and assertions made by company officers. For form provider contracts and PPO registrations, review is performed to establish compliance with regulations pertaining to carriers' responsibilities for arranging the provider networks to which insureds are directed. For URO registrations, review is performed to determine procedural compliance with regulations governing the utilization review process, as well as the member appeal process when care is denied.

Managed Care Filings

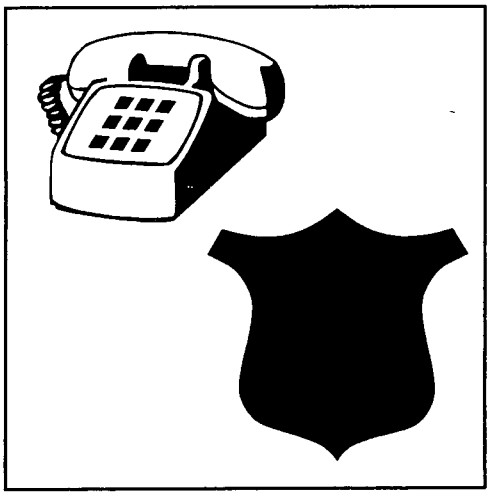
Year	Provider Form Contracts	PPO Registrations	URO Registrations
1994	not available	41	110
1995	250 (estimated)	84	140
1996	429	111	146

Commencing in the latter half of 1996, staffing resources have been dedicated to data collection and analysis of the managed care industry. Better data is expected to be of use to the department, in both its policy-making and enforcement efforts, as well as to legislators, other policy-makers, and researchers. Depending upon future directions, analyses useful to employers and/or consumers could be developed. Examples of possible data usage as a result of efforts currently underway include:

- the establishment of industry trends and norms relating to areas such as accessibility of provider networks (e.g. the types and numbers of health care providers included insurers' networks), utilization management practices (e.g. rate of denials of care, the timing and results of member appeals of such denials), member complaints about service and quality of care (e.g. reasons for member complaints and companies' policies for resolving complaints);
- assessment of managed care penetration, enrollment trends, and demographic and geographic enrollment information that may provide information about industry practices; and
- compilation of summary company information that provides interested parties with an overview of managed care industry presence and performance in North Carolina.

The number of licensed TPAs has grown from 118 as of December 31, 1994, to 149 as of December 31, 1996. An additional 48 TPAs which serve only self-funded single employer plans were registered with the Department as of December 31, 1996. Effective December 1996, TPA licensing was moved from the Managed Care and Health Benefits Division to the department's Life and Health Division.

Since laws were enacted to license multiple employer welfare arrangements, six licenses have been issued, three in 1993, two in 1994, and one in 1996.



Public Services Group

The Public Services Group is comprised of the Agent Services, Consumer Services, Special Services and Investigations Divisions.

The Agent Services Division regulates and issues licenses for insurance agents, adjusters, brokers and appraisers. The division reviews license applications, licensing examinations, and maintains a file on every licensed insurance professional doing business in the state of North Carolina.

The Consumer Services Division helps North Carolina consumers get answers to their insurance questions and resolve their insurance problems. A highly-trained staff of consumer specialists advise and acquaint consumers with courses of action they may pursue to solve their particular problems.

The Special Services Division is responsible for licensing and investigating complaints related to insurance premium finance companies, professional bail bondsmen and runners, collection agencies and motor clubs.

The Investigations Division is responsible for investigating criminal violations of North Carolina's insurance laws. Requests for investigations come from within the department, consumers, law enforcement agencies, local, state and federal agencies and insurance companies.

Consumer Services Division

The technical and complex nature of insurance generates a multitude of questions from the consuming public and from many segments of the insurance industry itself. Questions touching upon all types of insurance products are handled by our Consumer Services Division. Each year the division (a staff of 29 consumer service specialists and support personnel) provides valuable assistance to a broad array of our citizens.

During the 1995-96 biennium, division staff handled an average of more than 100,000 telephone calls and processed almost 10,000 written consumer complaints each year. A computerized data format allows for continuous updates and changes on each complaint file.

Such computerized complaint handling and the accumulation of related information offers important indications of how well departmental regulatory measures are affecting insurance market practices.

During the 1995-96 biennium, the consumer services staff was involved and active in a number of areas:

- The staff spoke to numerous community groups and educational gatherings on a variety of insurance topics, including automobile, health, workers compensation, and specialty coverage.
- The division helped to identify financially-troubled insurance agencies and assisted consumers in the resolution of resulting problems.
- The division, through its Market Assistance Plan, continued a remarkable record of helping prospective commercial policyholders locate and procure hard-to-find coverage that reduced their risks and allowed them to stay in business.
- The division provided direction and information to the department's Market Examinations Division relating to complaint experience regarding insurance companies' conduct in the marketplace.
- Staff provided front line participation at disaster recovery centers in the aftermath of natural calamities such as hurricanes, tornadoes and flooding.

In 1995-96, Consumer Services proceeded with the development of a new PC client/server data base. In early 1997, this new state of the art technology system will replace the division's first ever computer data base which was installed in 1985. The data collected and stored will be more readily accessible, and will enhance significantly the division's ability to monitor statutory and regulatory compliance of the insurance industry.

The Consumer Services Division serves as a significant front line service organization. Division staff continues to improve the quality of their service to consumers through professional training and continuing education.

Agent Services Division

The Agent Services Division protects the general public of North Carolina by ensuring that individuals representing the insurance industry have an adequate knowledge of the industry and possess the moral and ethical characteristics necessary to operate in a fiduciary capacity. The division's main function is to regulate all licensed agents, brokers, limited representatives, appraisers and adjusters authorized to do business in North Carolina. This regulation includes all activities concerning licensing, appointing and educating agents, brokers, adjusters and limited representatives (both resident and non-resident) selling insurance and adjusting claims of insurance in North Carolina.

The division operates in three separate and distinct sections. The Licensing/Pre-Licensing Education (PLE) Section establishes and administers minimum standards for licensure of agents, adjusters, brokers and limited representatives as well as recommending regulatory action. Division staff works closely with the Consumer Services Division, the Investigations Division, and the Attorney General regarding regulatory matters.

The Financial Section handles the billing and collection of all fees payable to the division. This section is responsible for adhering to the state's Daily Deposit Act and other state government accounting procedures. All reports are audited by the State Auditor.

The Continuing Education Section establishes and administers minimum education standards to maintain licensure through the Continuing Education program. This section also performs insurance agency examinations to determine compliance with the North Carolina statutes and regulations, and recommends regulatory action.

The division regulates the operation of 79 pre-licensing insurance schools conducted through private vendors, trade associations, universities, community colleges, and technical institutes. In addition, there are 4,661 approved continuing education courses being offered by 560 providers. An additional 235 seminars were approved for continuing education credits during 1996.

Agent Licensing Activity

	1995*	1996**
Examinations	13,852	13,506
Licenses Issued	21,155	23,109
Agent Appointments	128,770	150,685
Certification Letters	18,052	16,423
Renewals/Appointments	317,864	388,782

** Reflects dates 1/1/95 through 12/31/95*
*** Reflects dates 1/1/96 through 12/19/96*

In August 1996, the Licensing Voice Response Unit (VRU) was activated, (919) 981-5244. This number provides access to license status and general licensing information. The division is currently developing a computer program for the electronic download of insurance companies' appointments and terminations

The Continuing Education Voice Response Unit (VRU) is a toll-free number, 1-800-931-7111. Licensees may call this number from 7:30 a.m. - 11:30 p. m. Monday through Saturday to access their continuing education records and information on continuing education courses currently being offered.

The division continues to conduct routine examinations of insurance agencies. These examinations are conducted daily across the state by field examiners. The examination process gives the division an opportunity to review the records and operations of NC agencies. The purpose of the examination is to ensure that agency staff is appropriately licensed, review financial information, determine if files are accurately underwritten and to recommend continuing education courses. There has been a noticeable decrease in the number of agencies that have gone out of business since the implementation of routine examinations. The rules governing the continuing education program have been revised to give the division more control over the quality of instruction.

Investigations Division

Established in 1945 as the nation's first investigations bureau within an insurance department, the Investigations Division enjoys a long history in criminal investigation of insurance related crimes. The division conducts criminal investigations and supports prosecution of individuals, companies, and entities violating insurance and other criminal statutes.

During the biennium the Investigations Division initiated and concluded investigations of complex financial crimes in the area of health care fraud, while continuing the traditional vigilance over dishonest insurance agents and policyholders. Previous changes in management, investigative emphasis, and law enforcement personnel have produced positive results.

The recent criminal conviction and pre-trial diversion settlement of a medical laboratory fraud case is an example of the positive effect of these changes. The case was investigated jointly by state and federal law enforcement agencies, including the Investigations Division, and resulted in a criminal conviction with a $5 million fine, plus an additional $182 million in restitution to the federal, state, and local governments. These monetary penalties made this the largest criminal health care fraud case in North Carolina history, and the third largest in the nation. Individual settlements by insurance companies across the nation are now being pursued due to the investigative efforts and guidance of the Department of Insurance.

Other significant developments in the past two years include a less lenient stance by our court system for insurance agents convicted of embezzling premiums. Recently, four insurance agents or former agents have received active prison terms for stealing premium dollars from insurance companies. These sentences have ranged from a high of 20 years to three years incarceration. In previous years, active sentences were rarely imposed against insurance agents. Aggressive investigation and support of prosecution of insurance agents that divert and misapply funds from policyholders and insurers remains a major investigative initiative by the Investigations Division.

As evidenced by the statistical data below, the numbers of complaints and case referrals continue to increase. While the success of the Investigations Division cannot be measured only in numbers of convictions or amounts of money recovered, this data is an important measure of the success of our mission of combating insurance fraud.

Investigations Activities Report

	1995	1996
Complaints and case referrals received	441	532
Investigations Initiated	88	72
Criminal Convictions	29	32
Restitution/monetary recoveries	$804,346.58	$187,447,246.08
Pending criminal cases	115	100

Restitution Report					
County	1995	1996	County	1995	1996
Alamance	$0.00	$187,000,200.00	Madison	$0.00	$1,069.02
Brunswick	$0.00	$13,317.88	McDowell	$5,189.13	$0.00
Buncombe	$76,245.76	$0.00	Mecklenburg	$229,066.98	$17,641.53
Caldwell	$0.00	$19,762.00	Moore	$4,944.84	$0.00
Catawba	$71,839.00	$32,133.55	Nash	$0.00	$6,509.99
Chowan	$0.00	$117,025.98	Onslow	$9,046.00	$0.00
Cleveland	$955.14	$0.00	Orange	$0.00	$8,162.73
Columbus	$25,814.00	$0.00	Pasquotank	$0.00	$0.00
Cumberland	$0.00	$3,501.75	Pender	$2,994.57	$15,610.71
Davidson	$2,932.00	$0.00	Pitt	$0.00	$0.00
Duplin	$0.00	$20,485.00	Randolph	$642.83	$0.00
Durham	$49,134.72	$11,566.07	Richmond	$36,241.89	$3,015.18
Edgecombe	$0.00	$16,361.37	Rockingham	$0.00	$14,004.48
Forsyth	$33,025.67	$0.00	Stanley	$0.00	$0.00
Gaston	$0.00	$22,067.32	Union	$659.00	$3,862.00
Guilford	$13,114.00	$82,702.45	Wake	$0.00	$29,653.23
Henderson	$1,850.00	$0.00	Wayne	$32,864.40	$0.00
Hoke	$2,630.00	$0.00	Wilkes	$4,911.78	$0.00
Johnston	$5,168.00	$6,000.00	Wilson	$4,410.49	$0.00
Lenoir	$5,592.71	$0.00	Other states	$146,056.61	$0.00
Lincoln	$0.00	$2,593.84	Totals	**$804,346.58**	**$187,447,246.08**

Prospectus

Case referrals related to the approximately 425,000 Hurricane Fran claims were beginning to be reported at the end of 1996. These storm related claims will likely dominate the complaints received by the division in 1997. The Investigations Division has participated with insurance companies in a catastrophe task force that analyzes and investigates suspicious storm related claims. The division also has assigned investigators to work with investigators from the Federal Emergency Management Agency's Office of the Inspector General to pursue criminal investigations of fraud perpetrated by contractors, adjusters, and policyholders. In addition to significant health care fraud cases and catastrophe related crimes, the Investigations Division will continue the customary investigative role involving fraud committed by licensed insurance agents, insurance companies, workers compensation fraud, and staged automobile accidents.

Special Services Division

The Special Services Division is responsible for licensing, auditing, and monitoring insurance premium finance companies, motor clubs, collection agencies, professional bail bondsmen, bail bond runners and surety bondsmen. The division protects the public by investigating allegations of criminal as well as statutory violation by these licensed entities and seeking prosecution, restitution and/or disciplinary action.

In 1995-96, the division licensed the following entities to operate in North Carolina:

1995-96 Licensees

Name of Industry	No. of Licensees	
	1995	1996
Insurance Premium Finance Companies	213	192
Insurance Premium Finance Companies (Branch Office)	122	119
Collection Agencies In State (128) Out of State (181) In State (133) Out of State (166)	309	299
Professional Bail Bondsmen	230	219
Bail Bond Runners	354	311
Surety Bondsmen	Not Recorded	646
Motor Clubs	32	32
Motor Clubs (Branch Office)	401	421
Totals	**1,661**	**2239**

During this biennium, the division completed a total of 1,073 routine and criminal investigative assignments. As a result of these assignments, criminal and regulatory actions were taken against the violators. Fifty-two criminal charges by investigators of the division resulted in 29 arrests. Civil penalties totaling $305,600.00 were levied and $439,526.92 in restitution was ordered paid. The division monitored and administered $333,785.38 in consumer funds to North Carolina consumers. (See following tables detailing criminal/regulatory actions and refunds effected.)

Consumer Refunds

	Bail Bondsmen		Collection Agencies		Premium Finance Co.	
County	1995	1996	1995	1996	1995	1996
Alamance				$8,002.32		
Bladen		$605.00				
Cleveland	$500.00					
Columbus					$1,786.00	$165.00
Durham		$510.00			$237.53	$382.55
Edgecomb	$655.00					
Forsyth			$1,543.00	$156.95		
Gaston	$4,155.00	$5,500.00		$14,469.92		
Guilford			$4,000.00		$1,478.00	
Harnett					$327.17	$263.94
Haywood	$30.00					
Iredell		$3,150.00				
Mecklenburg*	$2,370.00	$4,085.00	$1,428.47			
Nash	$1,600.00	$275.00				
New Hanover	$650.00					
Onslow	$1,075.00					
Pasquotank		$75.00				
Pitt	$700.00	$50.00	$22.00			
Robeson	$3,300.00					
Surry	$425.00					
Vance		$11,000.00				
Wake	$11,890.00	$7,456.75	$375.00		$290.00	
Watauga				$226,870.78		
Wilkes			$290.00	$450.00		
Totals	$27,350.00	$34,106.75	$17,368.47	$249,949.97	$4,163.70	$811.49

*A Motor Club in Mecklenburg County refunded $35.00 in 1995.

Summary of Civil Penalties, Criminal Convictions, Restitution, and License Action

1995	Civil Penalties Number/Penalty Amount	Criminal Convictions Number/Restitution	License Action Denial, Revocation or Suspension
Bail Bondsmen	14/$34,250.00	8/$2,832.00	5
Collection Agencies	0/0	2/$417,975.00*	2
Premium Finance Co.	1/$3,100.00	0/0	0

1996	Civil Penalties Number/Penalty Amount	Criminal Convictions Number/Restitution	License Action Denial/Revocation, or Suspension
Bail Bondsmen	8/$10,250.00	6/$4,250.00	15
Collection Agencies	3/$254,500.00**	1/$14,469.92	1
Premium Finance Co.	1/$3,500.00	0/0	0

*The owner of the collection agency charged and convicted in Pitt County is currently serving the longest sentence ever ordered by the courts as a result of a criminal investigation conducted by the division.

**The $250,000 civil penalty against the collection agency located in Watauga County is the largest fine ever accessed by the division. Pursuant to Article IX, Section 7 of the North Carolina Constitution, this fine was remitted to the Watauga County School Board.

During this biennium the division processed findings of facts and request for payments from North Carolina county officials to satisfy bail bond judgements from security deposits held in trust by the department. The process resulted in payments to various clerks of courts (local school boards) totaling $761,344.18. The payments are detailed in the attached chart.

Bail Bond Judgements

County	1995	1996	County	1995	1996
Alamance	$529.00		Johnston	$3,075.00	$285.00
Alexander	$1,000.00	$6,235.23	Lenoir	$1,870.00	$6,330.00
Alleghany		$1,595.00	Martin		$95.39
Beaufort	$1,725.00	$3,903.47	Mecklenburg	$59,705.00	$35,650.00
Brunswick	$18,450.00		Nash	$7,457.10	$2,934.00
Buncombe	$7,820.00		New Hanover	$33,609.89	$41,880.00
Cabarrus	$10,247.63	$435.60	Northampton		$1,115.00
Caldwell	$2,410.00	$2,150.00	Onslow	$5,487.00	$101,485.66
Catawba	$5,735.00	$335.00	Orange		$2,375.00
Cleveland	$510.00		Pender	$620.00	$1,010.00
Columbus		$12,541.00	Pitt	$40,976.00	$26,644.86
Craven		$11,040.00	Polk		$500.00
Cumberland		$3,808.00	Robeson	$21,300.00	
Durham	$10,040.00	$15,599.12	Rowan	$555.75	$31.52
Edgecomb	$2,601.75	$8,007.12	Sampson	$33,105.00	
Forsyth	$71,835.04	$138.28	Surry		$7,436.54
Franklin	$1,175.00	$150.00	Vance	$7,550.00	$1,160.00
Gaston		$917.75	Wake	$37,827.09	$30,999.24
Granville	$2,435.00	$1,356.75	Warren		$1,150.00
Greene	$5,010.00	$1,715.00	Watauga	$600.00	
Guilford	$27,237.40	$3,560.00	Wayne		$835.00
Harnett	$1,810.00	$275.00	Wilson	$85.00	$20,840.00
Haywood		$250.00	Yadkin		$1,000.00
Henderson	$700.00				
Iredell		$185.00	Totals	$403,389.65	$357,344.18

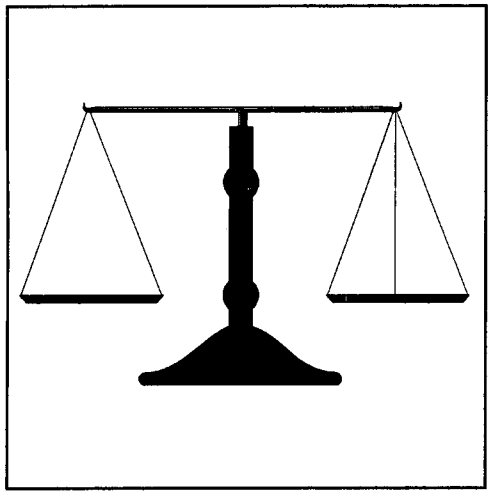
Legislative Action

The 1995 session of the General Assembly ratified Senate Bill 534, which regulates surety bondsmen, bail bondsmen, and runners. In summary, this act redefined the term "surety bondsmen" and changed the licensing procedures whereby all bail bondsmen (professional bail bondsmen and surety bondsmen) and bail bond runners would be licensed and regulated by the Special Services Division pursuant to North Carolina General Statute 58, Article 71.

Personnel

In 1995 one of the criminal investigators of the division was recognized for his devotion to duty and received the Governor's Award for Excellence. This was the first employee of the Department of Insurance to ever receive this award. In 1996, the Governmental Accounts Auditor of the division was nominated and elected as the candidate to represent the Department of Insurance for the Governor's Award for Excellence within the category of Devotion to Duty.

The Deputy Commissioner of the division has been instrumental in organizing and establishing the North American Collection Agency Regulatory Association (NACARA). The purpose of the NACARA is to enhance the administration and enforcement of collection license laws by providing members with opportunities for communication on license law matters, to conduct research and obtain information on license matters for professional improvement, and to encourage and develop cooperation with other organizations whose major objective is of a similar nature. In 1996, the Deputy Commissioner of the division was elected President of the NACARA.



Office of the General Counsel

This organizational unit provides internal legal advice to all divisions of the department. The division includes two Attorney IVs who litigate all rate cases for the department through final appellate adjudication. The department's General Counsel also acts as liaison with the Attorney General. The office coordinates hearings on a wide variety of administrative matters and prepares complex orders and memoranda for the Commissioner. The General Counsel serves as one of the Department's hearing officers having final agency decision authority, and reviews all department contracts with suppliers and consultants.

General Counsel

The General Counsel must give legal direction and counsel to the Commissioner, all members of the department, and the Attorney General in areas relating to insurance law, general civil practice, statutory and common law, criminal law and procedure. Further, the General Counsel serves as the hearing officer for a wide variety of administrative hearings. The General Counsel also provides legal direction and counsel concerning the laws relating specifically to the activities of the related non-insurance entities regulated by the divisions in the department. The General Counsel directly supervises the activities of two Attorney IVs and two administrative secretaries and evaluates the effectiveness of the work of the Attorney General in the context of providing advisory opinions and handling administrative proceedings and other litigation. The General Counsel also litigates cases at the instruction of the Commissioner of Insurance when the Department of Justice conflicts with representing the Department of Insurance.

Activities of the General Counsel		
	1995	1996
Hearings on Agent Summary Suspension/License Revocations	21	15
Hearings on Agent/Bailbondsmen Denial of License Applications	0	15
Hearings on Appeals from Decision of Joint Underwriting Authority, Beach Plan, FAIR Plan, and Guaranty Associations	3	5
Licensure Matters Relating to Insurance Companies	0	5
Other Administrative Hearings	8	3
Informal/Formal Opinions Produced In-House by General Counsel	0	106
Other Matters Handled by the General Counsel (Excluding Administrative Hearings)	0	34
Matters Referred to Attorney General's Office for Review/Informal Opinion	6	114
Market Conduct Hearings	2	0

Ratemaking Litigation

During the 1995-96 biennium the Office of the General Counsel continued to be closely involved in several pieces of significant litigation involving ratemaking for lines of insurance under the jurisdiction of the North Carolina Rate Bureau. Until early 1996, these cases were handled primarily by outside counsel and outside witnesses under the direction of the General Counsel. Beginning in early 1996, however, two Attorney IV positions and one staff position were created by the 1995 General Assembly. These positions assumed the ratemaking functions in the General Counsel's Office, thereby eliminating the necessity for contracting outside counsel in complex rate cases.

In September 1994, the Commissioner disapproved an auto insurance filing submitted by the Rate Bureau on February 1, 1994. The Commissioner stated that it was "excessive and unfairly discriminatory" in part because it added million of dollars to the bills of many of the state's drivers so others could be given "deviations," or premium discounts. The industry insisted that such cost shifting is authorized by state law, but after a five-week administrative hearing, the Commissioner found otherwise. The Commissioner's 1994 order was subsequently appealed to the North Carolina Court of Appeals.

In December 1996, the Court of Appeals issued its decision affirming in part, yet remanding the case to the Commissioner for further clarification. Notwithstanding the partial remand, the court's decision unanimously confirmed the Commissioner's authority to set rates and supported the Commissioner's ratemaking approach. By the close of 1996, it was unknown whether the industry would pursue further appeals.

If the Court of Appeal's decision becomes final, the Commissioner will order consumer refunds totaling millions of dollars. Until such time, the escrow funds will continue to accrue interest.

The Rate Bureau's 1995 filing was continued prior to its hearing. The delay was due to substantial data errors discovered by the industry in the ratemaking database underlying the filing. In April 1996 the Rate Bureau submitted a filing which satisfied the 1995 and 1996 filing requirements. The Department held a six-week hearing. The Commissioner issued his final "order" in October 1996 disapproving the filing. The Rate Bureau appealed the Commissioner's order to the Court of Appeals.

The 1994 and 1996 automobile rates cases are the only cases on appeal at this time. In past years, as many as five rates cases have been simultaneously on appeal by the Rate Bureau.

In its 1995 and 1996 filings, the Rate Bureau filed for significant decreases in Workers Compensation rates which were approved by the Commissioner without formal hearing. Department staff join the industry and businesses in hoping that the significant reforms enacted by the legislature in 1995 will continue to reduce workers compensation costs and, hence, the premiums paid by North Carolina businesses.

While these lengthy rate cases involve public expense in staff and consultant time, taxpayers have enjoyed an enormous rate of return on funds disbursed from the Consumer Protection Fund created by N.C.G.S. 58-2-215. The Fund has fulfilled its promise of "leveling the playing field" for state regulators facing the substantial resources of the insurance industry. The table below details this favorable cost-to-benefit ratio.

Departmental Rate Regulation

Rate Filing	Total Savings	Total Cost	Savings/Consumers
1994 Auto	$1,029,700,277	$911,210	$1,130
1995/1996 Auto	$320,675,852	$619,107	$518



Safety Services Group

Comprised of the Engineering, Manufactured Building, State Property Fire Insurance Fund, and the Fire and Rescue Services Divisions, the Safety Services Group administers and enforces life safety standards throughout the state, promotes risk management practices throughout government, and maintains a sound insurance program for state agencies.

The Engineering Division administers the state building code. Providing staff to the NC Building Code Council, the NC Code Official Qualifications Board and the Home Inspectors Licensing Board, the division is comprised of seven sections: code consultant, electrical, mechanical, modular, inspector certification, building code council and handicapped accessibility.

The Manufactured Building Division works to assure that construction standards for manufactured homes are maintained and that warranty obligations under state law are met. The division monitors handling of consumer complaints, licenses the makers of manufactured homes, dealers, sales representatives and set-up contractors, and acts as staff for the NC Manufactured Housing Board.

The State Property Fire Insurance Fund administers the self-insurance fund for state-owned property and vehicles, and assists local governments with property and casualty insurance programs. This program also makes available professional liability coverages for law enforcement officers, public officials and employees of any political subdivision in the state. This section also provides staff, administration, and research services to the Public Officers and Employees Liability Insurance Commission (POELIC).

The Fire and Rescue Services Division administers the Firemen's Relief Fund, trains fire departments and rescue squads and works to improve fire and rescue protection. The division also administers matching dollar-for-dollar grants to volunteer fire departments and rescue squads and offers fire prevention education in the public schools. And the division provides staff, administration, and research services to the Fire and Rescue Commission.

Engineering Division

North Carolina's General Statutes give the Commissioner of Insurance the responsibility of general supervision of the administration of the North Carolina State Building Codes. The codes contain regulations relating to plumbing, electrical, heating, air conditioning and fire protection systems and the construction of buildings in general. The division meets these responsibilities by providing interpretations of code requirements and assisting local government authorities with the application of the codes.

The division also inspects electrical systems in state-owned buildings, reviews plans and specifications of new buildings for code compliance, assists with code-related educational programs, and administers state examinations required for certification of city, county and state code enforcement officials.

Division staff also administer the state's accreditation program of independent inspection agencies who safety test and label electrical and mechanical equipment or monitor the performance of manufacturers who sell factory-fabricated modular buildings.

In addition to serving as an informal state code appeals agency, the division also serves as staff to the North Carolina State Building Code Council, the North Carolina Code Officials Qualification Board, and the North Carolina Home Inspectors Licensure Board.

Engineering Division Activities	
1995-1996	
Plans reviewed	4,207
Field inspections	2,953
Office conferences	6,888
Telephone information requests	126,365
Schools, seminars and conference participation	444
Building Code Council meetings	88
Qualification Board meetings/hearings	56
Qualification Board complaint investigations	36
Inspection certification schools coordinated	1,932
Inspector certification exams administered	2,562
Inspector certification applications reviewed	8,165
Inspector certificates renewed and issued	9,537
Code publication sales	$1,844,357
Electrical certificates of compliance issued	642

Code Administration and Enforcement

The division provides interpretations of the intent of the state building code to city and county inspection officials, architects, engineers, contractors, material suppliers, manufacturers, other state agencies, attorneys and the general public.

The division is responsible for reviewing plans and specifications for large buildings. Before a permit can be secured for these buildings, a letter of compliance must be issued by this division to the inspection department having jurisdiction.

State law requires that handicapped and disabled persons receive treatment equal to that afforded other persons. The division has an Accessibility Section which provides information to handicapped organizations, design and construction professionals and building owners in the application of these state laws and the building code requirements relating to accessibility. This assistance helps provide our disabled citizens with the full and free use of all buildings in the state. Accessibility regulations are currently being revised to make N.C. Code equivalent to federal Americans with Disabilities Act regulations.

This division inspects the electrical systems of all state-owned buildings during construction. When code violations are detected, the contractor or designer is advised of corrections required. Contractors cannot receive payment for their work until this division issues a certificate stating that the installation complies with safety regulations. In addition to these required inspections, this division assists local officials with the inspection of other construction aspects of buildings when requested.

Because some buildings require special construction, technical assistance is necessary from the division to ensure that the building is safe. Inspection assistance is also provided for structures when deterioration, fire or storms create conditions which appear to be hazardous to life.

Our staff also serves as the State Damage Assessment Team and assists the State Office of Emergency Management during disasters.

State Building Code Council Support

The building code council consists of 15 members appointed by the governor. The council is empowered to adopt and amend the state building code, hear appeals on the interpretation of the code and approve local building regulations which are different from the state code. The council holds regularly scheduled public hearings on the second Tuesday in March, June, September, and December. Additional meetings are held by council code committees.

State law permits the building code council to provide, in circumstances deemed appropriate, programs to certify independent testing laboratories as state-accredited third-party agencies to evaluate, inspect and label factory-built manufactured buildings, and electrical and mechanical building components. This program is administered by division staff.

Code Officials Qualification Board Support

This board develops standards for the training and certification of code enforcement officials. The division provides clerical and staff services in support of this effort. The board is also responsible for developing training schools and state examinations for inspector certification. Some division staff members serve as instructors; all state certification exams are administered by division staff.

Persons certified by the board are issued a certificate for each level and area of inspection for which they have met qualification requirements. The division also investigates written, substantiated complaints against inspectors made to the board, which may then schedule a hearing.

The division is divided into eight sections: code consultant, electrical, mechanical, modular, inspector certification, accessibility, code council, and fire prevention.

On July 1, 1991, North Carolina's first State Fire Prevention Code became effective. This required the hiring of an individual with fire prevention experience. This staff member has provided code interpretations to more than 1,500 city and county fire inspectors throughout the state and has assisted in the development of three levels of fire prevention courses.

Home Inspectors Licensure Board Support

This board was created by the legislature in 1994 to provide for the licensure and regulation of those who perform home inspections for compensation. This board is composed of seven members and a designee of the Commissioner of Insurance. This board provides for the development and maintenance of standards of practice, code of ethics, examinations, licensure, renewal, and disciplinary procedures for home inspectors in North Carolina. The division provides clerical and staff services in support of this effort. The staff provides all administrative functions for the board including administering the examinations, issuing licenses, and renewal of licenses.

Manufactured Building Division

This division acts both as a state administrative agency under the federal Manufactured Housing Constructions and Safety Standards Act and as staff to the North Carolina Manufactured Housing Board.

The role of a state administrative agency is to monitor manufacturers' handling of consumer complaints to assure compliance with federal standards. Staff support of the Manufactured Housing Board includes licensing all manufacturers, dealers, set-up contractors, and salespersons that do business in this state to ensure compliance with warranty requirements set forth in the General Statutes.

This division is also responsible for developing set-up and anchoring standards for manufactured homes and assisting local inspection departments in the inspection of homes for proper set-up and anchoring requirements. Division staff has rewritten the state set-up and anchoring standards which became effective July 1, 1995. Seminars have been held throughout the state to familiarize the local inspection departments, manufacturers, dealers, set-up contractors and other interested parties with the 1996 revisions to the code.

This division is entirely receipt supported. A portion of these receipts come from fees received from HUD for manufactured homes placed in our state for retail sale. The balance of the division's funding comes from license fees charged to manufacturers, dealers, set-up contractors, and salespersons.

In July 1992 the division began requiring salespeople to pass a formal test before issuing a sales license. These tests are offered in various locations across the state to facilitate the program.

The division is responsible for filing claims against surety bonds in the event dealers or manufacturers go out of business or cannot otherwise fulfill their warranty obligations. In 1995, the division collected approximately $10,400 and collected in 1996 about $19,700 on behalf of North Carolina consumers.

The division also supplements its receipts by participating in a contract with the National Conference of States on Building Codes Standards. During 1995-96, division staff spent approximately 1,000 hours on interstate monitoring inspections.

Manufactured Building Division Activities

	1995	1996
Complaints Received	806	1,121
Inspections Completed	503	657
Manufacturers Licensed	81	90
Dealers Licensed	735	862
Set-up Contractors Licensed	536	633
Salespersons Licensed	2,075	2,200
Salespersons Temp. Licensed	628	922
Board Hearings Scheduled	4	11
Pre-Hearing Conferences Scheduled	113	243

State Property Fire Insurance Fund

This division is responsible for the operation and maintenance of the State Property Fire Insurance Fund, the self-insurance plan for state property. The division currently has jurisdiction over 13,000 state-owned buildings with a combined value of $9.6 billion. With the approval of the Council of State, the division investigates and adjusts claims and pays losses.

The fund provides basic fire and lightning insurance coverage for state-owned property and offers insurance for wind, hail, riot, explosion, smoke, theft, sprinkler leakage, vandalism, flood, and business interruption. The division procures from private insurance carriers other needed insurance such as auto liability and physical damage, inland marine, ocean marine, aircraft liability and physical damage, boiler and machinery, workers compensation, accident and health, general liability, crime, professional liability, and bonds.

Another vital function of the division is plan approval for construction and renovation of all state buildings. Plans are reviewed to assure state construction is safe for building occupants and desirable for insurance purposes. Emphasis is placed on proper exits, building fire resistance, and fire protection systems.

The division also develops specifications for fire detection and alarm systems, sprinkler systems, and other life safety equipment used by designers of state buildings.

By statute, the division reviews and approves all building plans, insures finished buildings, and inspects them annually. Between plan approval and completion of construction, there is at present no statutory inspection for code compliance. One of our objectives for the coming biennium is to develop statutory requirements for such inspections.

Loss control through annual inspection of all state-owned buildings is accomplished by inspectors who are certified in the interpretation of codes and standards for fire protection and construction. Reports are made to agency management for correction of deficiencies. The staff also provides advice on corrective measures.

Updating fire protection systems in existing buildings is a continuous process. Emphasis is placed on improving the protection of major computer installations, libraries, high-risk buildings, places of assembly, and other areas with a high concentration of people or expensive property.

Because of the rapid increase in the use of computers and other electronic equipment, lightning damage has become the state's most frequent loss. Efforts to reduce lightning losses include communicating information to agencies on proper protective measures, and inspecting sites with recurring claims.

The risk management section serves as the resource for state agencies in resolving risk issues. The section administers the state's automobile insurance program covering 31,000 vehicles, and helps local governments review their insurance needs and implement risk management programs. Since 1985, 145 North Carolina communities and counties have received complete insurance surveys and risk management services.

The section also provides staff, administration, and research services to the Public Officers and Employees Liability Insurance Commission (POELIC). The commission is charged with making available a plan of professional liability coverages for all law enforcement officers, public officials, and employees of any political subdivision of the state.

The plan provides $11,000,000 in liability coverage on all 102,000 state employees for losses resulting in bodily injury or property damage, and for errors and omissions in the performance of their jobs. About 500 such claims are filed against state employees each year.

Fire and Rescue Services Division

Inspections

This section serves as the certifying agency for qualifying fire departments and their members for several benefit programs.

Since 1985, fire departments must be inspected by the Fire and Rescue Division in order to qualify for the In-Line-of-Duty Death Benefit, the Firemen's Pension Fund, and the Firemen's Relief Fund.

The Commissioner of Insurance sets the standards and qualifications for the initial certification of all fire departments. North Carolina has experienced an annual growth rate of approximately ten fire departments in each of the last ten years.

In October 1987, this section was given the duty of inspecting more than 1,000 fire departments in North Carolina. The first phase of this project has been completed. The results of these inspections have been reported to the North Carolina Fire Rate Bureau and are to be used by them in filing future rates for fire insurance costs. The fire departments are reinspected on a two-to-three year cycle in order to maintain a current picture of the quality of fire protection in North Carolina and to assist the departments in making improvements.

In August 1995, the third phase of the inspections program was completed with approximately 90% of the fire departments meeting state requirements. The information collected during the inspections is also used in the qualification process for the rural fire department and rescue grant programs. The inspections program has been instrumental in helping to upgrade fire protection in the state.

This section continues to assist local governments with fire district mapping, setting up tax districts, preparing fire departments for ISO surveys and by providing information on benefit programs. The section also serves as an information resource on rural fire protection for local government officials.

Safety Programs

Fighting the causes of unintentional injuries, fatalities and property loss is the focus of the Safety Programs Section. The section's primary goal is to raise awareness about the causes of injury through behavioral, environmental and legislative interventions. Support is also given to local fire and rescue providers in forming information networks such as the Fire and Life Safety Educators Network and developing resources for local safety projects.

Research is an important part of the Safety Programs Section. Items researched by this section include the impact study of legalizing fireworks, product-specific studies, educational methods research, and general trend analysis. Data collected through the North Carolina Fire Incident Reporting System and Casualty Reporting System provides the basis for fire/burn prevention programs to this section.

Specific programs managed by the Safety Programs Section include North Carolina Safe Kids, Learn Not To Burn, and the Buckle Up Kids Programs. North Carolina has eight Safe Kids coalitions and is growing. Buckle Up Kids has been implemented in 57 counties with 7 counties pending and has distributed more than 2,100 child passenger safety seats through fire/rescue agencies. The Learn Not To Burn Program educates more than 90,000 fourth graders annually.

Funds

Working closely with the NC Fireman's Association, division staff continues to improve collection and disbursement of the Firemen's Relief Fund. Significant effort has been made to reduce the number of fire departments disqualified due to ineligibility. The Rescue Relief Fund was created in 1987 to assist rescue personnel in need.

The Volunteer Fire Department Fund and Volunteer Rescue/EMS Fund were created in 1987 to financially aid local fire and rescue departments with equipment purchases and capital expenditures.

Volunteer Fire Department and Rescue/EMS Grants*		
	1995	1996
Volunteer Fire Department Fund	$1,800,089.81	$1,839,244.18
Volunteer Rescue/EMS Fund	$952,085.64	$995,998.41

** Total approved monies for both matching and non-matching state grants.*

North Carolina Fire and Rescue Commission

The Fire and Rescue Commission is an advisory board consisting of representatives from various fire and rescue organizations as well as state agencies. The Commission is responsible for developing voluntary certification programs and professional standards for all levels of fire and rescue personnel.

Presently, eight certification programs and 20 levels of certification are active, including: Firefighter, Instructor, Rescue Technician, Fire and Life Safety Educator, Fire Apparatus Driver/Operator, Emergency Vehicle Driver, Hazardous Materials Responder, and Fire/Arson Investigator.

The Firefighter, Instructor, Hazardous Materials and the Driver/Operator programs are currently accredited by the International Fire Service Accreditation Congress, of which the Commission is an active member.

The most recent undertaking of the commission is the development and dissemination of the Occupational Safety and Health Standard for Fire Departments and Rescue Squads. This is a compilation of the applicable NFPA Standards and OSHA General Industry Standards.

Future programs from the Commission will include a Fire Officer Certification program. A committee is currently working on the development of this standard and should be ready for pilot testing in early 1997.

The goal of such programs is to provide additional professional recognition, as well as enhance the safety of emergency services personnel in North Carolina.

North Carolina Code Officials Qualifications Board

The board is organized under the provisions of Chapter 143, Article 9C of the North Carolina General Statutes. A list of members follows, along with the individual or organization by whom they were appointed.

Mr. Charles England, Chair	Speaker of the House
Mr. Charles R. Horne, Vice-Chair	Governor
Mr. Richard D. Ducker	Institute of Government
Ms. Renee Cahoon	Governor
Mr. Kenard M. Knust	Lieutenant Governor
Mr. D. Edwin Rose	Speaker of the House
Mr. David Carelock	Governor
Mr. Nathaniel Cannady	Speaker of the House
Mr. Mike Pittman	Department of Community Colleges
Mr. Joseph D. Wheliss	Governor
Mr. James D. Kennedy	Lieutenant Governor
Mr. Hubert Jefferson	Governor
Mr. Rick Lee	Lieutenant Governor
Mr. C. Neil Styers	Speaker of the House
Mr. J. Lee Hauser, P.E.	Commissioner of Insurance
Mr. Jasper Ormond	Governor
Mr. Paul P. McCain, P.E.	N.C. State University
Mr. C.W. Williams	Governor
Ms. Barbara H. Mulkey, P.E.	Lieutenant Governor
Mr. Ronnie Bailey	N. C. A&T University

North Carolina Building Code Council

NC General Statutes 143-138 authorize the N.C. Building Code Council to prepare, adopt and amend the State Building Code. The council consists of 15 members appointed by the governor for six-year terms. Statutes require that members have expertise in areas relating to construction safety. The council meets quarterly in March, June, September and December.

Members

Mr. John R. Andrew, Chair

Mr. Sam T. Snowdon Jr., Vice-Chair

Mr. Clifton N. Bishop

Mr. Barry W. Gardner

Mr. James W. Smith II

Mr. Edward L. Woods

Mr. J. Harmon Byrd

Mr. Mark B. Trollinger

Mr. Stephen B. Peay

Mr. Brian Runnells

Mr. Ronald Decker

Mr. Robert C. Pierce

Mr. Jack F. Neel

Mr. Larry C. Hayes

North Carolina Fire and Rescue Commission

The NC Fire and Rescue Commission is charged with developing certification standards for all levels of fire service and rescue personnel and coordinating the state's involvement with the Federal Emergency Management Agency and the US Fire Administration.

The commission is also responsible for developing a master plan for fire prevention and control, increasing professional skills of fire protection and fire fighting personnel, serving as a central clearinghouse of information relating to the state's fire service activities, and handling federal and state grants.

Member	Organization
Mr. Richard Trexler, Chair	NC Association of Fire Chiefs
Mr. Dean Wall, Vice-Chair	NC Association of Rescue and EMS, Inc.
Mr. Zelodis Jay	NC Association of County Commissioners
Mr. Jerry Lewis	NC County Fire Marshal's Association
Mr. Bobby Joyner	NC Association of Fire Chiefs
Mr. Alan Nobles	NC Fire Marshal's Association
Mr. Jimmy Sanders	NC League of Municipalities
Mr. Fred O'Neal, Jr.	Governor's Appointee
Mr. Hiram Brinson	Lt. Governor's Appointee
Mr. John Horne	Nc Fireman's Association
Mr. Cloyce Anders	Public-at-large
Mr. Benny Scarbro	Speaker of the House Nominee
Mr. Buddy White	NC Association of Rescue and EMS, Inc.
Mr. C. Harley Cook	NC Society of Fire Service Instructors

North Carolina Home Inspectors Licensure Board

NC General Statutes 143-151.43 Article 9F created the North Carolina Home Inspectors Licensure Board to license those who perform home inspections for compensation. A list of the eight members follows, along with the individual by whom they were appointed.

Members	Representing
Mr. Roger R. Pierce, Chairman	Senator Marc Basnight
Mr. John J. Woodmansee, Vice-Chairman	Representative Dan Blue
Mr. T. Larry Summer, Secretary-Treasurer	Governor James B. Hunt
Mr. John W. Hamrick	Governor James B. Hunt
Mr. Jimmy A. Hughes	Senator Marc Basnight
Mr. Ralph L. McSwain	Representative Dan Blue
Mr. Grover L. Sawyer, Jr., P.E.	Commissioner Jim Long
Mr. Stephen C. Smallman	Governor James B. Hunt

North Carolina Manufactured Housing Board

The Board is empowered to issue and revoke licenses, require bonds, resolve complaints and promulgate rules as necessary to carry out these goals. The following is a list of members and the individual or industry they represent as of January 1997.

Members	Representing
Mr. Dascheil Propes, Chair	Commissioner of Insurance
Ms. Mickey Hanula	Commissioner of Insurance
Ms. Linda Willey	Commissioner of Insurance
Mr. Jim Johnson	Governor
Mr. J.T. Williams	Governor
Ms. Judy Ward	Finance
Mr. Larry Gilmore	Insurance
Mr. Bill Glover	Set-up Contractor
Mr. Durwood Batchelor	Supplies

Public Officers and Employees Liability Insurance Commission

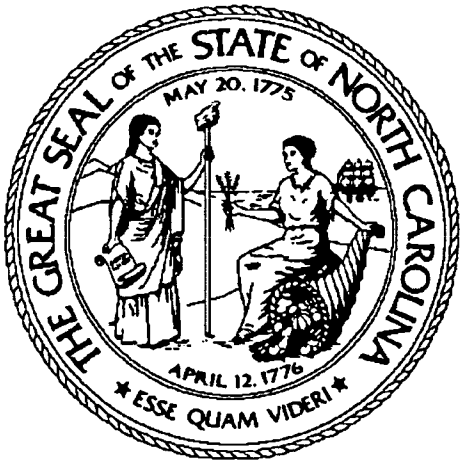
The Commission is given authority under North Carolina General Statutes 58-31-25 and 58-32-1 through 58-32-30 to make available a plan of professional liability insurance coverage for all law enforcement officers, public officials, and employees of any political subdivision of the State. POELIC is empowered to negotiate with insurance companies for the most favorable rates and coverage.

The commission also serves as liaison between the companies and those insured, to resolve any issues which may arise. The commission consists of 11 members representing city, county, and state governments, sheriffs and police departments, and the insurance industry. It meets at least four times each year, on or about the 15th of January, April, July, and October. Following is a list of the members:

Member	Representing
Mr. Joe R. Kluttz, Chairman	Independent Insurance Agents of North Carolina
Sheriff Dane Mastin, Vice Chairman	NC Sheriffs Association
Mr. James L. Bichsel	Speaker of the House
Mr. Pat Marshall	NC Association of County Commissioners
Mr. Bob G. Haynes	NC League of Municipalities
Mr. Hugh C. Talton, Jr.	Lt. Governor
Lt Col. Kent Fletcher	NC Police Chiefs, Police Executives Associations
Mr. J. Dal Snipes	Carolinas Assn. of Professional Insurance Agents
Ex-Officio Members:	
Mr. William A. Dudley	Secretary of Crime Control and Public Safety
Mr. Ralph B. Strickland, Jr.	Attorney General
Mr. J. Thomas Sutton, III	Commissioner of Insurance

HMOs in North Carolina

Status Report &
Analysis of 1995 Activity



North Carolina Department of Insurance
Managed Care and Health Benefits Division
January 1997

HMOs in North Carolina

Executive Summary

This report was prepared by the North Carolina Department of Insurance to provide a snapshot of the current North Carolina health maintenance organization (HMO) industry and a detailed analysis of HMO activity in North Carolina for 1995. It contains current information on company contacts and product profiles. In addition, the report contains HMO enrollment data as of the end of 1995 (with trends), and provides summary information related to financial performance, utilization and complaints received by the Department for the 1995 calendar year.

Summary of Results by Chapter

I. Administrative Profile of HMOs in North Carolina (current as of November 30, 1996)

- Twenty-seven companies are licensed as HMOs in North Carolina.
- Twenty-three are licensed as full-service HMOs, though only twenty-one full-service HMOs are active (two HMOs currently have restricted licenses at their own request). Four companies are licensed as single-service HMOs (3 Dental, 1 Vision).
- The number of full-service HMOs has grown from only ten at the end of 1993 to eighteen at the end of 1995 to its current number of twenty-three.
- Roughly one half of the HMOs are owned by or affiliated with national insurance companies or HMOs.
- All HMOs in North Carolina are independent practice associations (IPA) or group/IPA models.
- All HMOs in North Carolina are for-profit entities except the Kaiser Foundation Health Plan of North Carolina and the Blue Cross Blue Shield of North Carolina HMO Line of Business.
- All HMOs, except PHP, Inc., use some variation of a gatekeeper to monitor access to the services offered by the health plan. PHP offers both an open access and a gatekeeper access product.

II. Product Offerings (current as of September 30, 1996)

- All twenty active full-service HMOs offer group coverage and fifteen offer small group coverage.
- Fifteen HMOs offer individual coverage if converting from group coverage, but only three HMOs offer coverage to other individuals.
- Seven HMOs offer Medicaid coverage and only two offer Medicare coverage.
- Thirteen HMOs offer a point of service (POS) product.
- Ten HMOs offer a self-funded or administrative services only (ASO) product.

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III. HEDIS Reporting and NCQA Accreditation (current as of September 30, 1996)

- Eleven HMOs are reporting Health Plan Employer Data and Information Set (HEDIS) data.
- Six HMOs have undergone review by the National Committee on Quality Assurance (NCQA). Of these six, two HMOs have Full Accreditation (3 Years) from NCQA, two have One Year Accreditation from NCQA, and two have Provisional Accreditation from NCQA.

IV. Enrollment

- Insured enrollment was 654,381 at 12/31/95, with 534,068 in traditional HMO products and 120,313 in POS products (Figure 4.1).
- Traditional HMO enrollment grew 15% from 1994 to 1995, while POS enrollment grew 142% over the same period (Figure 4.1).
- Self-funded enrollment was 155,842 at 12/31/95, an increase of 60% from the previous year (Figure 4.1).
- At 12/31/95, 75% of insured HMO members resided in the metropolitan areas of the Triangle, Greensboro, and Charlotte (Figure 4.2).
- At 12/31/95, insured HMO penetration in North Carolina was 10.2%. Total HMO penetration (insured + ASO) was 12.6% (Figure 4.2).
- At 12/31/95, 86% of the insured market was held by five HMOs and nearly 94% of the market was held by six HMOs (Figure 4.3).
- Less than 5% of insured enrollment was in government products (Medicaid, Medicare, FEHBP, and CHAMPUS) (Figure 4.6).

V. Financial

- Weighted average premium revenue for 1995 was $129 PMPM weighted average Medical Loss Ratio for 1995 was .87(Figure 5.2).
- Weighted average premium revenue grew 26.2% from 1991-1995 (6% growth per year), while Medical and Hospital Expenses grew 28.6% over the same period (6.5% growth per year) (Figure 5.3).
- Premiums increased by less than 1% from 1994 to 1995, while medical spending increased nearly 5% (Figure 5.3).

VI. Utilization

- Median inpatient days per 1,000 members was 242 days. Median medical/surgical inpatient days was 167 days per 1,000 members.
- Median average length of stay (ALOS) for maternity (includes normal delivery and C-section) was 2.16 days.
- Median outpatient encounters (excluding ER, and scheduled outpatient surgeries and procedures) was 5.0 encounters per member.
- Median ER encounters was 134.4 per 1,000 members and median outpatient surgeries/procedures was 70.3 encounters per 1000 members.

VII. Complaints

- The weighted average rate of complaints for North Carolina HMOs was .326 per 1000 members (1 complaint for every 3,066 members enrolled for a full year) in 1995 and .303 (1 complaint for every 3,299 members enrolled for a full year) in 1994.
- The largest HMOs (those with greater than 1 million member months) had annualized complaint rates ranging from .209 per 1000 members to .318 per 1000 members in 1995.

HMOs in North Carolina

Introduction

This report was prepared by the North Carolina Department of Insurance to provide a snapshot of the current North Carolina health maintenance organization (HMO) industry and a detailed analysis of HMO activity in North Carolina for 1995. The report includes information on company contacts, product profiles, enrollment, and accreditation status (by the National Committee for Quality Assurance) for each of the HMOs. In addition, the report includes information related to HMO solvency and financial performance, which is compiled from the Annual Statements HMOs are required to file with the Department's Financial Evaluation Division. Finally, the report contains a summary of complaints received on each HMO by the Department's Division of Consumer Services.

The purpose of this report is to give legislators, state regulators, and the citizens of North Carolina a better understanding of the healthcare environment in North Carolina, of which HMOs are only a part. The Department is closely following developments in the measurement of HMO quality, and we hope to be able to provide measures which facilitate the evaluation of HMO quality in the near future.

Notes on Reading this Report

This report relies on graphs and charts to convey information. It was not always practical to include background and definition information adjacent to the chart. The notes that follow should be helpful in reading and interpreting this report:

1. **Use of Abbreviated Names for HMOs** - Each HMO has an official licensed name. However, due to space limitations, abbreviated names were used in several charts and in several areas of text. Appendix A contains a list of licensed names with the abbreviated names used in this report.
2. **Acronyms and Definitions** - Common acronyms and HMO terms are used throughout this report. Where practical, the acronym or term was defined in any figure in which it was used. In some cases, important terms or concepts were explained in the Background section of the chapter.
3. **Full-Service and Single-Service (e.g. dental, vision) HMOs** - This report focuses on full-service HMOs. Unless otherwise specified, data is presented for full-service HMOs only.
4. **Fully insured enrollment and Self-funded or Administrative Services Only (ASO) Enrollment** - This report will focus on data for fully insured products. Where it is not specified, the data presented is for fully insured business (referred to as insured business throughout this report).
5. **Commercial-Insured and Government-Insured Enrollment** - This report combines commercial-insured and government-insured products. Government-insured enrollment includes Medicaid, Medicare, Federal Employee Health Benefits Plan (FEHBP), and Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). *The Department of Insurance only has jurisdiction over fully-insured commercial products.*
6. **Traditional HMO Products and Point of Service (POS) Enrollment** - Except where identified as separate, this report combines HMO enrollment and POS enrollment.

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I. Administrative Profile of HMOs in North Carolina

Background

The information contained in this chapter was current as of November 30, 1996. This chapter contains tables with the parent company/owner, the date of licensure, the type of HMO model, the tax status, and the access type for each HMO. The tables also specify whether the HMO is federally qualified.

As a reference, the following are the most commonly used HMO model types:

- **Independent Practice Association (IPA)/Network Model** - An HMO that contracts with multiple physician groups to deliver health care services to its members. (Note that there that are definitional distinctions between IPA and Network models, but there is often little difference between these two models from an operational perspective). IPA/Network Models are, by far, the most common HMO model.
- **Group Model** - An HMO that contracts with a medical group for the provision of health care services. The relationship between the HMO and the group is generally very close.
- **Staff Model** - An HMO that employs providers directly.

Major Points

Figure 1.1 - Profile of Full-Service HMOs

- Number of Full-Service HMOs - There are twenty-three licensed full-service HMOs, though only twenty-one are active as two have restricted licenses at their own request.
- Ownership Of HMOs - Roughly one half of the HMOs are owned by or affiliated with national insurance companies or HMOs. This has been a strong trend in North Carolina as HMOs owned by United Healthcare, New York Life, U.S. Healthcare, and Aetna, have all entered the North Carolina market since 1994. Note that Blue Cross Blue Shield of North Carolina is the parent company of three licensed HMOs.
- Date of Licensure - Thirteen of the twenty two HMOs received their North Carolina license after 8/10/94.
- Model Type - All HMOs in North Carolina are IPA or Group/IPA models.
- Profit Status - All HMOs in North Carolina are for profit entities except the Kaiser Foundation Health Plan of North Carolina and the Blue Cross Blue Shield of North Carolina Line of Business HMO.
- Federally Qualified Health Plans - Five HMOs are Federally Qualified Health Plans.
- Access Type - All HMOs, except PHP, Inc., use some variation of a gatekeeper to monitor access to the services offered by the health plan. PHP offers both an open access and a gatekeeper access product.

Administrative Profile - continued

Figure 1.2 - Profile of Single-Service HMOs

- Number of Single-Service HMOs - Four companies are licensed as single-service HMOs.
- Date of Licensure - All single-service HMOs received their North Carolina license after 1/2/93.
- Profit Status - All single-service HMOs are for-profit entities.

Figure 1.1 - Profile of Full-Service HMOs

(Current at 11/1/96)

HMO Licensed Name	Parent Company/Ownership	Date of Licensure in NC	HMO Model Type(1)	Profit Status	Federally Qualified (2)	Access Type (3)
Aetna Health Plans of the Carolinas, Inc.	Aetna Inc.	8/11/94	Group/IPA	for profit	No	gatekeeper
Atlantic Health Plans of the Carolinas, Inc.	American Medical Security, Inc.	3/18/96	IPA	for profit	No	gatekeeper
Blue Cross Blue Shield of North Carolina Line of Business HMO	Blue Cross Blue Shield of North Carolina, Inc.	9/2/81	IPA	not for profit	No	gatekeeper
Carolina Summit Healthcare, Inc.	Summit Consulting, Inc.	2/14/96	IPA	for profit	No	gatekeeper
CIGNA Healthcare of North Carolina, Inc.	Cigna Healthcare, Inc.	2/14/86	IPA	for profit	No	gatekeeper
Community Choice of North Carolina, Inc.	Jefferson Pilot Insurance Company	1/23/96	IPA	for profit	No	gatekeeper
Doctors Health Plan, Inc.	Coastal Healthcare Group, Inc.	9/30/94	Group/IPA	for profit	No	gatekeeper
Health Maintenance Organization of North Carolina(4)	Blue Cross Blue Shield of North Carolina, Inc.	3/27/87	Group	for profit	No	gatekeeper
Healthsource North Carolina, Inc.	Healthsource, Inc.	4/18/86	IPA	for profit	No	gatekeeper
Kaiser Foundation Health Plan of North Carolina	Kaiser Foundation Health Plan, Inc.	6/18/84	Group/IPA	not for profit	Yes	gatekeeper
Kanawha Healthcare, Inc.	Kanawha Insurance Company, Inc.	11/13/96	IPA	for profit	No	gatekeeper
Maxicare North Carolina, Inc.	Maxicare, Inc.	2/27/84	IPA	for profit	Yes	gatekeeper
Optimum Choice of the Carolinas, Inc.	Optimum Choice,Inc.	7/12/95	IPA	for profit	No	gatekeeper
PARTNERS National Health Plans of North Carolina, Inc.	Health Options of the Carolinas, Inc.	10/30/86	IPA	for profit	Yes	gatekeeper
Personal Care Plan of NC, Inc.	Blue Cross Blue Shield of North Carolina, Inc.	11/19/85	IPA	for profit	Yes	gatekeeper
PHP, Inc.	United Healthcare, Inc.	5/2/85	IPA	for profit	No	open, gatekeeper
Principal Health Care of the Carolinas, Inc.	Principal Healthcare, Inc.	12/15/94	IPA	for profit	No	gatekeeper
Provident Health Care Plan, Inc. of North Carolina(4)	Healthsource, Inc.	8/18/94	IPA	for profit	No	gatekeeper
Prudential Health Care Plan, Inc.	The Prudential Insurance Company of America	3/11/85	Group/IPA	for profit	Yes	gatekeeper
Qualchoice of North Carolina, Inc.	Wake Forest University and Baptist Hospital	9/9/94	IPA	for profit	No	gatekeeper
The Wellness Plan of North Carolina, Inc.	Comprehensive Health Services, Inc.	3/18/96	IPA	for profit	No	gatekeeper
U.S. Healthcare of the Carolinas, Inc.	Aetna Inc.	9/20/95	IPA	for profit	No	gatekeeper
WellPath Community Health Plans, Inc.	NYLCare	10/26/95	Group/IPA	for profit	No	gatekeeper

Notes:

(1) See Background of this Chapter for discussion.

(2) The Health Care Financing Administration (HCFA) grants Federal Qualification Status to HMOs that submit applications and meet the standards specified in the Federal HMO Act.

(3) Access to the resources (hospital etc) of the HMO may be controlled by a primary care provider (gatekeeper) or there may be open access to all resources in the network (open).

(4) HMO license restricted at company request - Restricted status means company has no enrollment and is not marketing coverage. Approval from DOI is needed before company can resume marketing/selling coverage.

Figure 1.2 - Profile of Single-Service HMOs

(Current at 11/1/96)

HMO Licensed Name	Parent Company/Ownership	DateCOA	HMO Model Type(1)	Status	Federally Qualified (2)	Access Type (3)
American Dental Plan of North Carolina	American Prepaid Professional Services, Inc.	11/8/93	IPA	for profit	No	gatekeeper
Association of Eye Care Centers Total Vision Health Plan, Inc.	Consolidated Eye Care, Inc.	12/31/94	IPA	for profit	No	gatekeeper
CIGNA Dental Health of North Carolina, Inc.	Cigna Dental Health, Inc.	1/3/93	IPA	for profit	No	gatekeeper
Spectera Dental Services, Inc.	Spectera Healthcare, Inc.	7/1/95	IPA	for profit	No	gatekeeper

Notes:

(1) See Background of this Chapter for discussion.

(2) The Health Care Financing Administration (HCFA) grants Federal Qualification Status to HMOs that submit applications and meet the standards specified in the Federal HMO Act.

(3) Access to the resources (hospital etc) of the HMO may be controlled by a primary care provider (gatekeeper) or there may be open access to all resources in the network (open).

Source: DOI records and HMO responses to DOI surveys.

II. Product Offerings

Background

This chapter contains information on the products offered by full-service HMOs in North Carolina. Note that Kanawha Healthcare, Inc. is excluded because it became licensed after completion of the figures in this report. Figure 2.1 contains the premium categories offered: Group, Small group, Individual, Medicaid, Medicare, Federal Employee Health Benefits Plan (FEHBP), Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). Figure 2.2 shows which HMOs offer Point of Service (POS) products and Administrative Services Only (ASO) products. The information contained in this section was current as of 9/30/96 (the date that the HMOs responded to a survey from the Managed Care Division).

Major Points (out of 20 Active HMOs)

Figure 2.1 - Premium Categories

- Group - All twenty active HMOs offer large (>49) group coverage and fifteen offer small-group coverage.
- Individual Coverage - Fifteen HMOs offer individual coverage if converting from group coverage, but only three HMOs offer coverage to other individuals.
- Medicaid and Medicare - Seven HMOs offer Medicaid coverage and two offer Medicare coverage (1 cost, 1 risk).
- Federal Employees - Nine HMOs offer coverage to federal employees through the Federal Employees Health Benefit Plan (FEHBP).

Figure 2.2 - Point of Service (POS) and Administrative Services Only (ASO) Products

- POS - Thirteen HMOs offer a point of service (POS) product.
- ASO - Ten HMOs offer a self-funded or administrative services only (ASO) product.

Figure 2.1 - Premium Categories

(Current as of September 30, 1996)

	Commercial Insured				Government Insured				
	Group(1)		Individual (2)			Medicare(3)		FEHBP	CHAMPUS
HMO Licensed Name	>49	2-49	Conv	Non-conv	Medicaid	Cost	Risk	(4)	(5)
Aetna Health Plans of the Carolinas, Inc.	Yes	Yes	No	No	No	No	No	No	No
Atlantic Health Plans of the Carolinas, Inc.	Yes	Yes	No	No	Yes	No	No	No	No
Blue Cross Blue Shield of North Carolina Line of Business HMO	Yes	Yes	No	No	No	No	No	No	No
Carolina Summit Healthcare, Inc.	Yes	No	No	No	Yes	No	No	No	No
CIGNA Healthcare of North Carolina, Inc.	Yes	Yes	Yes	No	No	No	No	Yes	No
Community Choice of North Carolina, Inc.	Yes	No	Yes	No	No	No	No	No	No
Doctors Health Plan, Inc.	Yes	Yes	Yes	No	Yes	No	No	Yes	No
Healthsource North Carolina, Inc.	Yes	Yes	Yes	No	No	No	No	Yes	No
Kaiser Foundation Health Plan of North Carolina	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	No
Maxicare North Carolina, Inc.	Yes	No	Yes	No	Yes	No	No	Yes	No
Optimum Choice of the Carolinas, Inc.	Yes	Yes	Yes	Yes	Yes	No	No	No	No
PARTNERS National Health Plans of North Carolina, Inc.	Yes	Yes	Yes	No	No	No	Yes	Yes	No
Personal Care Plan of NC, Inc.	Yes	Yes	Yes	No	No	No	No	No	No
PHP, Inc.	Yes	Yes	Yes	No	No	No	No	Yes	No
Principal Health Care of the Carolinas, Inc.	Yes	Yes	Yes	No	No	No	No	Yes	No
Prudential Health Care Plan, Inc.	Yes	Yes	Yes	No	No	No	No	Yes	No
Qualchoice of North Carolina, Inc.	Yes	No	No	No	No	No	No	No	No
The Wellness Plan of North Carolina, Inc.	Yes	No	Yes	Yes	Yes	No	No	No	No
U.S. Healthcare of the Carolinas, Inc.	Yes	Yes	Yes	No	No	No	No	No	No
WellPath Community Health Plans, Inc.	Yes	Yes	Yes	No	No	No	No	No	No
Yes Totals (out of 20 Active HMOs)	20	15	15	3	7	1	1	9	0

(1) There are 2 types of group coverage in NC: group, which is greater than 49 people and small group which is 1-49 (1 person is considered a group if they are self-employed). Also note that the group size refers to the number of primary beneficiaries; dependents are excluded when determining group size.
(2) Policies offered to individuals may be converted from group policies (conversion) or not (non-conversion)
(3) HMOs may enroll Medicare members on a FFS (Medicare-Cost) and a prepaid basis (Medicare-Risk).
(4) FEHBP refers to the Federal Employee Health Benefit Plan.
(5) CHAMPUS refers to the Civilian Health and Medical Program of the Uniformed Services - It provides care to families of military personnel.

Source: Self[illegible]orted data from HMOs for DOI's Managed Care Division Sur[illegible]

Figure 2.2 - Point of Service (POS) and Administrative Services Only (ASO) Products

(Current as of September 30, 1996)

HMO Licensed Name	POS [1]		ASO
	All	Wrap	[2]
Aetna Health Plans of the Carolinas, Inc.	No	No	No
Atlantic Health Plans of the Carolinas, Inc.	Yes	No	Yes
Blue Cross Blue Shield of North Carolina Line of Business HMO	Yes	No	Yes
Carolina Summit Healthcare, Inc.	No	No	No
CIGNA Healthcare of North Carolina, Inc.	No	No	Yes
Community Choice of North Carolina, Inc.	Yes	No	Yes
Doctors Health Plan, Inc.	Yes	No	No
Healthsource North Carolina, Inc.	Yes	No	No
Kaiser Foundation Health Plan of North Carolina	Yes	Yes	No
Maxicare North Carolina, Inc.	No	No	No
Optimum Choice of the Carolinas, Inc.	Yes	No	No
PARTNERS National Health Plans of North Carolina, Inc.	Yes	No	Yes
Personal Care Plan of NC, Inc.	No	No	No
PHP, Inc.	Yes	Yes	Yes
Principal Health Care of the Carolinas, Inc.	Yes	No	Yes
Prudential Health Care Plan, Inc.	No	No	No
Qualchoice of North Carolina, Inc.	Yes	No	Yes
The Wellness Plan of North Carolina, Inc.	No	No	Yes
U.S. Healthcare of the Carolinas, Inc.	Yes	No	Yes
WellPath Select, Inc.	Yes	No	No
Yes Totals (out of 20 active HMOs)	13	2	10

(1) Point of Service (POS) enrollment is the combination of a traditional HMO product with an indemnity product option. A POS member has partial coverage when using a provider or accessing services without the approval of the HMO plan. The POS product is to be contrasted with the standard HMO product, under which there is little or often no coverage if a member chooses to access services without the approval of the HMO. An HMO can choose to underwrite the out of HMO network portion itself (POS-All) or it can contract with an insurer to underwrite the out of network services (POS-Wrap). It should be noted that under most POS plans, the coverage is usually substantially reduced or the copay substantially higher (NC laws specifies that the difference in benefits between a standard HMO product and a POS product may be no greater than 30%) when the POS member accesses services outside the HMO plan.

(2) Self-funded or ASO (administrative services only) enrollment is enrollment for which the HMO is paid an administrative fee to provide contracted services (e.g. arranging access to discounted providers, paying claims, performing utilization review etc.) related to the care of the beneficiaries in the self-funded group. The key distinction between ASO business and fully insured business is that the purchaser of ASO services (e.g. an employer) maintains the responsibility (i.e. retains the risk) for payment of incurred medical costs, while the purchaser of a fully-insured product prepays a premium and transfers risk for incurred medical costs to the HMO.

Source: Self-reported data from HMOs for Managed Care Division Survey.

III. HEDIS Reporting and NCQA Accreditation

Background

The Health Plan Employer Data and Information Set (HEDIS) is a system or set of rules for standardizing the reporting of medical data by health plans. HEDIS was initially developed by a group of large employers in conjunction with national health plans. HEDIS is now under the auspices of the National Committee on Quality Assurance (NCQA). HEDIS participation is voluntary, but nationwide most HMOs do participate. In addition to being the developer of HEDIS reporting standards, NCQA assesses and reports on the quality of HMOs across the nation. Many large employers only contract with health plans that have been accredited by the NCQA, and in several states a NCQA accreditation review will satisfy the state's licensure requirement for an external quality review. It should be noted that NCQA opposes efforts to directly link a health plan's licensure status to the outcome of an accreditation review (1). More information about HEDIS and NCQA can be obtained at the following internet address (http://www.ncqa.org).

Major Points (out of 20 Active HMOs).

Figure 3.1 - HEDIS Reporting and NCQA Accreditation

- HEDIS Reporting - As of 9/30/96, eleven HMOs indicated that they were reporting HEDIS data.
- Reviewed by NCQA - According to NCQA Accreditation Status List (http://info.ncqa.org/status.htm), six HMOs had undergone review by the National Committee on Quality Assurance as of 10/31/96.
- NCQA Accreditation Status (out of six HMOs that had a review) - According to NCQA Accreditation Status List as of 10/31/96, two HMOs have Full Accreditation (3 Years), two have One Year Accreditation, and two have Provisional Accreditation.

(1) Per NCQA Government page Winter 1995-96 (www.ncqa.org/govern/PWWINT96.HTM)

Figure 3.1 - HEDIS Reporting And NCQA Accreditation

HMO Licensed Name	HEDIS (1)	NCQA Accreditation(2)
Aetna Health Plans of the Carolinas, Inc.	Yes	
Atlantic Health Plans of the Carolinas, Inc.	No	
Blue Cross Blue Shield of North Carolina Line of Business HMO	Yes	One-Year
Carolina Summit Healthcare, Inc.	No	
CIGNA Healthcare of North Carolina, Inc.	No	
Community Choice of North Carolina, Inc.	No	
Doctors Health Plan, Inc.	No	
Healthsource North Carolina, Inc.	Yes	Provisional
Kaiser Foundation Health Plan of North Carolina	Yes	Full
Maxicare North Carolina, Inc.	Yes	
Optimum Choice of the Carolinas, Inc.	No	
PARTNERS National Health Plans of North Carolina, Inc.	Yes	Provisional
Personal Care Plan of NC, Inc.	Yes	One-Year
PHP, Inc.	Yes	
Principal Health Care of the Carolinas, Inc.	Yes	
Prudential Health Care Plan, Inc.	Yes	Full
Qualchoice of North Carolina, Inc.	No	
Spectera Dental Services, Inc.	No	
The Wellness Plan of North Carolina, Inc.	No	
U.S. Healthcare of the Carolinas, Inc.	Yes	
WellPath Community Health Plans, Inc.	No	

Source:

(1)Reported by HMOs in response to DOI's Managed Care Division Survey.
(2)Per NCQA Accreditation List (http://info.ncqa.org/status.htm) as of 10/31/96.
If the space is blank it indicates that the HMO has not undegone a review from the NCQA.

What the Ratings Mean:

Plans which undergo a review from NCQA are given one of the following statuses (definitions per the NCQA Web Page www.ncqa.org):

Full Accreditation is granted for a period of three years to those plans that have excellent programs for continuous quality improvement and meet NCQA's rigorous standards. Nationally, 33 percent of reviewed plans have Full Accreditation.
One-Year Accreditation is granted to plans that have well-established quality improvement programs and meet most NCQA standards. NCQA provides the plans with a specific list of recommendations, and reviews the plans again after a year to determine if they have progressed enough to move up to Full Accreditation. Nationally, 40 percent of plans have One-Year Accreditation.
Provisional Accreditation is granted for one year to plans that have adequate quality improvement programs and meet some NCQA standards. These plans need to demonstrate progress before they can qualify for higher levels of accreditation. Nationally, 13 percent of plans have Provisional Accreditation.
Denial is given to those plans that do not qualify for any of the categories above. Twelve percent of reviewed plans have failed to receive accreditation to date.
Under Review denotes those plans for which an initial accreditation determination has been made but is under review at the request of the plans. Currently, 2 percent of plans are under review.

Summary

1) 11/20 HMOs report HEDIS data.
2) 6/20 HMOs have had an NCQA exam and 2 have Full NCQA Accreditation, 2 have One-Year Accreditation, and 2 have Provisional Accreditation.

IV. Enrollment

Background

The Managed Care Division of the Department of Insurance recently began surveying HMOs quarterly to get enrollment by county, product line, and age and gender. The Department has enrollment figures for earlier years (by HMO only) based on Annual Statements filed by the HMOs with the Financial Evaluation Division of the Department.

This section focuses on market share among the HMOs, the overall HMO penetration in different geographic regions, and trends over the last few years. It also includes enrollment by premium age and gender. Note that self-funded or administrative services only (ASO) enrollment is excluded from all of figures in this section (except where identified). Also note that the data contained in this sections combines HMO and point of service (POS) product lines into a single "insured" total. Figure 4.7 contains a breakdown of insured enrollment (POS and traditional HMO) by HMO and a listing of ASO enrollment by HMO. The notes to Figure 4.7 also contain definitions for POS and ASO enrollment. Appendix C contains enrollment and penetration for all of the counties in North Carolina.

Major Points

Figure 4.1 - Enrollment Trends

- Insured Enrollment (includes traditional HMO and POS) was 654,381, up 28% from the end of 1994. This was the third straight year that enrollment increased more than 20% (Chart A).
- Breakdown of Insured Enrollment (traditional HMO Vs. POS) - At 12/31/95, enrollment in traditional HMO products was 534,068, while enrollment in POS products was 120,313 (Chart B).
- Growth in HMO Product Enrollment Vs. Growth in POS Product Enrollment - Traditional HMO enrollment grew 15% from 1994 to 1995, while POS enrollment grew 142% over the same period (Chart B).
- Self-funded enrollment Vs. Insured Enrollment - Self-funded enrollment with HMOs was 155,842 at 12/31/95, up 60% from a year earlier. This was more than double the growth rate in insured enrollment (Chart C).

Figure 4.2 - Enrollment Distribution & Market Penetration by MSA at 12/31/95

- Enrollment Distribution - 75% of insured HMO members resided in the metropolitan areas of the Triangle, Greensboro, and Charlotte (Chart A); HMO penetration was also highest in these three areas (Chart B).
- HMO Penetration for North Carolina - Insured HMO penetration in North Carolina was 10.2% of the population under age 65. Total HMO penetration (insured + ASO) was 12.6% (Chart B).
- Regional HMO Penetration - Insured HMO penetration was highest in the Triangle area with nearly 21%. The rural areas of North Carolina, in aggregate, had an insured HMO penetration of 4.1%.

Figure 4.3 - Enrollment and Market Share - North Carolina Total - 1991-1995

- Market Concentration - As in past years, the North Carolina market was dominated by a small number of HMOs during 1995. As of 12/31/95, over 86% of the insured market was enrolled with five HMOs and nearly 94% of the market was enrolled with six HMOs (Table E).
- Changes in Market Share From 1991-1995 - Healthsource and Blue Cross Blue Shield (through its Line of Business HMO) have substantially increased their market shares, while Kaiser's market share has steadily decreased during this five year time period (Tables A-E).

Figure 4.4 - Enrollment and Market Share by MSA at 12/31/95

- Variation in Market Share By Region - Kaiser and Healthsource held nearly 80% of insured enrollment in the Triangle area (Table A), PARTNERS and PHP held nearly 85% of the enrollment in Greensboro/Winston Salem area (Table B), and Prudential and Kaiser held nearly 55% of Charlotte-area enrollment (Tables C).

Figure 4.5 - Enrollment by Age and Gender at 12/31/95

- Overall Age Distribution - Close to half (47.4%) of the insured HMO population in North Carolina was between the ages of twenty and forty-four (inclusive) and less than 1% of the insured population was over age 65.
- Age Distribution by HMO - The age and gender distributions of the large HMOs were very similar; none of the large HMOs had a membership population that was markedly younger or older than the overall market.
- Overall Gender Breakdown - Women represented 53.4% of insured enrollment.
- Gender Breakdown by HMO - The breakdown of enrollment by gender was similar among the largest HMOs.

Figure 4.6 - Enrollment by Premium Category at 12/31/95

- Enrollment in government products - Enrollment in Medicaid, Medicare, FEHBP, and CHAMPUS was not an important part of the North Carolina market as of 12/31/95; less than 5% of insured enrollment was in government products.
- Group Coverage Vs. Individual Coverage - Over 90% of commercial insured enrollment was through large group, with 9% enrolled through small groups and less than 1% enrolled with individual policies.

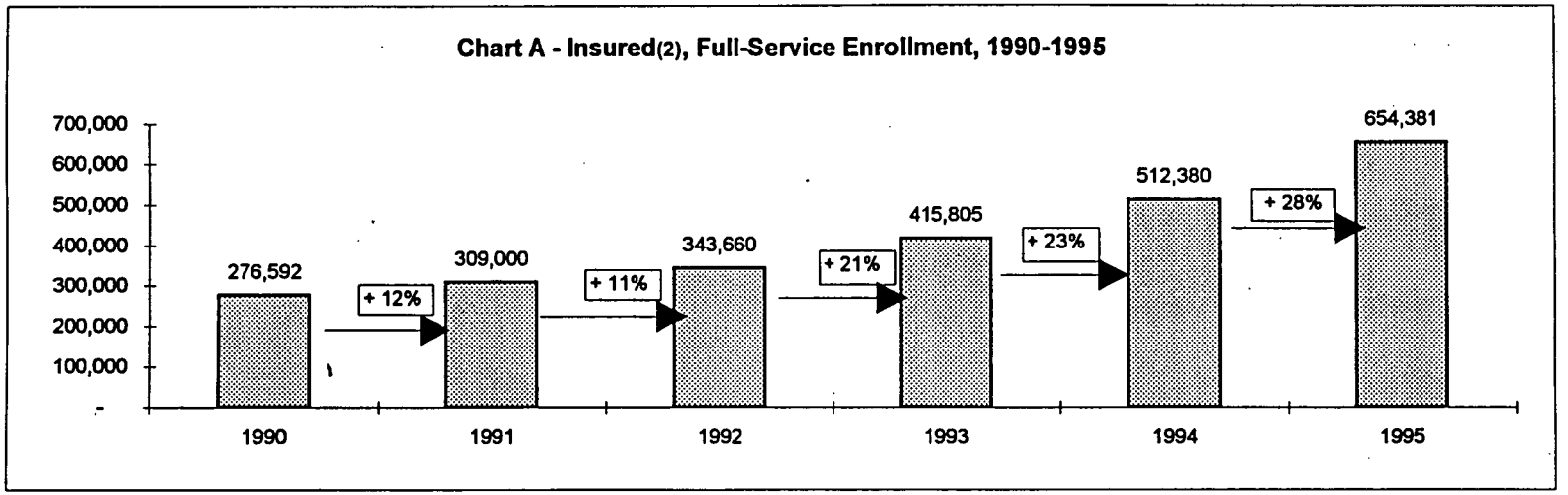
Figure 4.7 - ASO Enrollment and a Breakdown of Insured Enrollment by HMO at 12/31/95

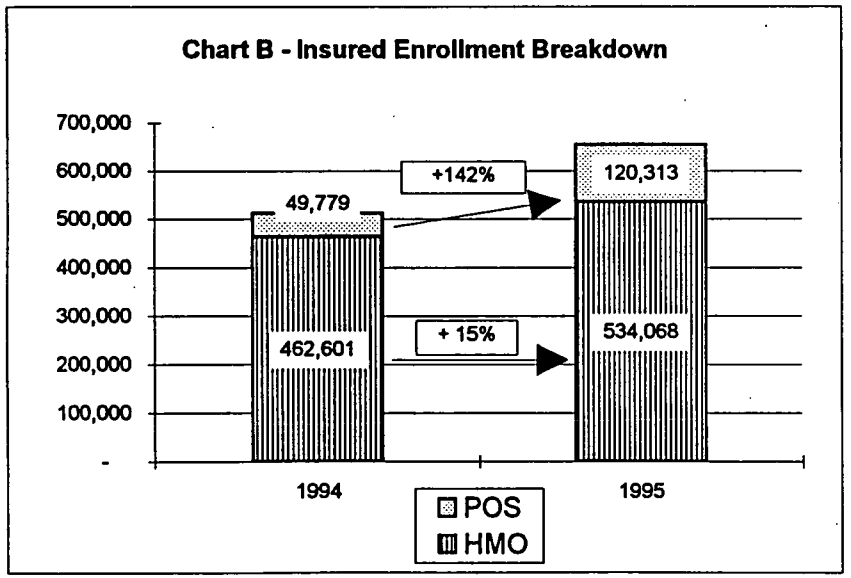
- ASO Enrollment - Over 19% of total HMO enrollment was through ASO products, but several HMOs had most or all of their enrollment through ASO products.
- POS Enrollment - Over 18% of insured HMO enrollment was through POS products, but this percentage also varied widely by HMO.

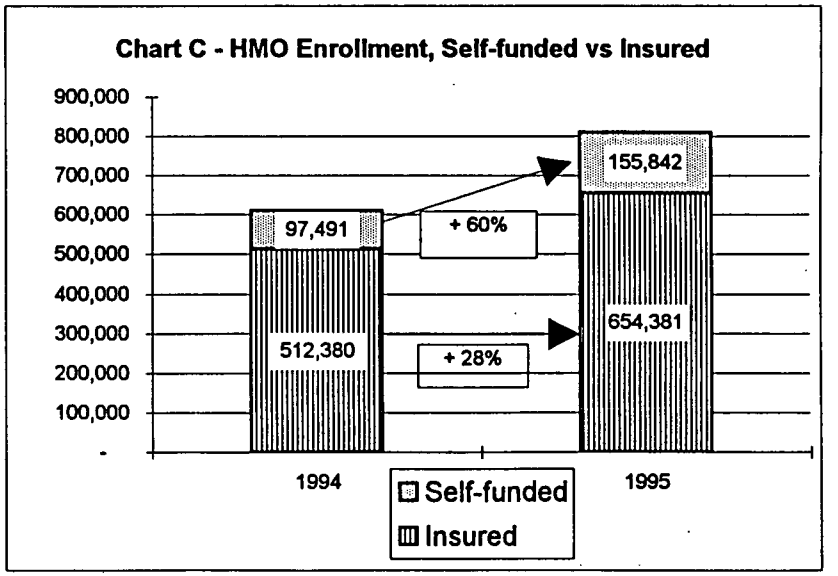
Figure 4.1 - Enrollment Trends (at December 31)

Highlights

1)Growth in HMO enrollment accelerated in the last 3 years (Chart A) and enrollment growth in POS (1) products was particularly strong (Chart B).
2)From 1994 to 1995, the percent increase in self-funded enrollment was much greater than than for insured enrollment (Chart C).





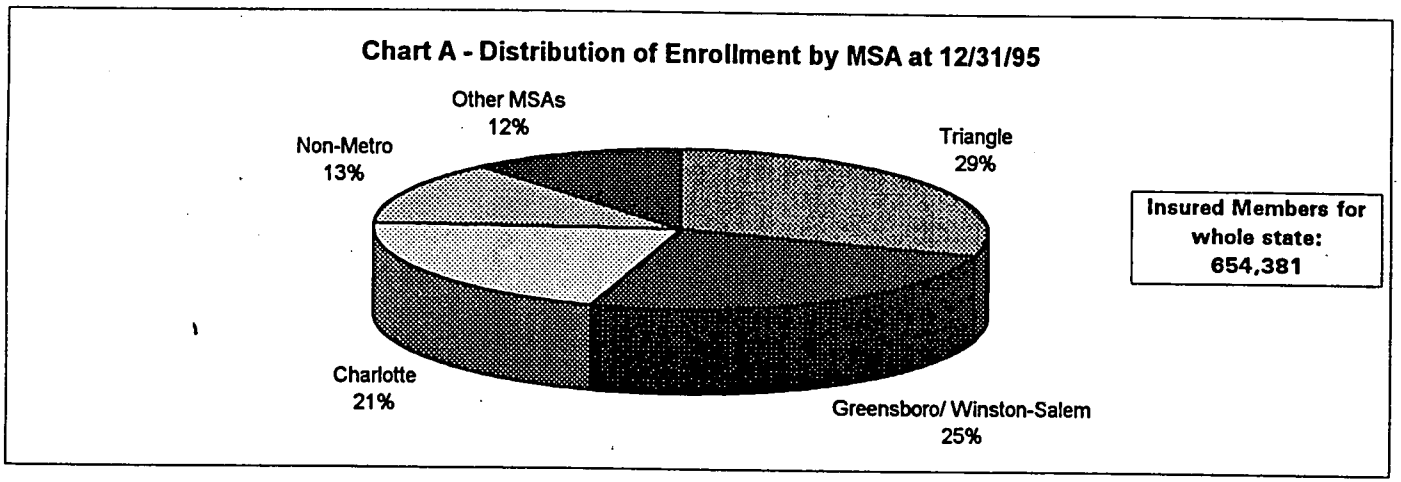


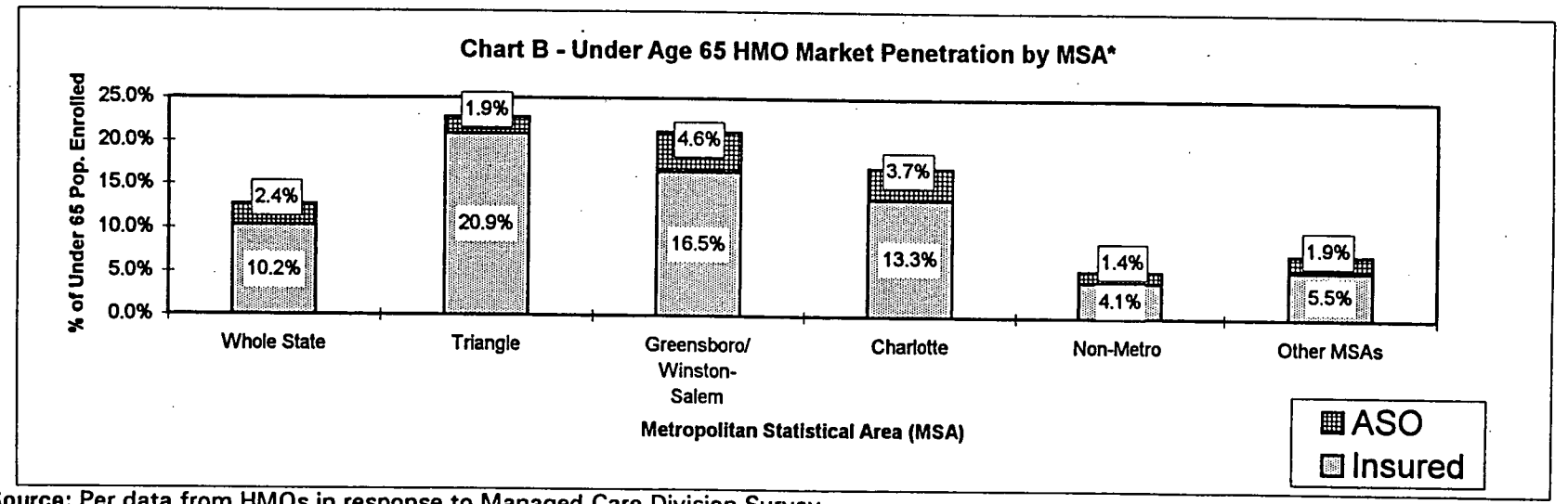
Source: 1994 and 1995 data: Per self-reported data from HMO for Mgd. Care Division Survey. 1990 - 1993 data: self reported from HMO to DOI's Financial Evaluation Division.
(1) Point of Service (POS) is defined in Figure 2.2 on page 7.
(2)Insur[illegible]ludes both POS products and traditional HMO products, see Figure 4.7 fo[illegible]S enrollment by HMO.

Figure 4.2 Enrollment Distribution & Market Penetration by MSA* at 12/31/95

Highlights:

1)About 3/4 of insured HMO enrollees resided in 3 MSAs (Triangle, Greensboro, Charlotte) (Chart A).
2)Market Penetration (% of population under 65) was also highest in these 3 MSAs (Chart B).





Source: Per data from HMOs in response to Managed Care Division Survey.

*MSA refers to Metropolitan Statistical Area. An MSA is a defined metropolitan area, composed of a city and surrounding counties. The counties which make up MSA are identified in the Commercial Atlas/MSA Trends.

For the counties in each MSA and other notes, see Appendix C. For enrollment and market penetration for all MSAs see Appendix D.

Figure 4.3 - Enrollment and Market Share - NC Total - 1991-1995 (at Dec. 31)

Table A - 1991(1)

	Members	% of Market
Kaiser	115,196	37.3%
PHP	46,466	15.0%
PARTNERS	45,412	14.7%
Prudential	32,705	10.6%
Healthsource (2)	29,185	9.4%
PCP	19,287	6.2%
HMO - NC	10,214	3.3%
Maxicare	8,457	2.7%
CIGNA	2,078	0.7%
Other	2,159	0.7%
	309,000	100.0%

Table B - 1992(1)

	Members	% of Market
Kaiser	118,790	34.8%
PHP	57,511	16.9%
PARTNERS	55,033	16.1%
Healthsource(2)	45,456	13.3%
Prudential	36,357	10.7%
PCP	10,478	3.1%
Maxicare	9,556	2.8%
HMO - NC	7,958	2.3%
	341,139	100.0%

Table C - 1993

	Members	% of Market
Kaiser	117,811	28.6%
PHP	73,809	17.9%
PARTNERS	62,075	15.0%
Healthsource(2)	60,414	14.6%
Prudential	42,443	10.3%
BCBS	33,461	8.1%
Maxicare	13,087	3.2%
PCP	9,379	2.3%
	412,479	100.0%

Table D - 1994

	Members	% of Market
Kaiser	122,910	24.0%
Healthsource	98,110	19.1%
PHP	89,208	17.4%
PARTNERS	73,895	14.4%
BCBS	53,088	10.4%
Prudential	40,132	7.8%
Maxicare	16,652	3.2%
CIGNA	12,341	2.4%
Other	6,044	1.2%
	512,380	100.0%

Highlights

1)Market share has been and continues to be concentrated with a small # of companies (6 HMOs have nearly 95% of 1995 enrollment)

2)Though Kaiser has had modest enrollment gains in the last 5 years, its market share has decreased from 37% to 18.5%.

3)Healthsource and BCBS have had rapid gains in enrollment and market share.

4)PHP and PARTNERS have had strong and steady enrollment growth and held on to their sizable shares of the NC market.

Table E - 1995

	Members	% of Market
Healthsource	138,715	21.2%
Kaiser	123,542	18.9%
BCBS	111,211	17.0%
PHP	103,801	15.9%
PARTNERS	88,560	13.5%
Prudential	47,399	7.2%
Maxicare	15,636	2.4%
CIGNA	12,693	1.9%
Other	12,824	2.0%
	654,381	100.0%

Note: Market Share varied widely by geographic area of the state - See next page for market share by MSA

Source: 1994 and 1995 data: Per self-reported data from HMOs for DOI's Managed Care Division Survey. 1990 - 1993 data: self reported from HMOs to Financial Evaluation Division for Annual Statement.

(1) Enrollment figures for the BCBS Line of Business HMO were not available prior to 1993.
(2) Healthsource was formerly known as Carolina Physicians Health Plan.

For Enrollment [illegible] All HMOs from 1990-1995, See Appendix E

Figure 4.4 - HMO Enrollment & Market Share By MSA at 12/31/95

Table A -Triangle

HMO	Members	% of Market
Kaiser	78,046	40.2%
Healthsource	76,791	39.6%
BCBS	23,767	12.3%
Maxicare	5,180	2.7%
Prudential	4,953	2.6%
CIGNA	2,138	1.1%
Doctors	1,844	1.0%
PCP	652	0.3%
Other	609	0.3%
	193,980	100.0%

Counties in Triangle MSA:
Chatham, Durham, Franklin, Johnston, Orange, Wake

Table B - Greensboro/Winson-Salem

HMO	Members	% of Market
PARTNERS	76,017	46.5%
PHP	62,479	38.2%
BCBS	17,558	10.7%
Healthsource	2,054	1.3%
Qualchoice	1,894	1.2%
Maxicare	1,706	1.0%
Kaiser	800	0.5%
CIGNA	474	0.3%
Other	527	0.3%
	163,509	100.0%

Counties in Greensboro/Win. Salem MSA:
Alamance, Davidson, Davie, Forsyth, Guilford, Randoplh, Stokes, Yadkin

Table C - Charlotte

HMO	Members	% of Market
Prudential	40,901	29.6%
Kaiser	34,919	25.3%
BCBS	22,539	16.3%
Healthsource	15,895	11.5%
CIGNA	7,916	5.7%
Maxicare	7,224	5.2%
PARTNERS	3,731	2.7%
PCP	2,820	2.0%
Other	2,029	1.5%
	137,974	100.0%

Counties in Charlotte MSA:
Cabarrus, Gaston, Lincoln, Mecklenburg, Rowan, Union

Table D - Other MSAs Combined

HMO	Members	% of Market
BCBS	25,675	34.1%
PHP	25,049	33.3%
Healthsource	16,325	21.7%
Kaiser	4,600	6.1%
PCP	1,490	2.0%
CIGNA	787	1.0%
Maxicare	765	1.0%
PARTNERS	445	0.6%
Other	122	0.2%
	75,258	100.0%

Includes following MSAs (See Appendix for Counties)
Asheville, Fayetteville, Goldsboro, Greenville, Hickory/Morganton, Jacksonville, Rocky Mount, Wilmington

Highlights

1)Market share varied widely by region, with dominant players in one region being minor players in others.
2)In the Triangle MSA, Kaiser and Healthsource dominated the market with a combined market share of 79%.
3)In the Greensboro/WS MSA, PARTNERS and PHP dominated the market with a combined market share of nearly 85%.

Table E - Non-Metro

HMO	Members	% of Market
Healthsource	27,650	33.1%
BCBS	21,673	25.9%
PHP	15,717	18.8%
PARTNERS	8,146	9.7%
Kaiser	5,177	6.2%
Prudential	1,383	1.7%
PCP	1,507	1.8%
CIGNA	1,378	1.6%
Other	1,030	1.2%
	83,661	100.0%

(See Appendix for Counties)

Source: Self-reported data from HMOs for DOI's Managed Care Division Survey.
Insured Enrollment for all HMOs by MSA is shown in Appendix G and total enrollment (Insured & ASO) for all HMOs is shown in Appendix H.

Figure 4.5 - Age and Gender Distribution of Insured Enrollment at 12/31/95

Highlights:

1)Nearly 50% of the NC HMO insured enrollment was between the ages of 20-44 (inclusive).
2)Less than 1% of the NC insured enrollment was over age 65.

HMO Licensed Name	<1	1-4	5 - 19	20 - 44	45 - 64	>65	Total Members (1)	Estimated Average Age(2)	% Male	% Female
Aetna Health Plans of the Carolinas, Inc.	2.0%	7.1%	19.9%	55.1%	14.4%	1.6%	508	28.71	46.9%	53.1%
Blue Cross Blue Shield of North Carolina Line of Business HMO	1.3%	6.2%	22.7%	49.2%	20.0%	0.7%	113,082	30.30	47.3%	52.7%
CIGNA Healthcare of North Carolina, Inc.	1.0%	6.6%	20.9%	48.4%	22.0%	0.9%	12,708	31.12	45.7%	54.3%
Doctors Health Plan, Inc.	2.1%	6.7%	20.1%	56.8%	13.8%	0.5%	2,170	28.36	43.8%	56.2%
Healthsource North Carolina, Inc.	1.6%	6.9%	24.0%	46.4%	20.4%	0.7%	138,715	29.93	46.2%	53.8%
Kaiser Foundation Health Plan of North Carolina	1.3%	6.2%	23.2%	46.5%	22.2%	0.6%	104,691	30.76	46.2%	53.8%
Maxicare North Carolina, Inc.	1.2%	5.9%	24.5%	41.4%	24.0%	2.9%	15,636	32.13	46.9%	53.1%
PARTNERS National Health Plans of North Carolina, Inc.	1.5%	6.8%	23.3%	47.9%	19.8%	0.7%	94,641	29.89	46.3%	53.7%
Personal Care Plan of NC, Inc.	1.7%	7.2%	27.3%	46.5%	17.0%	0.3%	6,976	28.29	48.6%	51.4%
PHP, Inc.	Did not receive sufficient age breakdown from PHP									
Principal Health Care of the Carolinas, Inc.	1.8%	4.9%	19.7%	48.4%	23.8%	1.4%	1,252	32.42	53.0%	47.0%
Provident Health Care Plan, Inc. of North Carolina	2.4%	8.8%	23.2%	40.0%	25.6%	0.0%	125	30.97	50.4%	49.6%
Prudential Health Care Plan, Inc.	1.4%	6.6%	22.6%	47.7%	20.2%	1.5%	64,451	30.55	47.4%	52.6%
Qualchoice of North Carolina, Inc.	1.2%	4.6%	18.0%	57.4%	18.4%	0.4%	1,894	30.61	43.1%	57.3%
Overall Mean	1.4%	6.5%	23.2%	47.4%	20.6%	0.9%	556,849	30.29	46.6%	53.4%
Median	1.5%	6.6%	22.7%	47.9%	20.2%	0.7%		30.55	46.9%	53.1%
High	2.4%	8.8%	27.3%	57.4%	25.6%	2.9%		32.42	53.0%	57.3%
Low	1.0%	4.6%	18.0%	40.0%	13.8%	0.0%		28.29	43.1%	47.0%

See Appendix K for age breakdown with greater detail

Source: Self-reported data from HMOs for Managed Care Division Survey

(1) The HMO total does not agree with HMO total in Figure 4.1 Chart A. Most of the difference is due PHP not reporting. PHP did not report because PHP did not track the age of its member in the detail requested in the survey

(2)Estimated by [redacted]ing enrollment by midpoint of age groups (<1, 1-4, 5-80(in 5yr. increme[redacted]80)

M&F Combin[redacted] [redacted]ly age[redacted]

Figure 4.6 - Insured Enrollment by Premium Category at 12/31/95

Highlights:

1)Enrollment in government products (Medicaid, Medicare, Federal Employee Health Benefits Plan (FEHBP), and Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) was less than 5% of total insured enrollment in the state.
2)Over 90% of the commercial insured enrollment was through group coverage and less than 1% was through individual coverage.

	Commercial Insured Enrollment					Government Products Enrollment						
HMO Licensed Name	Group	Small Group	Individual Conversion	Individual	Total Commercial Insured	Medicaid	Medicare Cost	Medicare Risk	FEHBP	Champus	Total Government Insured	HMO Totals (1)
Aetna Health Plans of the Carolinas, Inc.	238	270	0	0	508	0	0	0	0	0	0	508
Blue Cross Blue Shield of North Carolina Line of Business HMO	89,491	24,674	0	0	114,165	0	0	0	0	0	0	114,165
CIGNA Healthcare of North Carolina, Inc.	4,262	2,204	6	0	6,472	0	0	0	747	0	747	7,219
Doctors Health Plan, Inc.	2,085	85	0	0	2,170	0	0	0	0	0	0	2,170
Healthsource North Carolina, Inc.	133,936	1,961	0	0	135,897	0	0	0	2,818	0	2,818	138,715
Kaiser Foundation Health Plan of North Carolina	91,262	8,247	2,339	2,843	104,691	4,872	4,098	0	9,881	0	18,851	123,542
Maxicare North Carolina, Inc.	14,711	0	30	0	14,741	0	0	0	1,995	0	1,995	16,736
PARTNERS National Health Plans of North Carolina, Inc.	93,993	3,735	12	0	97,740	0	0	0	1,291	0	1,291	99,031
Personal Care Plan of NC, Inc.	6,979	0	35	0	7,014	0	0	0	0	0	0	7,014
PHP, Inc.	89,935	11,824	0	94	101,853	0	0	0	1,408	0	1,408	103,261
Principal Health Care of the Carolinas, Inc.	493	759	0	0	1,252	0	0	0	0	0	0	1,252
Provident Health Care Plan, Inc. of North Carolina	125	0	0	0	125	0	0	0	0	0	0	125
Prudential Health Care Plan, Inc.	52,914	4,328	0	0	57,242	0	0	0	1,415	0	1,415	58,657
Qualchoice of North Carolina, Inc.	769	0	0	0	769	0	0	0	0	0	0	769
Product Totals	581,193	58,087	2,422	2,937	644,639	4,872	4,098	0	19,555	0	28,525	673,164
Percentage of Product Type	90.2%	9.0%	0.4%	0.5%		17.1%	14.4%	0.0%	68.6%	0.0%		
Percentage of Total Enrollment	86.3%	8.6%	0.4%	0.4%	95.8%	0.7%	0.6%	0.0%	2.9%	0.0%	4.2%	

Source: Self-reported data from HMOs for DOI's Managed Care Division Survey. See Figure 2.1 for category definitions.

(1) The HMO total of 673,164 does not agree to the HMO total in Figure 1, Chart A, and the HMO total in Figure 4.7. The variance is due to several HMOs reporting different totals for enrollment by County and Premium Category. The department has taken steps to ensure that schedules will reconcile in the future.

Figure 4.7 - ASO Enrollment and Breakdown of Insured Enrollment at 12/31/95

Highlights:

1) Over 25% of total HMO enrollment was through ASO products, but there was a wide variation in the proportion of ASO enrollment to overall enrollment by HMO.
2)Nearly 20% of insured HMO enrollment was through POS products, but this percentage also varied widely by HMO.

	ASO (1)		Insured				Total
HMO Licensed Name	Enrollment	% of Total Enrollment	POS (2) Enrollment	POS as % of Insured Enrollment	Traditional HMO (3) Enrollment	Total Insured Enrollment (4)	Total Enrollment (5)
Aetna Health Plans of the Carolinas, Inc.	0	0.0%	0	0.0%	508	508	508
Blue Cross Blue Shield of North Carolina Line of Business HMO	43,194	28.0%	28,556	25.7%	82,655	111,211	154,405
CIGNA Healthcare of North Carolina, Inc.	65,015	83.7%	0	0.0%	12,693	12,693	77,708
Doctors Health Plan, Inc.	0	0.0%	0	0.0%	2,170	2,170	2,170
Healthsource North Carolina, Inc.	0	0.0%	54,400	39.2%	84,315	138,715	138,715
Kaiser Foundation Health Plan of North Carolina	0	0.0%	80	0.1%	123,462	123,542	123,542
Maxicare North Carolina, Inc.	0	0.0%	0	0.0%	15,636	15,636	15,636
PARTNERS National Health Plans of North Carolina, Inc.	5,906	6.3%	16,090	18.2%	72,470	88,560	94,466
Personal Care Plan of NC, Inc.	0	0.0%	0	0.0%	6,842	6,842	6,842
PHP, Inc.	13,609	11.6%	18,178	17.5%	85,623	103,801	117,410
Principal Health Care of the Carolinas, Inc.	0	0.0%	1,114	89.0%	138	1,252	1,252
Provident Health Care Plan, Inc. of North Carolina	0	0.0%	0	0.0%	125	125	125
Prudential Health Care Plan, Inc.	6,252	11.7%	0	0.0%	47,399	47,399	53,651
Qualchoice of North Carolina, Inc.	21,866	92.0%	1,894	100.0%	0	1,894	23,760
U.S. Healthcare of the Carolinas, Inc.	0	0.0%	1	3.0%	32	33	33
Totals	155,842	19.2%	120,313	18.4%	534,068	654,381	810,223

Notes

(1) Self-funded or ASO (administrative services only) enrollment is enrollment for which the HMO is paid an administrative fee to provide contracted services (e.g. arranging access to discounted providers, paying claims, performing utilization review etc.) related to the care of the beneficiaries in the self-funded group. The key distinction between ASO business and fully insured business is that the purchaser of ASO services (e.g. an employer) maintains the responsibility (i.e. retains the risk) for payment of incurred medical costs, while the purchaser of a fully-insured product prepays a premium and transfers risk for incurred medical costs to the HMO.
(2) Point of Service (POS) enrollment is the combination of a traditional HMO product with an indemnity product option. See note (1) on page 7 for further description.
(3) Traditional HMO Enrollment refers to the standard HMO product under which there is little or often no coverage if a member chooses to see a provider outside the HMO network.
(4) Total of Point of Service and Traditional HMO Enrollment (Column (2) + Column (3)).
(5) Total of ASO and Insured Enrollment

V. Solvency and Financial Performance

Background

All of the HMOs in North Carolina are required to submit a financial report (the "Annual Statement") to the Financial Evaluation Division of the Department annually. The Annual Statement was developed by the National Association of Insurance Commissioners (NAIC) for a nationally uniform means of reporting financial data. The Annual Statement contains a great deal of information that can be helpful in evaluating the solvency and profitability of an HMO.

Solvency refers to the ability of an organization to meet its financial obligations. Several sections of the North Carolina General Statute (NCGS) address solvency issues. NCGS 58-67-25 requires that North Carolina HMOs make and maintain a deposit (under the control of the Department of Insurance) of at least $500,000 as a condition of licensure. NCGS 58-67-110 specifies that each HMO is required to have a minimum net worth (difference between total assets and total liabilities) of $1,000,000 to be increased by the statutory contingency reserve. NCGS 58-67-40 mandates that each HMO is required to set up and maintain a balance in a contingency reserve account (a contingency reserve represents a segregation of a portion of retained earnings or fund balance). The balance needed in the contingency reserve account is based on a sliding scale of annual premiums, but the required balance is capped at three months of medical expenses.

This chapter contains information related to the solvency of HMOs in North Carolina as of 12/31/95. The section on solvency focuses on two of the many possible measures, net worth and contingency reserve. Both net worth and contingency are addressed in NCGS (see above). However, it should be noted that many other measures are commonly used to evaluate solvency and the reader is referred to the Annual Statement to get a more complete picture of an HMO's solvency.

This chapter also presents revenue and expense information for each HMO for the 1995 calendar year and presents trend data on premium revenues, medical and hospital expenses, and medical loss ratios from 1991-1995. The information is presented on a per member per month (PMPM) basis, except the medical loss ratio, which is simply a ratio of the medical hospital expenses to the premium revenues.

Major Points

Figure 5.1 - Contingency Reserves and Net Worth

- The median net worth at 12/31/95 was $4.9 million, with a range from $1.1 million to $37.5 million.

Figure 5.2- Premium Revenue, Medical Expense and Medical Loss Ratio by HMO for 1995

- Weighted Average for the North Carolina Industry- Weighted averages for premium revenue, medical expense, and medical loss ratio were $129, $112, and .87, respectively.
- Revenues for Large HMOs Vs. Small HMOs - The larger HMOs all had premium revenues of close to $130 PMPM, while several of the smaller HMOs had revenues below $120 PMPM.

Figure 5.3 Aggregate Premium Revenue, Medical Expense, and Medical Loss Ratio for 1991-1995

- Long-Term Trend in Revenues and Expenses - Weighted average premium revenue grew from $102 PMPM in 1991 to $129 PMPM in 1995, an increase of 26.2% for the whole period and 6% per year. Medical and Hospital Expenses grew from $87 PMPM to $112 PMPM, a total increase of 29.3% and 6.5% per year (Chart A).
- Recent Trend in Revenues and Expenses - From 1994 to 1995, weighted average medical expenses increased 4.8%, while weighted average premium revenues increased less than 1% (Chart A)
- Medical Loss Ratio *(Prepaid Premium Revenue/Medical & Hospital Expenses)* - Medical Loss Ratio for the North Carolina HMO industry was .87, its highest level in the last five years (Chart B).

Figure 5.1 - Contingency Reserves and Net Worth 1995

HMO Licensed Name [1]	Date HMO Licensed	Total 1995 Premium Revenues	Total Monthly Exp	Contingency Reserve	Net Worth
Aetna Health Plans of the Carolinas, Inc.	08/11/94	$339,343	$30,889	$0	$3,118,276
CIGNA Healthcare of North Carolina, Inc.	02/14/86	$17,036,834	$1,607,687	$480,985	$2,063,934
Doctors Health Plan, Inc.	09/30/94	$1,400,563	$365,970	$15,055	$3,376,927
Healthsource North Carolina, Inc.	04/18/86	$198,214,069	$15,310,933	$6,102,381	$15,952,623
Kaiser Foundation Health Plan of North Carolina	06/18/84	$193,296,597	$16,570,520	$10,955,344	$37,527,385
Maxicare North Carolina, Inc.	02/27/84	$24,424,210	$2,202,891	$2,357,923	$3,841,144
PARTNERS National Health Plans of North Carolina, Inc.	10/30/86	$142,111,517	$10,894,228	$5,597,763	$26,985,078
Personal Care Plan of NC, Inc.	11/19/85	$8,510,669	$732,535	$1,549,708	$7,647,955
PHP, Inc.	05/02/85	$155,349,981	$12,526,334	$5,815,190	$27,174,472
Principal Health Care of the Carolinas, Inc.	12/15/94	$558,420	$217,815	$0	$1,957,345
Provident Health Care Plan, Inc. of North Carolina	8/18/94	$177,791	$42,619	$0	$6,031,370
Prudential Health Care Plan, Inc.	3/11/85	$66,003,293	$6,422,044	$3,675,000	(1)
Qualchoice of North Carolina, Inc.	9/9/94	$1,717,212	$671,501	$14,346	$1,158,216
Mean		$62,241,577	$5,199,690	$2,812,592	$11,402,894
Median		$17,036,834	$1,607,687	$1,549,708	$4,936,257

Note: Table only includes HMOs that had enrollment as of 12/31/95.

Source: Annual Statements filed with the Financial Evaluation Division.

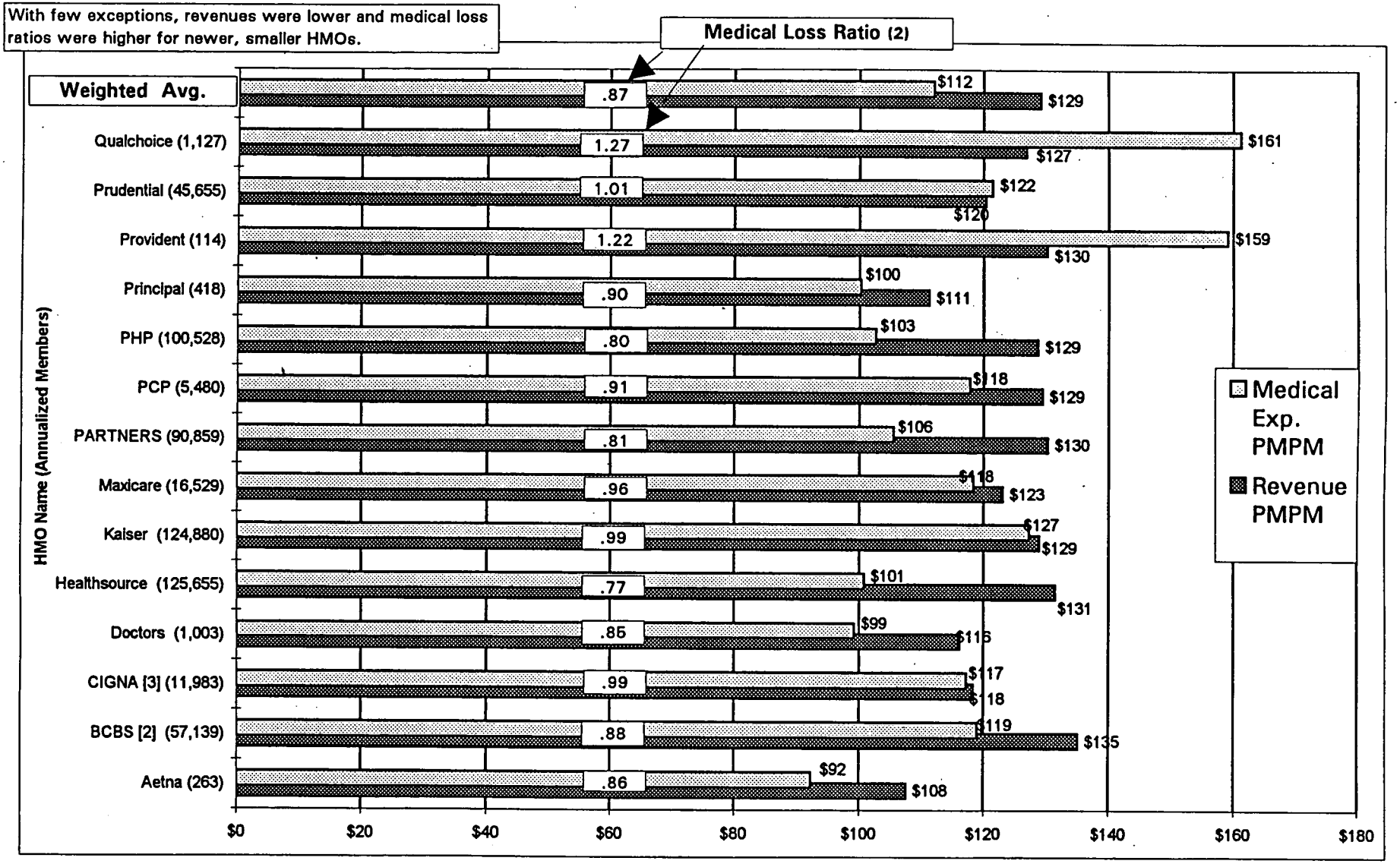
Important: See Background of this chapter on page 19.

(1) Prudential is domiciled in Texas and licensed in many states. Prudential submits a consolidated Annual Statement and reported a consolidated net worth of $177.7 million.

Figure 5.2 - Premium Revenue [1], Medical Expense [1], and Medical Loss Ratio for 1995

Highlight:

With few exceptions, revenues were lower and medical loss ratios were higher for newer, smaller HMOs.



[1] Premium Revenue and Medical Expenses are stated on a per member per month (PMPM) basis.

[2] Medical Loss Ratio = (Medical & Hospital Expenses)/Premium Revenue

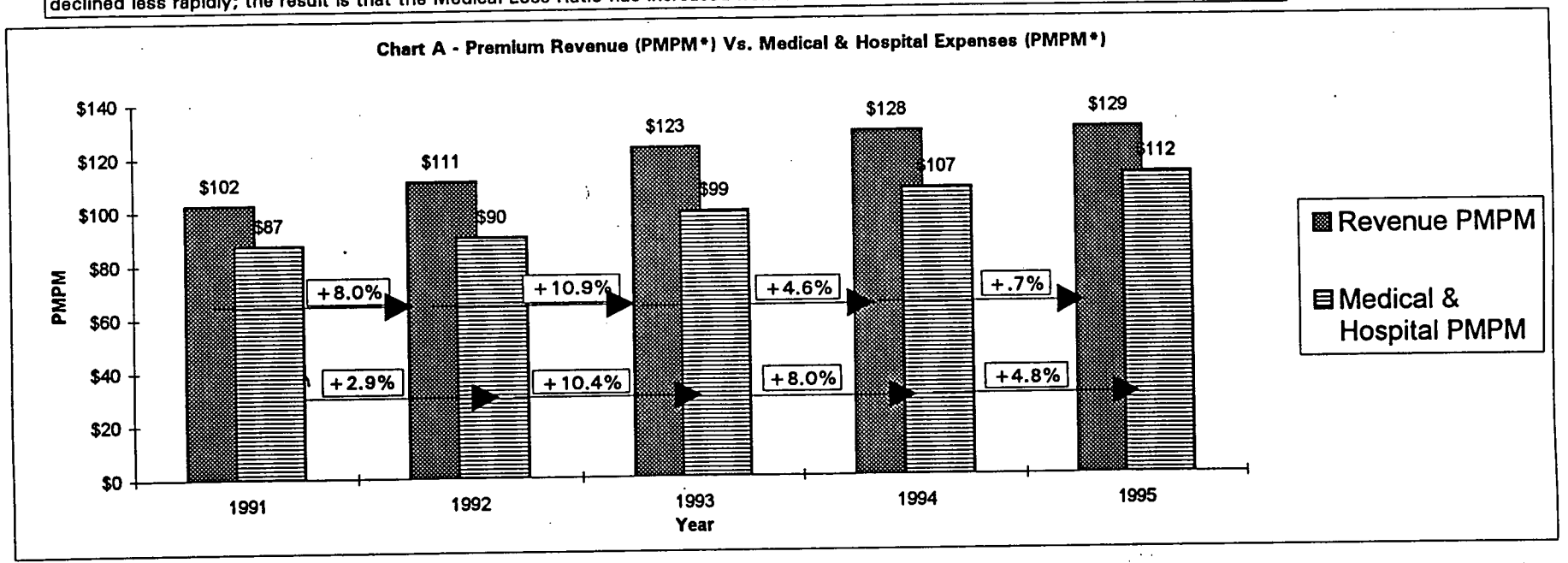
[3] The figures for BCBS do not include its POS product line, its POS membership was 28,566 at 12/31/95

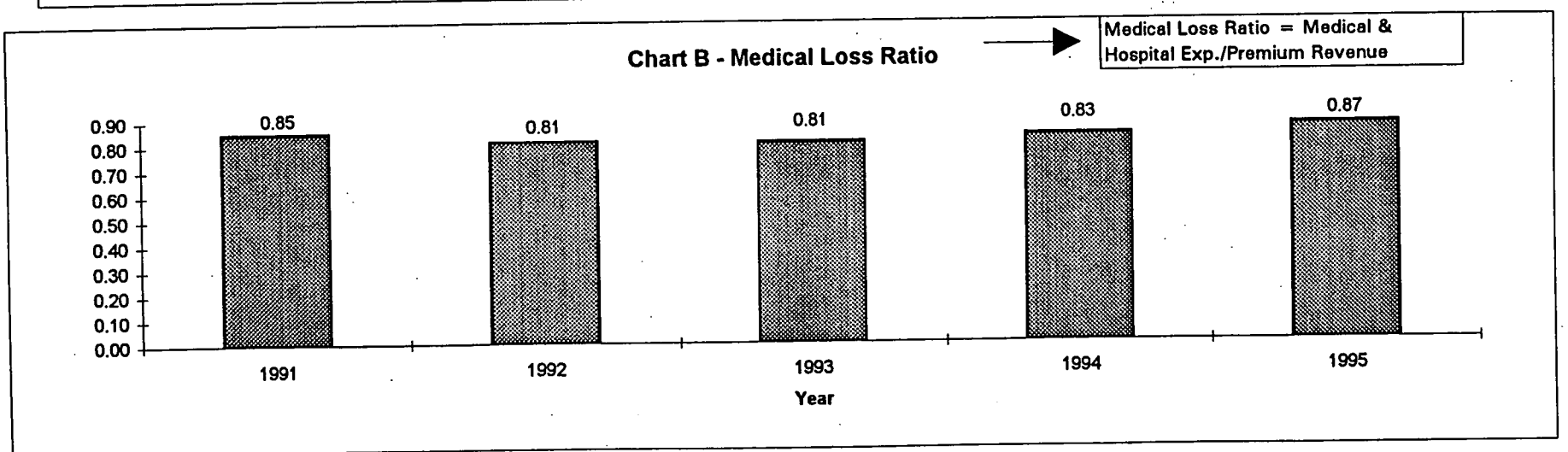
See Appendix L for more detailed financial data.

Source: Annual Statements filed with the Financial Evaluation Division.

Figure 5.3 - Weighted Average Premium Revenues, Medical Expenses, and Medical Loss Ratios for the NC HMO Industry for 1991-1995

The rate of growth in premiums has slowed substantially in the last two years, while the rate of growth for medical expenses has declined less rapidly; the result is that the Medical Loss Ratio has increased from .81 to .87 in the last two years.





Source: Annual Statements filed with the Financial Evaluation Division.
*PMPM = Per member per month

See Appendix L for the financial results of each HMO for 1994-1995

VI. Utilization

Background

This chapter contains North Carolina HMO industry aggregate-level data on the utilization of healthcare services by HMO subscribers. The HMOs submitted the data used in this chapter through an independent actuarial and consulting firm. The actuarial firm prepared a report of summary statistics for the Department using definitions specified by the Department.

Major Points

- Inpatient Days per 1,000 Members - Median total inpatient days per 1,000 members was 242 days, with a range from 207 days to 277 days. Median medical/surgical was 167 days per 1,000 members and median mental health was 14.8 days per 1,000 members.
- Average Length of Stay (ALOS) - Median ALOS was 3.89 days for total inpatient. Median ALOS for maternity (includes normal delivery and C-section) was 2.16 days with a low of 1.90 days and a high of 2.79 days.
- Outpatient Office Encounters per 1,000 Members - Median outpatient encounters (excluding ER, and scheduled outpatient surgeries and procedures) was five encounters per member, with a low of four per member and a high of eleven per member.
- Emergency Room (ER) Encounters per 1,000 Members - Median ER encounters was 134.4 per 1,000 members, with a low of 69.5 encounters per 1,000 members and a high of 222.7 per 1,000 members.
- Outpatient Surgeries and Procedures per 1,000 Members - Median outpatient surgeries/procedures was 70.3 encounters per 1000 members, with a low of 42.9 encounters per 1,000 members and a high of 182.3 encounters per 1,000 members.

Figure 6.1 - 1995 Aggregate Inpatient Utilization for HMOs with At least 5,000 Members [1]

Table A - Inpatient Days/1000 Members

	# of HMOs Reporting (1)	Members (Annualized)	Weighted Mean	Mean	Median	Low	25th%	75th%	High
Medical (a)	8	557,692	85.3	87.5	76.4	64.5	69.6	104.1	134.0
Surgical (b)	8	557,692	70.2	73.1	70.3	53.0	57.7	86.4	102.6
Subtotal 1 ((a) + (b))	8	557,692	155.5	160.7	167.0	123.8	142.6	176.5	187.0
Mental Health (c)	6	454,747	13.6	13.9	14.8	6.4	8.0	19.3	21.0
Chemical Dependency (d)	6	454,747	3.6	4.5	3.8	2.1	3.5	4.8	9.1
Subtotal 2 ((c) + (d))	6	454,747	17.2	18.5	18.9	10.2	11.4	25.3	26.3
Maternity (e)	7	466,844	33.5	34.1	31.2	29.5	29.7	36.8	45.0
Newborn (f)	7	466,844	26.8	21.7	18.1	6.0	17.0	29.7	34.5
Subtotal 3 ((e) + (f))	7	466,844	60.3	55.8	61.0	36.0	49.8	64.2	65.6
Non-acute care (g)	6	445,240	12.0	11.6	13.4	1.1	6.1	15.2	22.0
Other/unknown (h)	4	254,343	28.5	23.2	10.1	2.5	7.4	25.9	70.1
Total Inpatient	8	557,692	242.6	243.6	242.3	206.9	228.0	259.4	277.0

Table B - Average Length of Stay (ALOS)

	# of HMOs Reporting (1)	Members (Annualized)	Median	Low	25th%	75th%	High
Medical (a)	8	557,692	4.29	3.56	3.96	4.40	4.57
Surgical (b)	8	557,692	4.45	3.49	3.99	4.71	4.92
Subtotal 1 ((a) + (b))	8	557,692	4.21	3.99	4.12	4.39	4.61
Mental Health (c)	6	454,747	5.14	3.14	3.74	6.06	7.20
Chemical Dependency (d)	6	454,747	4.00	3.14	3.42	5.60	6.30
Subtotal 2 ((c) + (d))	6	454,747	4.90	3.16	3.63	5.30	6.51
Maternity (e)	7	466,844	2.16	1.90	2.05	2.38	2.79
Newborn (f)	7	466,844	3.57	1.44	2.73	7.49	15.80
Subtotal 3 ((e) + (f))	7	466,844	2.50	2.22	2.40	2.58	3.06
Non-acute care (g)	6	445,240	27.49	8.00	12.75	38.27	101.00
Other/unknown (h)	4	254,343	5.64	2.78	4.60	13.38	35.33
Total Hospital/Inpatient	8	557,692	3.89	3.55	3.73	3.96	4.76

Highlights:

1)Median inpatient days/1000 was 242 days, with a range from 207 days to 277 days

2)Median Medical/Surgical days/1000 was 167 days, with a range from 124 days to 187 days.

3)Median Mental Health days/1000 was 14.8 days, with a range from 6.4 days to 21.0 days - It should be noted that mental health benefits are generally done on a rider basis, thus many contracts between HMO and employer may not include a mental health benefit.

4)Median average length of stay (LOS) for maternity was 2.16 days, with a low of 1.90 days and a high of 2.79 days.

(1) Based on self-reported data from the HMOs in NC HMO Association with at least 5,000 members. Some HMOs were not able to report in all categories. The data was aggregated by an independent actuarial firm.

Note: The subtotal/total rows do not always add because several HMOs reported totals but did not place all encounters in one of the categories listed.

Definitions: The definitions below were used by the HMOs in reporting and these definitions closely follow HEDIS 2.5.

(a) **Medical** - discharges for which no major surgical procedure was performed.

(b) **Surgical** - discharges for which a surgical procedures was the primary method of treatment.

(c) **Mental Health** - discharges related to treatment of a mental disorder, *excludes chemical dependency.*

(d) **Chemical Dependency** - discharges principally for the treatment of substance abuse.

(e) **Maternity** - discharges connected with live births only (normal delivery and C-section) - *mothers' days should be counted separately from newborns' days.*

(f) **Newborn** - inpatient care provided to newborn from birth to discharge to home.

(g) **Non-acute Care** - discharges for Hospice, Nursing Home, Rehabilitation, SNF, Transitional Care or Respite, regardless of the type of facility.

(h) **Other/unknown** - discharges reported in this category should be minimal, as discharges should be classified in one of the other categories listed above.

Figure 6.2 - 1995 Aggregate Outpatient Utilization for HMOs with At Least 5,000 Members [1]

Highlights:

1)Median office encounters for the seven HMOs reporting was 4,989 per 1,000 members or almost 5 per member.
2)Median ER encounters was 128 encounters per 1,000 members and median outpatient surgery/procedures was 70 per 1,000 members.

Table A - Office-Based Encounters per 1,000 Members

	# of HMOs	Members (Annualized)	Weighted Mean	Mean	Median	Low	25th%	75th%	High
Physician Encounters									
Adult Medicine	7	457,336	1,800	1,922	1,951	1,372	1,841	2,106	2,234
Pediatrics	7	457,336	725	711	708	454	618	806	965
OB/GYN	7	457,336	275	256	230	125	217	299	403
Subtotal (Primary Care Physician Encounters)	7	457,336	2,801	2,888	3,046	2,070	2,900	3,076	3,148
Mental Health/Psychiatry/CD	5	354,391	138	101	62	44	46	107	246
All Other Physician Encounters (in total)	7	457,336	2,156	2,160	1,238	947	1,173	1,725	7,137
Subtotal (Specialty care)	7	457,336	2,263	2,232	1,257	1,193	1,239	1,748	7,199
Total Physician Encounters	7	457,336	5,064	5,120	4,386	3,310	4,194	4,812	10,130
Other Provider Encounters									
Mental Health	5	354,391	74	86	130	1	12	133	154
Optometry	4	215,090	65	32	10	6	8	34	104
Podiatry	6	351,491	18	16	19	2	6	27	28
Dentistry	4	293,842	2	3	3	1	2	4	4
Chiropractic	6	351,491	25	30	18	0	5	47	87
Physician Assitants	0	-							
Nurse Practitioners	2	231,498	395	432	432	0	216	648	863
PT, OT, Other Therapies	6	331,684	98	107	116	34	82	126	177
Other	7	457,336	96	226	24	0	1	106	1,344
Unknown	1	125,652	6	6	6	6			6
Total Non-Physician Encounters	7	457,336	491	564	341	92	216	774	1,530
Total Office Based Encounters	7	457,336	5,555	5,683	4,989	4,233	4,518	5,492	10,539

Table B - Emergency Room Encounters per 1,000 Members

In-Area Utilization	8	557,692	113.5	117.6	128.2	69.5	85.5	135.6	170.8
Out-of-Area Utilization(2)	7	451,847	12.1	13.4	7.8	3.7	4.9	10.4	51.8
Unknown	0	-							
Total Emergency Room Encounters	8	557,692	123.3	129.3	134.4	69.5	94.8	140.7	222.7

Table C - Scheduled OP Surgery/Procedures per 1,000 Members

Surgical Center (non-hospital)	8	557,692	20.6	19.3	16.2	4.6	11.6	29.2	37.4
In/Out Surgery (Hospital)	8	557,692	68.2	69.5	51.3	38.3	42.8	69.1	174.3
Total OP Surgery/Proced. Encounters	8	557,692	88.9	88.7	70.3	42.9	65.4	94.7	182.3

(1) See note (1) for Figure 6.1 on Page 25.

Note: The subtotal/total rows do not add because several HMOs reported totals but did not place all encounters in one of the categories listed.

(1) A total of seven HMOs reported outpatient utilization

(2) Refers to ER [illegible] outside what is considered the local area of the HMO.

VII. Complaints

Background

This chapter contains a table which lists the number of complaints received by the Consumer Services Division of the Department for each HMO for the 1995 calendar year. The reader is advised that some complaints may be of a more serious nature than others and no attempt was made to weight the seriousness of complaints received.

Major Points

- Overall Complaint Ratio - The weighted average rate of complaints for North Carolina HMOs was .297 per 1000 member equivalents in 1995 and .283 in 1994.
- Complaint Ratios for Large HMOs - The largest HMOs (those with greater than 1 million member months) had complaint ratios ranging from .209 per 1000 member equivalents to .318 per 1000 member equivalents.

Figure 7.1 - Summary Complaint Data 1994 & 1995

Highlights

1)The largest HMOs (> 1 million member months) had complaint ratios ranging from .209 per 1000 member equivalents to .318 per 1000 member equivalents in 1995.
2) The weighted average for the NC HMOs was .297 per 1000 member equivalents in 1995 and .283 in 1994.

	1994			1995		
HMO Licensed Name	Complaints Received (1)	Member Months	Complaints/ 1000 Member Equivalent (2)	Complaints Received (1)	Member Months	Complaints/ 1000 Member Equivalent (2)
Aetna Health Plans of the Carolinas, Inc.	0	0		1	3,151	3.808
Blue Cross Blue Shield of North Carolina Line of Business HMO (3)	Not available					
CIGNA Healthcare of North Carolina, Inc.	8	72,475	1.325	12	143,800	1.001
Doctors Health Plan, Inc.	0	0		0	12,043	0.000
Healthsource North Carolina, Inc.	31	1,050,843	0.354	39	1,507,870	0.310
Kaiser Foundation Health Plan of North Carolina	29	1,335,984	0.260	31	1,498,562	0.248
Maxicare North Carolina, Inc.	4	177,252	0.271	7	198,352	0.423
PARTNERS National Health Plans of North Carolina, Inc.	14	851,333	0.197	19	1,090,302	0.209
Personal Care Plan of NC, Inc. (3)	Not available					
PHP, Inc.	22	1,016,339	0.260	32	1,206,335	0.318
Principal Health Care of the Carolinas, Inc.	0	0		0	5,013	0.000
Provident Health Care Plan, Inc. of North Carolina	0	152	0.000	1	1,365	8.791
Prudential Health Care Plan, Inc.	9	464,647	0.232	13	547,861	0.285
Qualchoice of North Carolina, Inc.	0	0		0	13,525	0.000
Totals	117	4,969,025	0.283	154	6,225,028	0.297

(1) Complaints received by the Consumer Services Division of the Department of Insurance during 1994 and 1995.

(2) A member equivalent is = (member months/12). Thus, this measure is a substitute for complaints per 1000 members, and is more accurate than using enrollment at one point in time during the year.

(3) The Consumer Services Division was unable to segregate the HMO complaints from the complaints it received relating to BCBS's PPO and traditional indemnity products.

Appendix A - List of Abbreviated HMO Names Used In Report

HMO Licensed Name	Abbreviated Name
Aetna Health Plans of the Carolinas, Inc.	Aetna
Atlantic Health Plans of the Carolinas, Inc.	Atlantic
Blue Cross Blue Shield of North Carolina - Line of Business HMO	BCBS
Carolina Summit Healthcare, Inc.	Carolina Summit
CIGNA Healthcare of North Carolina, Inc.	Cigna
Community Choice of North Carolina, Inc.	Community Choice
Doctors Health Plan, Inc.	Doctors
Health Maintenance Organization of North Carolina	HMO - NC
Healthsource North Carolina, Inc.	Healthsource
Kaiser Foundation Health Plan of North Carolina	Kaiser
Maxicare North Carolina, Inc.	Maxicare
Optimum Choice of the Carolinas, Inc.	Optimum
PARTNERS National Health Plans of North Carolina, Inc.	Partners
Personal Care Plan of NC, Inc.	PCP
PHP, Inc.	PHP
Principal Health Care of the Carolinas, Inc.	Principal
Provident Health Care Plan, Inc. of North Carolina	Provident
Prudential Health Care Plan, Inc.	Prudential
Qualchoice of North Carolina, Inc.	QualChoice
The Wellness Plan of North Carolina, Inc.	Wellness Plan
U.S. Healthcare of the Carolinas, Inc.	US Healthcare
WellPath Select, Inc.	Wellpath

Appendix B - Contact Information for Licensed HMOs

Full-Service HMOs

HMO Licensed Name	CEO/President	Phone#	City	State
Aetna Health Plans of the Carolinas, Inc.	Amy Williams, President	(704) 353-7173	Charlotte	NC
Atlantic Health Plans of the Carolinas, Inc.	Wallace James Hilliard, President	(800) 335-2501	Charlotte	NC
Blue Cross Blue Shield of North Carolina Line of Business HMO	Kenneth C. Otis, II, President/ CEO	(919) 489-7431	Durham	NC
Carolina Summit Healthcare, Inc.	William B. Bull, President	(919) 832-2744	Raleigh	NC
CIGNA Healthcare of North Carolina, Inc.	Joe Murgo, President	(704) 544-4350	Charlotte	NC
Community Choice of North Carolina, Inc.	Randolph Ferguson, President	(910) 691-4301	Greensboro	NC
Doctors Health Plan, Inc.	Gary Whitaker, MD	(800) 476-2303	Durham	NC
Health Maintenance Organization of North Carolina	Kenneth C. Otis II, President/CEO	(800) 227-3727	Durham	NC
Healthsource North Carolina, Inc.	Robert Grecyzn, CEO	(919) 460-1610	Morrisville	NC
Kaiser Foundation Health Plan of North Carolina	Theodore M. Carpenter, Jr.	(919) 981-6000	Raleigh	NC
Kanawha Healthcare, Inc.	James L. Tillotson	(803) 283-5677	Lancaster	SC
Maxicare North Carolina, Inc.	Richard Hedlund, VP/General Manager	(704) 525-0880	Charlotte	NC
Optimum Choice of the Carolinas, Inc.	George T. Jochum, President/CEO	(301) 294-1580	Rockville	MD
PARTNERS National Health Plans of North Carolina, Inc.	John Jones, President/CEO	(910) 760-4822	Winston-Salem	NC
Personal Care Plan of NC, Inc.	Kenneth C. Otis II, Prsident/CEO	(919) 489-7431	Durham	NC
PHP, Inc.	Frank Mascia, President/CEO	(910) 282-0900	Greensboro	NC
Principal Health Care of the Carolinas, Inc.	Chuck Trinchitella, President	(704) 357-1421	Charlotte	NC
Provident Health Care Plan, Inc. of North Carolina	Carol A. Hefner, Executive Director	(704) 556-5400	Charlotte	NC
Prudential Health Care Plan, Inc.	James Ebbitt, VP North Carolina Operations	(704) 365-6070	Charlotte	NC
Qualchoice of North Carolina, Inc.	Doug Cueny, President/CEO	(910) 716-0900	Winston-Salem	NC
The Wellness Plan of North Carolina, Inc.	Timothy J. O'Brien, CEO	(704) 679-3700	Charlotte	NC
U.S. Healthcare of the Carolinas, Inc.	Michael J. Cardillo, President	(215) 628-4800	Blue Bell	PA
WellPath Select, Inc.	Anna M. Lore President Executive Dir.	(919) 493-1210	Chapel Hill	NC

Single-Service HMOs

American Dental Plan of North Carolina	Dr. David Klock	(919) 380-9267	Cary	NC
Association of Eye Care Centers Total Vision Health Plan, Inc.	Sam Petteway, President	(919) 937-6650	Rocky Mount	NC
CIGNA Dental Health of North Carolina, Inc.	David O. Cannady	(800) 257-5800	Plantation	FL
Spectera Dental Services, Inc.	Oscar B. Camp, MD, President	(410) 265-6033	Baltimore	MD

Appendix C - MSA Definition, Enrollment and Market Penetration by County at 12/31/95

County	MSA (1)	Under 65 Population (2)	Insured Enrollment	% of < 65 Population (3)	Enrollment: Self-Funded + Insured	% of < 65 Population
Alamance	Greensboro/Winston-Salem	98,791	11,459	11.6%	14,162	14.3%
Alexander	Hickory/Morganton	27,050	255	0.9%	404	1.5%
Alleghany	Non-Metro	7,621	424	5.6%	594	7.8%
Anson	Non-Metro	19,947	1,131	5.7%	1,181	5.9%
Ashe	Non-Metro	18,865	63	0.3%	320	1.7%
Avery	Non-Metro	12,787	22	0.2%	31	0.2%
Beaufort	Non-Metro	36,847	1,215	3.3%	1,312	3.6%
Bertie	Non-Metro	17,576	185	1.1%	187	1.1%
Bladen	Non-Metro	25,537	1,525	6.0%	2,085	8.2%
Brunswick	Wilmington	52,455	1,945	3.7%	2,529	4.8%
Buncombe	Asheville	159,837	14,366	9.0%	17,293	10.8%
Burke	Hickory/Morganton	71,217	2,438	3.4%	2,674	3.8%
Cabarrus	Charlotte	98,208	12,489	12.7%	16,698	17.0%
Caldwell	Hickory/Morganton	64,504	1,066	1.7%	2,782	4.3%
Camden	Non-Metro	5,527	4	0.1%	8	0.1%
Carteret	Non-Metro	49,444	539	1.1%	633	1.3%
Caswell	Non-Metro	17,956	616	3.4%	915	5.1%
Catawba	Hickory/Morganton	111,687	1,213	1.1%	3,134	2.8%
Chatham	Triangle	37,005	2,744	7.4%	3,440	9.3%
Cherokee	Non-Metro	17,799	10	0.1%	10	0.1%
Chowan	Non-Metro	11,527	22	0.2%	23	0.2%
Clay	Non-Metro	6,180	12	0.2%	12	0.2%
Cleveland	Non-Metro	77,085	5,112	6.6%	6,023	7.8%
Columbus	Non-Metro	44,173	2,016	4.6%	3,560	8.1%
Craven	Non-Metro	75,972	651	0.9%	1,049	1.4%
Cumberland	Fayetteville	276,766	12,696	4.6%	20,048	7.2%
Currituck	Non-Metro	14,163	6	0.0%	6	0.0%
Dare	Non-Metro	23,229	16	0.1%	18	0.1%
Davidson	Greensboro/Winston-Salem	120,742	9,702	8.0%	10,515	8.7%
Davie	Greensboro/Winston-Salem	25,678	5,800	22.6%	6,512	25.4%
Duplin	Non-Metro	37,171	457	1.2%	551	1.5%
Durham	Triangle	174,763	40,345	23.1%	44,095	25.2%
Edgecombe	Rocky Mount	49,487	4,127	8.3%	6,900	13.9%
Forsyth	Greensboro/Winston-Salem	247,123	54,595	22.1%	84,617	34.2%
Franklin	Triangle	37,151	5,645	15.2%	6,224	16.8%

County	MSA (1)	Under 65 Population (2)	Insured Enrollment	% of < 65 Population (3)	Enrollment: Self-Funded + Insured	% of < 65 Population
Gaston	Charlotte	156,404	27,384	17.5%	35,169	22.5%
Gates	Non-Metro	8,409	20	0.2%	20	0.2%
Graham	Non-Metro	6,251	15	0.2%	15	0.2%
Granville	Non-Metro	36,375	6,051	16.6%	6,935	19.1%
Greene	Non-Metro	14,824	516	3.5%	650	4.4%
Guilford	Greensboro/Winston-Salem	329,987	65,373	19.8%	71,902	21.8%
Halifax	Non-Metro	49,133	453	0.9%	674	1.4%
Harnett	Non-Metro	69,496	5,612	8.1%	6,415	9.2%
Haywood	Non-Metro	40,304	3,305	8.2%	3,975	9.9%
Henderson	Non-Metro	59,899	3,217	5.4%	5,270	8.8%
Hertford	Non-Metro	18,937	68	0.4%	85	0.4%
Hoke	Non-Metro	25,788	610	2.4%	682	2.6%
Hyde	Non-Metro	4,256	24	0.6%	25	0.6%
Iredell	Non-Metro	91,480	4,339	4.7%	5,292	5.8%
Jackson	Non-Metro	24,931	855	3.4%	1,133	4.5%
Johnston	Triangle	86,488	14,246	16.5%	15,426	17.8%
Jones	Non-Metro	8,087	70	0.9%	123	1.5%
Lee	Non-Metro	40,353	2,481	6.1%	4,110	10.2%
Lenoir	Non-Metro	50,713	1,332	2.6%	1,442	2.8%
Lincoln	Charlotte	49,841	3,009	6.0%	3,864	7.8%
Macon	Non-Metro	20,501	373	1.8%	743	3.6%
Madison	Asheville	14,922	1,390	9.3%	1,518	10.2%
Martin	Non-Metro	21,991	718	3.3%	802	3.6%
McDowell	Non-Metro	31,843	1,075	3.4%	1,116	3.5%
Mecklenburg	Charlotte	536,175	81,239	15.2%	101,661	19.0%
Mitchell	Non-Metro	12,024	44	0.4%	69	0.6%
Montgomery	Non-Metro	20,825	408	2.0%	479	2.3%
Moore	Non-Metro	53,425	1,067	2.0%	1,306	2.4%
Nash	Rocky Mount	74,713	5,007	6.7%	5,773	7.7%
New Hanover	Wilmington	124,923	11,829	9.5%	16,608	13.3%
Northampton	Non-Metro	17,030	94	0.6%	105	0.6%
Onslow	Jacksonville	142,527	1,937	1.4%	2,104	1.5%
Orange	Triangle	98,513	17,388	17.7%	18,441	18.7%
Pamlico	Non-Metro	9,754	78	0.8%	116	1.2%
Pasquotank	Non-Metro	28,726	5	0.0%	6	0.0%
Pender	Non-Metro	30,535	2,061	6.8%	3,169	10.4%
Perquimans	Non-Metro	8,684	16	0.2%	16	0.2%
Person	Non-Metro	27,884	3,444	12.4%	3,616	13.0%

County	MSA (1)	Under 65 Population (2)	Insured Enrollment	% of < 65 Population (3)	Enrollment: Self-Funded + Insured	% of < 65 Population
Pitt	Greenville	107,426	11,045	10.3%	12,417	11.6%
Polk	Non-Metro	11,921	99	0.8%	125	1.1%
Randolph	Greensboro/Winston-Salem	102,494	5,666	5.5%	9,014	8.8%
Richmond	Non-Metro	39,013	568	1.5%	700	1.8%
Robeson	Non-Metro	99,705	2,909	2.9%	4,366	4.4%
Rockingham	Non-Metro	75,846	8,189	10.8%	9,921	13.1%
Rowan	Charlotte	102,295	5,661	5.5%	9,348	9.1%
Rutherford	Non-Metro	49,994	329	0.7%	347	0.7%
Sampson	Non-Metro	43,574	1,338	3.1%	1,788	4.1%
Scotland	Non-Metro	30,957	603	1.9%	634	2.0%
Stanley	Non-Metro	46,229	3,256	7.0%	4,010	8.7%
Stokes	Greensboro/Winston-Salem	37,058	6,380	17.2%	7,596	20.5%
Surry	Non-Metro	55,673	4,347	7.8%	6,894	12.4%
Swain	Non-Metro	9,766	125	1.3%	133	1.4%
Transylvania	Non-Metro	21,703	316	1.5%	426	2.0%
Tyrell	Non-Metro	3,079	5	0.2%	9	0.3%
Union	Charlotte	91,639	8,192	8.9%	9,513	10.4%
Vance	Non-Metro	35,030	2,931	8.4%	3,118	8.9%
Wake	Triangle	495,334	113,612	22.9%	123,963	25.0%
Warren	Non-Metro	14,802	431	2.9%	484	3.3%
Washington	Non-Metro	11,620	91	0.8%	92	0.8%
Watuaga	Non-Metro	35,958	42	0.1%	65	0.2%
Wayne	Goldsboro	99,995	1,650	1.7%	2,742	2.7%
Wilkes	Non-Metro	53,489	1,292	2.4%	1,500	2.8%
Wilson	Non-Metro	59,415	4,101	6.9%	10,088	17.0%
Yadkin	Greensboro/Winston-Salem	29,127	4,534	15.6%	4,897	16.8%
Yancey	Non-Metro	13,298	309	2.3%	339	2.5%
Other States (4)	N/A		4,293		4,293	
Totals		6,395,261	654,381	10.2%	810,223	12.7%

(1) MSA refers to Metropolitan Statistical Area. An MSA is a defined metropolitan area, composed of a city and surrounding counties. The counties which make up MSA are identified in the Commercial Atlas/MSA Trends.
(2) Population figures were projections for 6/30/96 from the State Library of NC. Note that other than census years, all figures are projections. Also note that using 6/30/96 projections understates penetration slightly since population is growing in most areas of NC (using 6/30/95 figures would have overstated penetration) .
(3) Insured enrollment included 4,745 people over age 65. Inclusion of these individuals overstates penetration slightly (about 1/10 of 1%).
(4) Other states refers to NC business (HMO contracted with NC employer) for which the member lives in another state.

Appendix D - Enrollment & Market Penetration by MSA at 12/31/95

MSA(1)	Population Under 65 (2)	Insured Enrollment	% of < 65 Population	Insured & Self-funded Enrollment	% of < 65 Population
Asheville	174,759	15,756	9.0%	18,811	10.8%
Charlotte	1,034,562	137,974	13.3%	176,255	17.0%
Fayetteville	276,766	12,696	4.6%	20,048	7.2%
Goldsboro	99,995	1,650	1.7%	2,742	2.7%
Greensboro/Winston-Salem	991,000	163,509	16.5%	209,215	21.1%
Greenville	107,426	11,045	10.3%	12,417	11.6%
Hickory/Morganton	274,458	4,971	1.8%	8,994	3.3%
Jacksonville	142,527	1,937	1.4%	2,104	1.5%
Rocky Mount	124,200	9,135	7.4%	12,674	10.2%
Triangle	929,254	193,980	20.9%	211,590	22.8%
Wilmington	177,378	13,774	7.8%	19,137	10.8%
ZNon-Metro	2,062,936	83,661	4.1%	111,943	5.4%
Other States(3)		4,293		4,293	
Totals	6,395,261	654,381	10.2%	810,223	12.7%

(1)MSA refers to Metropolitan Statistical Area. An MSA is a defined metropolitan area, composed of a city and surrounding counties. The counties which make up MSA are identified in the Commercial Atlas/MSA Trends.
(2)Population was estimated using population projections for counties and the MSA definitions (See Appendix C).
(3)Other states refers to NC business (HMO contracted with NC employer) for which the member lives in another state.

Appendix E - Full-Service HMO Enrollment 1990-1995

HMO Licensed Name	1990	1991	1992	1993	1994	1995
Aetna Health Plans of the Carolinas, Inc.	NL	NL	NL	NL	56	508
Blue Cross Blue Shield of North Carolina Line of Business HMO	Not avail	Not avail	Not avail	33,461	53,088	111,211
CIGNA Healthcare of North Carolina, Inc.	1,136	2,078	2,521	3,326	12,341	12,693
Doctors Health Plan, Inc.	NL	NL	NL	NL	0	2,170
Health Maintenance Organization of North Carolina	9,561	10,214	7,958	Inactive	Inactive	Inactive
Healthsource North Carolina, Inc.	36,321	29,185	45,456	60,414	98,110	138,715
Kaiser Foundation Health Plan of North Carolina	108,849	115,196	118,790	117,811	122,910	123,542
Maxicare North Carolina, Inc.	9,420	8,457	9,556	13,087	16,652	15,636
Optimum Choice of the Carolinas, Inc.	NL	NL	NL	NL	NL	0
PARTNERS National Health Plans of North Carolina, Inc.	35,653	45,412	55,033	62,075	73,895	88,560
Personal Care Plan of NC, Inc.	12,736	19,287	10,478	9,379	5,874	6,842
PHP, Inc.	30,985	46,466	57,511	73,809	89,208	103,801
Principal Health Care of the Carolinas, Inc.	NL	NL	NL	NL	0	1,252
Provident Health Care Plan, Inc. of North Carolina	NL	NL	NL	NL	114	125
Prudential Health Care Plan, Inc.	31,931	32,705	36,357	42,443	40,132	47,399
Qualchoice of North Carolina, Inc.	NL	NL	NL	NL	0	1,894
U.S. Healthcare of the Carolinas, Inc.	NL	NL	NL	NL	NL	33
WellPath Community Health Plans, Inc.	NL	NL	NL	NL	NL	0
TOTAL (1991-92 totals exclude Blue Cross*)	276,592	309,000	343,660	415,805	512,380	654,381

*Blue Cross Blue Shield did not report enrollment for its Line of Business HMO prior to 1993.

NL = Not licensed

Source: For 1994 and 1995, self-reported data from HMOs for Managed Care Divsion Survey
For 1993 and earlier, self-reported data from HMO to Financial Evaluation Division for Annual Statement.

Appendix F - Single-Service HMO Enrollment 1993-1995

HMO Licensed Name	1993	1994	1995
American Dental Plan of North Carolina	131	11,069	14572
Association of Eye Care Centers Total Vision Health Plan, Inc.	NL	0	0
CIGNA Dental Health of North Carolina, Inc.	15,133	21,804	31,514
Spectera Dental Services, Inc.	NL	NL	0
TOTAL	15,264	32,873	46,086

NOTE: Membership does not include business subcontracted to Full Service HMOs.

Appendix G - Insured Enrollment by HMO and MSA[(1)] at 12/31/95

HMO Licensed Name	HMO Total	Asheville	Charlotte	Fayetteville	Goldsboro	Greensboro/ Winston-Salem	Greenville	Hickory/ Morganton	Jacksonville	Rocky Mount	Triangle	Wilmington	Non-Metro	Other States (2)
Aetna Health Plans of the Carolinas, Inc.	508	0	498	0	0	0	0	0	0	0	0	0	10	
Blue Cross Blue Shield of North Carolina Line of Business HMO	111,211	9,891	22,539	2,847	1,070	17,558	5,058	1,927	841	752	23,767	3,288	21,673	
CIGNA Healthcare of North Carolina, Inc.	12,693	0	7,916	535	6	474	7	32	0	207	2,138	0	1,378	
Doctors Health Plan, Inc.	2,170	0	33	2	2	67	0	0	1	4	1,844	5	212	
Healthsource North Carolina, Inc.	138,715	123	15,895	673	549	2,054	5,859	104	75	7,706	76,791	1,236	27,650	
Kaiser Foundation Health Plan of North Carolina	123,542	0	34,919	0	0	800	0	47	0	283	78,046	0	5,177	4,270
Maxicare North Carolina, Inc.	15,636	701	7,224	13	3	1,706	4	18	0	25	5,180	1	761	0
Optimum Choice of the Carolinas, Inc.	0	0	0	0	0	0	0	0	0	0	0	0	0	0
PARTNERS National Health Plans of North Carolina, Inc.	88,560	9	3,731	17	1	76,017	1	378	0	6	221	33	8,146	0
Personal Care Plan of NC, Inc.	6,842	1,069	2,820	12	9	373	100	165	0	124	652	11	1,507	
PHP, Inc.	103,801	3,960	174	8,589	9	62,479	12	2,250	1,020	10	382	9,199	15,717	0
Principal Health Care of the Carolinas, Inc.	1,252	0	1,189	4	0	3	1	1	0	0	6	1	47	
Provident Health Care Plan, Inc. of North Carolina	125	0	125	0	0	0	0	0	0	0	0	0	0	
Prudential Health Care Plan, Inc.	47,399	3	40,901	4	1	84	3	49	0	18	4,953	0	1,383	
Qualchoice of North Carolina, Inc.	1,894	0	0	0	0	1,894	0	0	0	0	0	0	0	
U.S. Healthcare of the Carolinas, Inc.	33	0	10	0	0	0	0	0	0	0	0	0	0	23
WellPath Community Health Plans, Inc.	0	0	0	0	0	0	0	0	0	0	0	0	0	
Totals	654,381	15,756	137,974	12,696	1,650	163,509	11,045	4,971	1,937	9,135	193,980	13,774	83,661	4,293

(1) MSA refers to Metropolitan Statistical Area. An MSA is a defined metropolitan area, composed of a city and surrounding counties. See Appendix C for the counties that make up each MSA.

(2) Other States = business that was sold in NC for which the enrollee lives in another state.

Appendix H - Total Enrollment (Insured and ASO) by HMO and MSA[1] at 12/31/95

HMO Licensed Name	HMO Total	Asheville	Charlotte	Fayetteville	Goldsboro	Greensboro/ Winston-Salem	Greenville	Hickory/ Morganton	Jacksonville	Rocky Mount	Triangle	Wilmington	Non-Metro	Other States (2)
Aetna Health Plans of the Carolinas, Inc.	508	0	498	0	0	0	0	0	0	0	0	0	10	
Blue Cross Blue Shield of North Carolina Line of Business HMO	154,405	11,656	27,132	6,671	1,753	27,326	6,293	4,952	993	1,480	30,244	5,305	30,600	
CIGNA Healthcare of North Carolina, Inc.	77,708	0	35,932	4,035	415	5,749	144	1,002	5	3,018	12,789	2,033	12,586	
Doctors Health Plan, Inc.	2,170	0	33	2	2	67	0	0	1	4	1,844	5	212	
Healthsource North Carolina, Inc.	138,715	123	15,895	673	549	2,054	5,859	104	75	7,706	76,791	1,236	27,650	
Kaiser Foundation Health Plan of North Carolina	123,542	0	34,919	0	0	800	0	47	0	283	78,046	0	5,177	4,270
Maxicare North Carolina, Inc.	15,636	701	7,224	13	3	1,706	4	18	0	25	5,180	1	761	0
Optimum Choice of the Carolinas, Inc.	0	0	0	0	0	0	0	0	0	0	0	0	0	0
PARTNERS National Health Plans of North Carolina, Inc.	94,466	10	3,818	17	1	81,700	1	378	0	6	222	33	8,280	0
Personal Care Plan of NC, Inc.	6,842	1,069	2,820	12	9	373	100	165	0	124	652	11	1,507	
PHP, Inc.	117,410	5,241	180	8,613	9	67,620	12	2,262	1,030	10	407	10,510	21,516	0
Principal Health Care of the Carolinas, Inc.	1,252	0	1,189	4	0	3	1	1	0	0	6	1	47	
Provident Health Care Plan, Inc. of North Carolina	125	0	125	0	0	0	0	0	0	0	0	0	0	
Prudential Health Care Plan, Inc.	53,651	11	46,480	8	1	107	3	65	0	18	5,409	2	1,547	
Qualchoice of North Carolina, Inc.	23,760	0	0	0	0	21,710	0	0	0	0	0	0	2,050	
U.S. Healthcare of the Carolinas, Inc.	33	0	10	0	0	0	0	0	0	0	0	0	0	23
WellPath Select, Inc.	0	0	0	0	0	0	0	0	0	0	0	0	0	
Totals	810,223	18,811	176,255	20,048	2,742	209,215	12,417	8,994	2,104	12,674	211,590	19,137	111,943	4,293

(1) MSA refers to Metropolitan Statistical Area. An MSA is a defined metropolitan area, composed of a city and surrounding counties. See Appendix C for the counties that make up each MSA.

(2) Other States = business that was sold in NC for which the enrollee lives in another state.

Appendix I- Enrollment by HMO and County as of 12/31/95 (Insured Business Only)

County Name	County Total	Aetna Health Plans of the Carolinas, Inc.	Blue Cross Blue Shield of North Carolina Line of Business HMO	CIGNA Healthcare of North Carolina, Inc.	Doctors Health Plan, Inc.	Healthsource North Carolina, Inc.	Kaiser Foundation Health Plan of North Carolina	Maxicare North Carolina, Inc.	Optimum Choice of the Carolinas, Inc.	PARTNERS National Health Plans of North Caroline, Inc.	Personal Care Plan of NC, Inc.	PHP, Inc.	Principal Health Care of the Carolinas, Inc.	Provident Health Care Plan, Inc. of North Carolina	Prudential Health Care Plan, Inc.	Qualchoice of North Carolina, Inc.	U.S. Healthcare of the Carolinas, Inc.	Wellpath Select, Inc.
Alamance	11,459	0	2,556	50	43	1,195	753	181	0	435	22	6,161	0	0	63	0	0	0
Alexander	255	0	57	0	0	12	0	0	0	67	0	116	0	0	3	0	0	0
Alleghany	424	0	6	0	0	0	0	0	0	415	0	3	0	0	0	0	0	0
Anson	1,131	0	311	4	0	699	0	22	0	4	77	2	0	0	12	0	0	0
Ashe	63	0	14	0	0	0	0	0	0	46	0	3	0	0	0	0	0	0
Avery	22	0	12	0	0	0	0	0	0	0	0	10	0	0	0	0	0	0
Beaufort	1,215	0	457	0	0	737	0	0	0	0	17	3	0	0	1	0	0	0
Bertie	185	0	63	0	0	119	0	0	0	0	2	1	0	0	0	0	0	0
Bladen	1,525	0	196	1	4	164	0	3	0	0	0	1,157	0	0	0	0	0	0
Brunswick	1,945	0	524	0	0	100	0	0	0	6	4	1,311	0	0	0	0	0	0
Buncombe	14,366	0	8,636	0	0	120	0	675	0	8	1,038	3,886	0	0	3	0	0	0
Burke	2,438	0	1,009	1	0	13	0	1	0	62	146	1,206	0	0	0	0	0	0
Cabarrus	12,489	13	2,796	649	2	1,759	1,304	618	0	163	144	13	92	0	4,934	0	2	0
Caldwell	1,066	0	425	4	0	1	0	0	0	53	0	581	0	0	2	0	0	0
Camden	4	0	1	0	0	2	0	0	0	0	0	1	0	0	0	0	0	0
Carteret	539	0	486	0	1	28	0	0	0	0	7	15	2	0	0	0	0	0
Caswell	616	0	169	5	6	134	17	9	0	40	5	225	0	0	6	0	0	0
Catawba	1,213	0	437	27	0	78	47	17	0	196	19	347	1	0	44	0	0	0
Chatham	2,744	0	683	60	7	1,072	699	54	0	42	2	117	0	0	8	0	0	0
Cherokee	10	0	5	0	0	0	0	0	0	0	0	5	0	0	0	0	0	0
Chowan	22	0	21	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
Clay	12	0	12	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Cleveland	5,112	0	197	49	0	4,277	0	61	0	345	3	33	2	0	145	0	0	0
Columbus	2,016	0	305	0	0	460	0	0	0	1	0	1,250	0	0	0	0	0	0
Craven	651	0	504	0	0	137	0	0	0	2	1	7	0	0	0	0	0	0
Cumberland	12,696	0	2,847	535	2	673	0	13	0	17	12	8,589	4	0	4	0	0	0
Currituck	6	0	1	0	0	0	0	0	0	0	0	5	0	0	0	0	0	0
Dare	16	0	7	0	0	9	0	0	0	0	0	0	0	0	0	0	0	0
Davidson	9,702	0	716	27	2	28	0	14	0	6,152	8	2,316	0	0	5	434	0	0
Davie	5,800	0	731	0	0	11	0	0	0	4,849	9	194	2	0	4	0	0	0
Duplin	457	0	178	1	0	91	0	0	0	0	0	187	0	0	0	0	0	0
Durham	40,345	0	6,445	261	887	14,279	16,650	964	0	34	46	45	0	0	734	0	0	0
Edgecombe	4,127	0	296	167	0	3,567	0	0	0	1	95	1	0	0	0	0	0	0
Forsyth	54,595	0	6,350	11	2	80	0	72	0	39,103	86	7,725	0	0	6	1,160	0	0

County Enrollment

County Name	County Total	Aetna Health Plans of the Carolinas, Inc.	Blue Cross Blue Shield of North Carolina Line of Business HMO	CIGNA Healthcare of North Carolina, Inc.	Doctors Health Plan, Inc.	Healthsource North Carolina, Inc.	Kaiser Foundation Health Plan of North Carolina	Maxicare North Carolina, Inc.	Optimum Choice of the Carolinas, Inc.	PARTNERS National Health Plans of North Carolina, Inc.	Personal Care Plan of NC, Inc.	PHP, Inc.	Principal Health Care of the Carolinas, Inc.	Provident Health Care Plan, Inc. of North Carolina	Prudential Health Care Plan, Inc.	Qualchoice of North Carolina, Inc.	U.S. Healthcare of the Carolinas, Inc.	Wellpath Select, Inc.
Franklin	5,645	0	514	256	13	1,950	2,552	111	0	5	152	4	0	0	88	0	0	0
Gaston	27,384	19	2,274	787	2	4,771	8,498	961	0	1,163	130	10	87	0	8,682	0	0	0
Gates	20	0	9	0	0	0	0	0	0	0	0	11	0	0	0	0	0	0
Graham	15	0	12	0	0	0	0	1	0	0	0	2	0	0	0	0	0	0
Granville	6,051	0	836	18	80	3,174	1,777	114	0	0	9	14	0	0	29	0	0	0
Greene	516	0	189	1	0	299	0	0	0	0	27	0	0	0	0	0	0	0
Guilford	65,373	0	5,291	50	18	638	47	1,364	0	16,066	192	41,700	1	0	6	0	0	0
Halifax	453	0	24	11	0	401	0	1	0	0	14	2	0	0	0	0	0	0
Harnett	5,612	0	670	76	7	2,989	1,478	117	0	3	38	189	0	0	45	0	0	0
Haywood	3,305	0	1,545	0	0	5	0	33	0	4	192	1,526	0	0	0	0	0	0
Henderson	3,217	0	943	0	0	374	0	47	0	1	723	1,129	0	0	0	0	0	0
Hertford	68	0	33	0	0	33	0	0	0	0	0	0	0	0	2	0	0	0
Hoke	610	0	362	0	0	60	0	0	0	1	0	187	0	0	0	0	0	0
Hyde	24	0	20	0	0	0	0	0	0	0	0	4	0	0	0	0	0	0
Iredell	4,339	10	698	51	2	911	332	98	0	1,107	34	422	17	0	657	0	0	0
Jackson	855	0	633	0	0	1	0	2	0	0	11	204	3	0	1	0	0	0
Johnston	14,246	0	1,927	86	23	5,297	6,157	613	0	10	35	12	0	0	86	0	0	0
Jones	70	0	38	0	0	13	0	0	0	0	0	19	0	0	0	0	0	0
Lee	2,481	0	683	332	2	1,275	0	11	0	26	79	73	0	0	0	0	0	0
Lenoir	1,332	0	432	1	0	870	0	0	0	3	15	6	5	0	0	0	0	0
Lincoln	3,009	2	329	79	0	835	657	117	0	81	49	82	12	0	766	0	0	0
Macon	373	0	228	0	0	6	0	0	0	123	0	16	0	0	0	0	0	0
Madison	1,390	0	1,255	0	0	3	0	26	0	1	31	74	0	0	0	0	0	0
Martin	718	0	171	3	0	530	0	0	0	0	4	10	0	0	0	0	0	0
McDowell	1,075	0	651	0	0	11	0	11	0	3	20	379	0	0	0	0	0	0
Mecklenburg	81,239	407	12,631	5,835	29	7,107	22,854	5,089	0	861	1,682	34	810	125	23,767	0	8	0
Mitchell	44	0	31	0	0	8	0	2	0	0	0	3	0	0	0	0	0	0
Montgomery	408	0	305	37	0	24	0	0	0	10	0	28	0	0	4	0	0	0
Moore	1,067	0	167	40	5	731	0	4	0	42	22	56	0	0	0	0	0	0
Nash	5,007	0	455	40	4	4,139	283	25	0	5	29	9	0	0	18	0	0	0
New Hanover	11,829	0	2,764	0	5	1,136	0	1	0	27	7	7,888	1	0	0	0	0	0
Northampton	94	0	52	0	0	36	0	0	0	0	2	4	0	0	0	0	0	0
Onslow	1,937	0	841	0	1	75	0	0	0	0	0	1,020	0	0	0	0	0	0
Orange	17,388	0	4,534	143	203	5,882	5,512	561	0	49	67	94	0	0	343	0	0	0
Pamlico	78	0	66	0	0	10	0	0	0	2	0	0	0	0	0	0	0	0
Pasquotank	5	0	4	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0
Pender	2,061	0	416	0	0	159	0	0	0	1	0	1,485	0	0	0	0	0	0

Insured Only

Appe

County Enrollment

County Name	County Total	Aetna Health Plans of the Carolinas, Inc.	Blue Cross Blue Shield of North Carolina Line of Business HMO	CIGNA Healthcare of North Carolina, Inc.	Doctors Health Plan, Inc.	Healthsource North Carolina, Inc.	Kaiser Foundation Health Plan of North Carolina	Maxicare North Carolina, Inc.	Optimum Choice of the Carolinas, Inc.	PARTNERS National Health Plans of North Carolina, Inc.	Personal Care Plan of NC, Inc.	PHP, Inc.	Principal Health Care of the Carolinas, Inc.	Provident Health Care Plan, Inc. of North Carolina	Prudential Health Care Plan, Inc.	Qualchoice of North Carolina, Inc.	U.S. Healthcare of the Carolinas, Inc.	Wellpath Select, Inc.
Perquimans	16	0	4	0	0	0	0	0	0	0	0	12	0	0	0	0	0	0
Person	3,444	0	514	3	93	1,800	938	49	0	2	0	14	0	0	31	0	0	0
Pitt	11,045	0	5,058	7	0	5,859	0	4	0	1	100	12	1	0	3	0	0	0
Polk	99	0	32	0	0	1	0	1	0	0	23	42	0	0	0	0	0	0
Randolph	5,666	0	486	336	2	94	0	67	0	1,163	10	3,508	0	0	0	0	0	0
Richmond	568	0	363	0	0	166	0	1	0	5	1	25	0	0	7	0	0	0
Robeson	2,909	0	659	67	0	213	0	0	0	0	0	1,970	0	0	0	0	0	0
Rockingham	8,189	0	1,963	7	0	22	0	50	0	2,045	52	4,050	0	0	0	0	0	0
Rowan	5,661	9	2,605	220	0	378	75	112	0	1,340	32	33	7	0	850	0	0	0
Rutherford	329	0	30	8	0	228	0	0	0	11	0	48	0	0	4	0	0	0
Sampson	1,338	0	627	28	2	181	0	2	0	0	0	498	0	0	0	0	0	0
Scotland	603	0	28	1	0	535	0	0	0	0	0	39	0	0	0	0	0	0
Stanley	3,256	0	1,269	431	0	717	246	84	0	34	24	16	18	0	417	0	0	0
Stokes	6,380	0	817	0	0	5	0	8	0	4,815	40	679	0	0	0	16	0	0
Surry	4,347	0	1,436	0	0	0	0	0	0	2,758	1	152	0	0	0	0	0	0
Swain	125	0	110	0	0	5	0	0	0	0	4	6	0	0	0	0	0	0
Transylvania	316	0	81	0	0	81	0	8	0	0	48	98	0	0	0	0	0	0
Tyrell	5	0	5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Union	8,192	48	1,904	346	0	1,045	1,531	327	0	123	783	2	181	0	1,902	0	0	0
Vance	2,931	0	234	45	7	2,205	389	14	0	0	13	5	0	0	19	0	0	0
Wake	113,612	0	9,664	1,332	711	48,311	46,476	2,877	0	81	350	110	6	0	3,694	0	0	0
Warren	431	0	59	3	0	336	0	8	0	0	23	1	0	0	1	0	0	0
Washington	91	0	35	0	0	55	0	0	0	0	0	1	0	0	0	0	0	0
Watuaga	42	0	16	0	0	4	0	0	0	6	0	16	0	0	0	0	0	0
Wayne	1,650	0	1,070	6	2	549	0	3	0	1	9	9	0	0	1	0	0	0
Wilkes	1,292	0	150	0	2	2	0	0	0	1,104	3	31	0	0	0	0	0	0
Wilson	4,101	0	1,603	155	1	2,321	0	3	0	1	13	2	0	0	2	0	0	0
Yadkin	4,534	0	611	0	0	3	0	0	0	3,434	6	196	0	0	0	284	0	0
Yancey	309	0	289	0	0	0	0	5	0	0	0	15	0	0	0	0	0	0
Other States(1)	4,293						4,270	0	0			0					23	
Totals	654,381	508	111,211	12,693	2,170	138,715	123,542	15,636	0	88,560	6,842	103,801	1,252	125	47,399	1,894	33	0

Source: Self-reported data from HMOs for DOI's Managed Care Division Survey.

Notes: (1) Other States = business that was sold in NC for which the enrollee lives in another state.

Appendix J - Primary Care Physicians (PCP) by County for all HMOs at 12/31/95

County Name	Aetna Health Plans of the Carolinas, Inc.	Blue Cross Blue Shield of North Carolina Line of Business HMO	CIGNA Healthcare of North Carolina, Inc.	Doctors Health Plan, Inc.	Healthsource North Carolina, Inc.	Kaiser Foundation Health Plan of North Carolina	Maxicare North Carolina, Inc.	Optimum Choice of the Carolinas, Inc.	PARTNERS National Health Plans of North Carolina, Inc.	Personal Care Plan of NC, Inc.	PHP, Inc.	Principal Health Care of the Carolinas, Inc.	Provident Health Care Plan, Inc. of North Carolina	Prudential Health Care Plan, Inc.	Qualchoice of North Carolina, Inc.	U.S. Healthcare of the Carolinas, Inc.	WellPath Community Health Plans, Inc.
Alamance	0	26	34	1	33	0	5	0	35	0	59	0	0	0	0	0	0
Alexander	0	0	0	0	0	0	0	0	0	0	4	0	0	0	0	0	0
Alleghany	0	0	0	0	0	0	0	0	5	0	0	0	0	0	7	0	0
Anson	0	2	0	0	7	0	0	0	0	0	0	0	0	0	0	0	0
Ashe	0	4	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0
Avery	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Beaufort	0	6	0	0	18	0	0	0	0	0	0	0	0	0	0	0	0
Bertie	0	0	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0
Bladen	0	7	0	0	8	0	0	0	0	0	9	0	0	0	0	0	0
Brunswick	0	8	0	0	11	0	0	0	0	0	12	0	0	0	0	0	0
Buncombe	0	52	1	0	60	0	24	0	0	0	118	0	0	0	0	0	0
Burke	0	12	1	0	23	0	0	0	16	0	32	0	0	0	0	0	0
Cabarrus	1	41	47	0	65	0	39	0	17	0	0	55	0	42	0	5	0
Caldwell	0	4	5	0	6	0	0	0	4	0	20	0	0	0	0	0	0
Camden	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Carteret	0	11	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0
Caswell	0	5	0	0	5	0	5	0	0	0	4	0	0	0	0	0	0
Catawba	0	42	51	0	1	0	2	0	44	0	12	0	0	2	0	0	0
Chatham	0	6	4	0	15	6	7	0	1	0	1	0	0	0	0	0	0
Cherokee	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Chowan	0	0	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0
Clay	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Cleveland	0	0	0	0	37	0	8	0	3	0	0	0	0	0	0	0	0
Columbus	0	12	0	0	16	0	0	0	0	0	17	0	0	0	0	0	0
Craven	0	6	0	0	9	0	0	0	0	0	0	0	0	0	0	0	0
Cumberland	0	29	26	0	60	0	0	0	0	0	85	0	0	0	0	0	0
Currituck	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Dare	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Davidson	0	14	0	0	35	0	0	0	44	0	41	0	0	0	42	0	0
Davie	0	9	0	0	0	0	0	0	4	0	9	0	0	0	2	0	0
Duplin	0	2	1	0	10	0	0	0	0	0	3	0	0	0	0	0	0
Durham	0	75	88	56	181	30	35	0	10	0	53	0	0	57	0	0	77
Edgecombe	0	8	13	0	16	0	0	0	0	0	5	0	0	0	0	0	0
Forsyth	0	79	36	0	3	0	0	0	120	0	144	0	0	0	121	0	0

Primary Care Physicians by County

County Name	Aetna Health Plans of the Carolinas, Inc.	Blue Cross Blue Shield of North Carolina Line of Business HMO	CIGNA Healthcare of North Carolina, Inc.	Doctors Health Plan, Inc.	Healthsource North Carolina, Inc.	Kaiser Foundation Health Plan of North Carolina	Maxicare North Carolina, Inc.	Optimum Choice of the Carolinas, Inc.	PARTNERS National Health Plans of North Carolina, Inc.	Personal Care Plan of NC, Inc.	PHP, Inc.	Principal Health Care of the Carolinas, Inc.	Provident Health Care Plan, Inc. of North Carolina	Prudential Health Care Plan, Inc.	Qualchoice of North Carolina, Inc.	U.S. Healthcare of the Carolinas, Inc.	WellPath Community Health Plans, Inc.
Franklin	0	9	5	4	10	4	5	0	0	0	0	0	0	0	0	0	3
Gaston	7	37	46	3	75	4	15	0	37	0	0	11	0	34	0	1	0
Gates	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Graham	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Granville	0	12	0	0	16	0	0	0	0	0	4	0	0	7	0	0	8
Greene	0	7	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
Guilford	0	33	38	0	111	0	59	0	150	0	231	0	0	34	112	0	0
Halifax	0	0	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0
Harnett	0	8	1	0	25	0	8	0	0	0	10	0	0	0	0	0	0
Haywood	0	16	0	0	0	0	0	0	0	0	32	0	0	0	0	0	0
Henderson	0	13	41	0	44	0	20	0	0	0	34	0	0	0	0	0	0
Hertford	0	0	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0
Hoke	0	4	4	0	4	0	0	0	0	0	7	0	0	0	0	0	0
Hyde	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Iredell	2	15	28	1	54	0	18	0	35	0	32	2	0	0	17	1	0
Jackson	0	16	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Johnston	0	3	2	3	20	0	14	0	0	0	6	0	0	0	0	0	0
Jones	0	5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Lee	0	10	16	2	21	0	0	0	5	0	17	0	0	0	0	0	0
Lenoir	0	10	0	0	24	0	0	0	0	0	0	0	0	0	0	0	0
Lincoln	0	5	2	3	19	0	9	0	8	0	2	0	0	5	0	4	0
Macon	0	8	0	0	0	0	0	0	7	0	0	0	0	0	0	0	0
Madison	0	11	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Martin	0	2	0	0	8	0	0	0	0	0	0	0	0	0	0	0	0
McDowell	0	10	0	0	4	0	0	0	0	0	11	0	0	0	0	0	0
Mecklenbur	89	118	148	147	326	86	119	0	117	0	2	119	69	160	0	114	131
Mitchell	0	7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Montgomer	0	0	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0
Moore	0	1	0	0	28	0	0	0	0	0	0	0	0	0	0	0	0
Nash	0	2	12	0	65	0	0	0	0	0	6	0	0	0	0	0	0
New	0	22	28	0	84	0	0	0	0	0	68	0	0	0	0	0	0
Northampto	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Onslow	0	10	0	0	13	0	0	0	0	0	22	0	0	0	0	0	0
Orange	0	91	28	61	138	35	56	0	60	0	19	0	0	13	0	0	8
Pamlico	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pasquotank	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pender	0	5	7	0	8	0	0	0	0	0	12	0	0	0	0	0	0

Primary Care Physicians by County

County Name	Aetna Health Plans of the Carolinas, Inc.	Blue Cross Blue Shield of North Carolina Line of Business HMO	CIGNA Healthcare of North Carolina, Inc.	Doctors Health Plan, Inc.	Healthsource North Carolina, Inc.	Kaiser Foundation Health Plan of North Carolina	Maxicare North Carolina, Inc.	Optimum Choice of the Carolinas, Inc.	PARTNERS National Health Plans of North Carolina, Inc.	Personal Care Plan of NC, Inc.	PHP, Inc.	Principal Health Care of the Carolinas, Inc.	Provident Health Care Plan, Inc. of North Carolina	Prudential Health Care Plan, Inc.	Qualchoice of North Carolina, Inc.	U.S. Healthcare of the Carolinas, Inc.	WellPath Community Health Plans, Inc.
Perquimans	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Person	0	0	0	0	11	0	9	0	0	0	5	0	0	0	0	0	0
Pitt	0	72	0	0	129	0	0	0	0	0	2	0	0	0	0	0	0
Polk	0	0	0	0	1	0	0	0	0	0	2	0	0	0	0	0	0
Randolph	0	6	23	0	0	0	0	0	5	0	19	0	0	0	0	0	0
Richmond	0	0	0	0	13	0	0	0	1	0	0	0	0	0	0	0	0
Robeson	0	6	1	0	31	0	0	0	0	0	37	0	0	0	0	0	0
Rockingham	0	18	0	0	3	0	11	0	25	0	44	0	0	0	3	0	0
Rowan	6	17	23	0	29	0	10	0	22	0	0	6	0	0	2	6	0
Rutherford	0	0	0	0	4	0	0	0	0	0	4	0	0	0	0	0	0
Sampson	0	10	0	2	13	0	0	0	0	0	10	0	0	0	0	0	0
Scotland	0	1	0	0	18	0	0	0	0	0	4	0	0	0	0	0	0
Stanley	0	2	11	0	19	0	12	0	3	0	0	0	0	1	0	0	0
Stokes	0	6	1	0	1	0	0	0	8	0	8	0	0	0	10	0	0
Surry	0	28	3	0	0	0	0	0	28	0	14	0	0	0	27	0	0
Swain	0	5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Transylvani	0	0	0	0	18	0	0	0	0	0	9	0	0	0	0	0	0
Tyrell	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Union	0	10	0	5	24	2	9	0	14	0	0	7	0	5	0	0	0
Vance	0	5	0	0	16	0	0	0	0	0	0	0	0	5	0	0	0
Wake	0	136	91	110	305	115	125	0	2	0	82	0	0	117	0	0	107
Warren	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
Washington	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
Watuaga	0	0	0	0	1	0	0	0	0	0	4	0	0	0	0	0	0
Wayne	0	13	0	0	14	0	0	0	0	0	0	0	0	0	0	0	0
Wilkes	0	0	0	0	0	0	0	0	5	0	0	0	0	0	19	0	0
Wilson	0	16	15	0	27	0	0	0	0	0	17	0	0	0	0	0	0
Yadkin	0	14	2	0	0	0	0	0	13	0	6	0	0	0	7	0	0
Yancey	0	8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other States (1)						0	0	0	53		0					0	
Totals	105	1,329	883	398	2,416	282	624	0	902	0	1,410	200	69	482	369	131	334

Source: Self-reported data from HMOs for DOI's Managed Care Division Survey.

Notes: (1) Other States = business that was sold in NC for which the enrollee lives in another state.

Appendix K - Age and Gender Distribution of Insured Enrollment at 12/31/95

HMO Licensed Name (1)	<1	1-4	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	>80	Totals(2)
Aetna Health Plans of the Carolinas, Inc.	10	36	42	31	28	49	69	70	51	41	36	13	14	10	7	1	0	0	508
Female Only	4	16	15	9	12	32	45	40	23	29	18	9	8	4	5	1	0	0	270
Blue Cross Blue Shield of North Carolina Line of Business HMO	1,497	6,957	9,132	9,000	7,489	7,202	11,361	12,663	12,476	11,929	9,898	6,301	3,983	2,401	511	188	73	22	113,082
Female Only	660	3,385	4,427	4,318	3,671	4,106	6,504	6,898	6,787	6,513	5,285	3,350	2,059	1,182	271	84	39	11	59,550
CIGNA Healthcare of North Carolina, Inc.	126	845	1,010	918	734	743	1,373	1,410	1,393	1,237	1,088	792	560	359	78	27	10	5	12,708
Female Only	58	412	474	449	358	479	821	807	792	684	597	443	297	174	38	11	5	2	6,901
Doctors Health Plan, Inc.	46	145	174	147	115	142	366	312	244	169	137	100	41	22	3	2	0	5	2,170
Female Only	19	64	80	67	59	96	241	187	134	98	78	55	27	8	2	1	0	3	1,219
Healthsource North Carolina, Inc.	2,187	9,613	12,367	11,240	9,707	7,640	11,509	15,102	15,791	14,327	12,394	8,131	4,875	2,851	685	179	72	45	138,715
Female Only	1,067	4,636	5,988	5,530	4,810	4,379	6,980	8,763	8,850	8,174	6,842	4,317	2,501	1,377	319	100	34	29	74,696
Kaiser Foundation Health Plan of North Carolina	1,365	6,448	8,520	8,072	7,710	6,866	9,005	11,342	11,072	10,409	9,033	6,398	4,549	3,252	456	131	39	24	104,691
Female Only	653	3,183	4,310	4,025	3,825	3,897	5,284	6,328	6,092	5,833	4,968	3,456	2,410	1,725	203	65	22	10	56,289
Maxicare North Carolina, Inc.	190	925	1,369	1,320	1,142	706	1,085	1,478	1,644	1,564	1,433	1,121	715	484	224	131	62	43	15,636
Female Only	91	456	687	640	602	409	634	834	878	853	779	599	351	243	121	71	30	28	8,306
PARTNERS National Health Plans of North Carolina, Inc.	1,413	6,426	8,180	7,366	6,550	5,859	8,819	10,930	10,554	9,124	7,905	5,147	3,545	2,122	485	126	49	41	94,641
Female Only	656	3,135	3,997	3,592	3,249	3,497	5,143	6,236	5,892	5,098	4,293	2,755	1,890	1,099	213	55	27	23	50,850
Personal Care Plan of NC, Inc.	122	502	762	646	495	297	499	913	881	652	542	377	175	94	14	5	0	0	6,976
Female Only	65	241	367	300	257	182	305	496	437	345	260	189	85	49	5	3	0	0	3,586
PHP, Inc.	Did not report with necessary breakdown																		
Female Only																			
Principal Health Care of the Carolinas, Inc.	23	61	90	88	69	72	121	142	143	128	105	85	62	46	11	3	3	0	1,252
Female Only	13	36	35	41	37	35	60	70	61	59	49	44	24	19	2	2	1	0	588
Provident Health Care Plan, Inc. of North Carolina	3	11	5	10	14	4	11	9	13	13	12	8	6	6	0	0	0	0	125
Female Only	3	4	2	4	7	1	6	5	7	7	7	5	2	2	0	0	0	0	62
Prudential Health Care Plan, Inc.	900	4,282	5,274	4,959	4,315	3,886	6,121	7,495	6,928	6,306	5,337	3,627	2,452	1,591	591	238	94	55	64,451
Female Only	421	2,101	2,550	2,443	2,124	2,166	3,500	4,083	3,777	3,415	2,870	1,879	1,251	788	310	120	52	40	33,890
Qualchoice of North Carolina, Inc.	22	88	136	113	92	186	307	238	196	160	139	109	63	38	6	0	1		1,894
Female Only	12	39	68	55	45	108	166	142	123	97	92	75	38	22	3	0	0	0	1,085
Total	7,904	36,339	47,061	43,910	38,460	33,652	50,646	62,104	61,386	56,059	48,059	32,209	21,040	13,276	3,071	1,031	403	240	556,849
Total Female	3,722	17,708	23,000	21,473	19,056	19,387	29,689	34,889	33,853	31,205	26,138	17,176	10,943	6,692	1,492	513	210	146	297,292
% Female	47%	49%	49%	49%	50%	58%	59%	56%	55%	56%	54%	53%	52%	50%	49%	50%	52%	61%	53%

(1) For each HMO, the total enrollment (male and female) in age group is reported on the first line and the female enrollment is reported on the second line

(2) The HMO total does not agree with HMO total in Figure 4.1 Chart A. Most of the difference is due to PHP not reporting.
PHP did not report because PHP did not track the age of its member in the detail requested in the survey.

Appendix L - Summary Financial Data for 1994-1995(1)

1995

HMO Licensed Name	Member Months	Total Revenues ($)	Premium Revenue ($)	Medical & Hosp Exp ($)	Total Admin Exp ($)	Income (Loss) ($)
Aetna Health Plans of the Carolinas, Inc.	3,151	518,282	339,343	290,998	79,666	147,618
Blue Cross Blue Shield of North Carolina Line of Business HMO (2)	685,672	98,618,907	92,692,398	81,667,000	12,037,964	4,913,943
CIGNA Healthcare of North Carolina, Inc. (3)	143,800	17,501,896	17,036,834	16,880,240	2,412,001	(1,790,345)
Doctors Health Plan, Inc.	12,043	1,642,095	1,400,563	1,195,768	3,195,866	(2,749,539)
Healthsource North Carolina, Inc.	1,507,870	200,080,053	198,214,069	152,092,451	31,638,746	16,348,856
Kaiser Foundation Health Plan of North Carolina	1,498,562	198,919,393	193,296,597	190,803,866	8,042,369	73,158
Maxicare North Carolina, Inc.	198,352	25,006,346	24,424,210	23,494,133	2,940,561	(1,428,348)
PARTNERS National Health Plans of North Carolina, Inc. (4)	1,090,302	144,536,522	142,111,517	115,141,148	15,589,583	13,805,791
Personal Care Plan of NC, Inc.	65,758	8,952,305	8,510,669	7,755,576	1,034,842	161,887
PHP, Inc.	1,206,335	160,903,381	155,349,981	123,902,566	26,413,436	10,587,379
Principal Health Care of the Carolinas, Inc.	5,013	686,952	558,420	502,680	2,111,101	(1,926,829)
Provident Health Care Plan, Inc. of North Carolina	1,365	1,237,647	177,791	217,433	294,000	726,214
Prudential Health Care Plan, Inc.	547,861	65,954,572	66,003,293	66,594,429	10,470,103	(11,109,960)
Qualchoice of North Carolina, Inc.	13,525	3,888,812	1,717,212	2,181,337	5,876,678	(4,169,203)

1994

CIGNA Healthcare of North Carolina, Inc.(3)	72,475	9,296,673	9,246,726	8,127,827	1,136,471	32,375
Healthsource North Carolina, Inc.	1,050,843	138,833,911	137,328,172	103,930,287	14,873,562	20,030,062
Kaiser Foundation Health Plan of North Carolina	1,455,652	197,456,173	190,673,429	157,533,069	35,896,912	4,026,192
Maxicare North Carolina, Inc.	177,252	21,447,451	21,181,676	17,755,405	2,354,308	1,337,738
PARTNERS National Health Plans of North Carolina, Inc. (4)	851,425	115,479,730	114,117,382	91,830,662	11,443,772	12,205,296
Personal Care Plan of NC, Inc.	98,327	12,626,986	12,223,232	10,045,977	1,280,567	1,300,442
PHP, Inc.	1,016,339	127,568,560	125,655,270	103,886,676	15,224,735	8,457,149
Provident Health Care Plan, Inc. of North Carolina	152	163,213	19,842	33,399	882,982	(753,168)
Prudential Health Care Plan, Inc.	464,647	55,107,056	55,105,127	61,644,696	13,725,239	(20,262,879)

Source: 1995 Annual Statements filed by the HMO with the Financial Evaluation Division of the Department of Insurance

(1) Only HMOs with membership in 1994 or 1995 are listed.

(2) The figures for BCBS do not include its POS product line; its POS membership was 28,566 at 12/31/95.

(3) The figures [illegible] CIGNA only includes its commercial business; ASO business is exclude[illegible]

VISITOR REGISTRATION SHEET

SENATE PENSIONS & RETIREMENT / INSURANCE 2-5-97

Name of Committee Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
John McMillan	Manning, Fulton & Skinner P.A.
Susan Valauri	Nationwide
Alan Miles	Bailey & Dixon LLP
Ann Duncan	Womble Carlyle
Robert Pryor	BSA NC Hosp. Cos
Robert Paschal	Young, Moore & Henderson
Kelly Kaplan	
John Bawdish	Zeb Alley PA
Sam Johnson	Atty
Ken Wright	BCBS NC
PAUL MAHONEY	NC HOSP ASSOCIATION
Charles Cramer	NCATL

VISITOR REGISTRATION SHEET

SENATE PENSIONS & RETIREMENT / INSURANCE 3-5-97

Name of Committee **Date**

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Sheila H. McKenney	N.C. Dept. of Insurance
Cena Arthur	N.C. Dept. of Insurance
Jim Long	N.C. Dept. of Insurance
Bill Hale	N.C. Dept. of Insurance
Daschell Propes	N.C. Dept. of Insurance
William Riddick	Self
Evelyn Hawthorne	NCHA
J Craig Jones	PCMH
[illegible]	NCHA
Steve Wade	NCMS
[illegible]	NC Med Society
[illegible]	NCAFP

VISITOR REGISTRATION SHEET

SENATE PENSIONS & RETIREMENT / INSURANCE 3-5-97

Name of Committee Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Eugene Hafer	CAPIA
Ken Eudy	Capital Strategies
M A Pulley	NCHA
[illegible]	NCMS
Adam Searing	NC Health Access Coalition
Nancy Bradley	NCCBD

Pensions & Retirement/ Insurance Committee
March 12,1997
1124 LB
10:00 am
Sen. Jenkins, Chariman

AGENDA

SB 273 Mastectomy/Hospital Stay
Sen. Forrested

SB 234 Increase Amounts for Insurance Points
Sen. Kincaid

Pensions & Retirement/ Insurance Committee

MINUTES

The Pension & Retirement/Insurance Committee met Wednesday at 10:00 am in room 1124 of the Legislative Building. Sixteen members were present, including Sen. Jenkins, who presided. Action was taken on the following bills:

SB 273 Mastectomy/Hospital Stay. The bill was explained by Sen. Forrester. Sen. Bob Shaw moved for a favorable report. The motion for a favorable report of the bill carried.

SB 234 Increase Amounts for Insurance Points. The bill was explained by Sen. Kincaid. Sen. Soles sent forth an amendment. The motion to accept the amendment carried. The amendment was rolled into a committee substitute. Sen. Reeves moved for an unfavorable as to bill, but favorable as to committee substitute.

The meeting was adjourned.

Sen. Jenkins, Chairman

Katy Haynes, Clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

PENSION& RETIREMENT/ INSURANCE COMMITTEE REPORT
Senator Tommy Jenkins, Chair
Sen. Bob Martin, Sen. Eric Reeves, Sen. Larry Shaw, Sen Donald Kincaid, Co-Chair

Wednesday, March 12, 1997

SENATOR TOMMY JENKINS,
submits the following with recommendations as to passage:

FAVORABLE

S.B. 273 Mastectomy/Hospital Stay
Sequential Referral: None
Recommended Referral: None

TOTAL REPORTED: 1

Committee Clerk Comment: Hold for Sen. Jenkins to sign.

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

PENSIONS & RETIREMENT/INSURANCE COMMITTEE REPORT
Senator Tommy Jenkins, Chairman

Thursday, March 13, 1997

SENATOR JENKINS,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO C.S. BILL

S.B. **234** Increased Amounts of Insurance Points

Draft Number:	PCS7596
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 1

Committee Clerk Comment: Sen. Jenkins to sign.

GENERAL ASSEMBLY OF NORTH CAROLINA
1997 SESSION

S.L. 1997-440
SENATE BILL 273

AN ACT PERTAINING TO THE COVERAGE OF POSTMASTECTOMY INPATIENT CARE UNDER HEALTH INSURANCE PLANS.

The General Assembly of North Carolina enacts:

Section 1. Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-3-171.1. Coverage for postmastectomy inpatient care.**

(a) Every entity providing a health benefit plan that provides coverage for mastectomy, including coverage for postmastectomy inpatient care, shall ensure that the decision whether to discharge the patient following mastectomy is made by the attending physician in consultation with the patient, and shall further ensure that the length of postmastectomy hospital stay is based on the unique characteristics of each patient taking into consideration the health and medical history of the patient.

(b) As used in this section, 'health benefit plans' means accident and health insurance policies or certificates; nonprofit hospital or medical service corporation contracts; health, hospital, or medical service corporation plan contracts; health maintenance organization (HMO) subscriber contracts; and plans provided by a MEWA or plans provided by other benefit arrangements, to the extent permitted by ERISA.

(c) As used in this section, 'mastectomy' means the surgical removal of all or part of a breast as a result of breast cancer or breast disease."

Section 2. This act is effective when it becomes law and applies to health benefit plans issued, renewed, or amended on and after that date.

In the General Assembly read three times and ratified this the 19th day of August, 1997.

s/ Marc Basnight
President Pro Tempore of the Senate

s/ Harold J. Brubaker
Speaker of the House of Representatives

s/ James B. Hunt, Jr.
Governor

Approved 10:22 a.m. this 28th day of August, 1997

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

S 1

SENATE BILL 234

Short Title: Increase Amounts for Insurance Points. (Public)

Sponsors: Senators Kincaid; Carpenter, Cochrane, and Garwood.

Referred to: Pensions & Retirement and Insurance.

February 24, 1997

A BILL TO BE ENTITLED

AN ACT TO INCREASE THE STATUTORY AMOUNTS THAT DETERMINE THE ASSESSMENT OF SAFE DRIVER INCENTIVE PLAN POINTS.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-36-75(a) reads as rewritten:

"(a) The subclassification plan promulgated pursuant to G.S. 58-36-65(b) may provide for separate surcharges for major, intermediate, and minor accidents. A 'major accident' is an at-fault accident that results in either (i) bodily injury or death or (ii) only property damage of ~~two thousand dollars ($2,000)~~ four thousand dollars ($4,000) or more. An 'intermediate accident' is an at-fault accident that results in only property damage of more than ~~one thousand dollars ($1,000)~~ two thousand dollars ($2,000) but less than ~~two thousand dollars ($2,000).~~ four thousand dollars ($4,000). A 'minor accident' is an at-fault accident that results in only property damage of ~~one thousand dollars ($1,000)~~ two thousand dollars ($2,000) or less. The subclassification plan may also exempt certain minor accidents from the Facility recoupment surcharge."

Section 2. The North Carolina Rate Bureau shall amend the subclassification plan to implement the provisions of this act no later than September 1, 1997. The amendment to the plan shall become effective January 1, 1998, and shall apply only to at-fault accidents that occur on or after January 1, 1998. With respect to any at-fault accidents occurring prior to January 1, 1998, the surcharge and period for which the surcharge is applied and collected shall be determined by the subclassification plan in effect at the time the at-fault accident occurred.

Section 3. This act is effective when it becomes law.

North Carolina General Assembly
Legislative Services Agency

George R. Hall, Legislative Services Officer
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March 5, 1997

MEMORANDUM

TO: Senate Committee on Pensions & Retirement and Insurance

FROM: M. Lynn Marshbanks, Committee Counsel MLM

RE: Senate Bill 273: Mastectomy/Hospital Stay

Senate Bill 273 would require each health benefit plan covering mastectomy, including coverage for postsurgery inpatient care, to ensure that the physician, in consultation with the patient, makes the decision as to whether to discharge. Also, a plan would have to ensure that the length of hospitalization is based on the individual patient's unique characteristics, including health and medical history.

Effective date: When bill becomes law. Applies to health benefit plans issued, renewed, or amended on and after that date.

North Carolina General Assembly
Legislative Services Agency

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March 3, 1997

MEMORANDUM

TO: Senate Committee on Pensions & Retirement and Insurance

FROM: M. Lynn Marshbanks, Committee Counsel

RE: Senate Bill 234: Increase Amounts for Insurance Points

Senate Bill 234 would increase the threshold money amounts for purpose of assigning Safe Driver Incentive Plan points (insurance points). Currently, the law provides the following three categories:

1. Major accident -- An at-fault accident resulting in either (i) bodily injury or death or (ii) only property damage of $2,000 or more.

2. Intermediate accident -- An at-fault accident resulting in only property damage of between $1,000 and $2,000.

3. Minor accident -- An at-fault accident resulting in only property damage of $1,000 or less.

The bill would raise the major accident threshold to $4,000 of property damage and would raise the intermediate accident category to between $2,000 and $4,000 of property damage.

Under G.S. 58-36-75(a1), no premium surcharge or assessment of points is allowed where an accident is a minor accident and certain other criteria are met.

Effective date: When bill becomes law. The Rate Bureau would amend the subclassification plan no later than September 1, 1997, and the change would apply to accidents occurring on or after January 1, 1998.

VISITOR REGISTRATION SHEET

Insurance — 3/12/97

Name of Committee — Date

VISITORS: Please sign below and return to Committee Clerk.

NAME	FIRM OR STATE AGENCY AND ADDRESS
Brenda Summers	NC Equity
Susan Valauri	Nationwide
Richard Hatch	AARP
Harold H Webb	Johnston, Mercer et al
Sam Johnson	Johnston, Mercer et al
Kelly Taylor	
Dan Roach	None
Beth A Christensen	Fiscal Research
Marion S. White	DEHNR - Advisory Comm. on Cancer
Judy Barker	NC Nurses Association
Gale Adcock	NC Nurses Association
Myrna Mills	NATL Assoc. of Social Workers-NC Chapter
Deborah Ross	ACLU
Robert Paschal	Young, Moore
Danielle Mathis	American Cancer Society
Alice Becky Greene	American Cancer Society
Hope Smiley	American Cancer Society - Duke University Student
Becky Brown	Labor
Dana Cope	Labor
David Simmons	Zeb Alley PA
Tommy Worth	Carolinas HealthCare System

Pension &Retirement/ Insurance Committee
March 19,1997
10:00 am
1124 LOB

Sen. Jenkins, Chairman

AGENDA

SB 345 Update Mortality Tabbles
Sen. Reeves

SB 118 Accident Prevention Course Reduction
Sen. Perdue

Pension & Retirement/ Insurance Committee

The Pension & Retirement/ Insurance committee met March 19,1997 at 10:00 am in room 1124 LB. There were 14 members in attendance including Sen. Jenkins, who presided. The following bills were taken up:

SB 345 Update Mortality Tables. Sen. Reeves explained the bill. He called upon Rep. Wayne Goodwin to provide further information. After a period of questions and answers, Sen. Reeves moved to place the bill in a sub-committee. The motion carried. Sen. Jenkins appointed the following members to serve on the sub-committee: Sen. Reeves, Chairman; Sen. Webster, Sen. Wellons, Sen. Odom, and Sen. McDaniels.

SB 118 Accident Prevention Course Reduction. Sen. Perdue explained the bill. Speakers for the bill were: Richard Whitcomb, AAA; Clifton Crandell, AARP; Chip McDonald, Safety & Health Council of NC. Susan Valarie, Nationwide Insurance, spoke against the bill.

The meeting was ajourned.

Sen. Jenkins, Chairman

Katy Haynes, Clerk

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

S 1

SENATE BILL 345

Short Title: Update Mortality Tables. (Public)

Sponsors: Senators Reeves; and Hartsell.

Referred to: Pensions & Retirement and Insurance.

March 10, 1997

A BILL TO BE ENTITLED

AN ACT UPDATING THE STATUTORY MORTALITY TABLES USED AS EVIDENCE TO ESTABLISH THE EXPECTANCY OF CONTINUED LIFE.

The General Assembly of North Carolina enacts:

Section 1. G.S. 8-46 reads as rewritten:

"**§ 8-46. ~~Mortuary~~ Mortality tables as evidence.**

Whenever it is necessary to establish the expectancy of continued life of any person from any period of ~~such~~ the person's life, whether ~~he be~~ the person is living at the time or not, the table hereto appended shall be received in all courts and by all persons having power to determine litigation, as evidence, with other evidence as to the health, constitution and habits of ~~such~~ the person, of such expectancy represented by the figures in the columns headed by the words 'completed age' and 'expectation' respectively:

Completed Age	Expectation
0	~~68.40~~ 75.8
1	~~69.64~~ 75.4
2	~~68.78~~ 74.5
3	~~67.86~~ 73.5
4	~~66.92~~ 72.5
5	~~65.98~~ 71.6
6	~~65.02~~ 70.6
7	~~64.06~~ 69.6
8	~~63.09~~ 68.6
9	~~62.12~~ 67.6
10	~~61.15~~ 66.6
11	~~60.18~~ 65.6

1	12	~~59.20~~ 64.6
2	13	~~58.22~~ 63.7
3	14	~~57.25~~ 62.7
4	15	~~56.29~~ 61.7
5	16	~~55.34~~ 60.7
6	17	~~54.39~~ 59.8
7	18	~~53.45~~ 58.8
8	19	~~52.52~~ 57.9
9	20	~~51.58~~ 56.9
10	21	~~50.65~~ 56.0
11	22	~~49.72~~ 55.1
12	23	~~48.80~~ 54.1
13	24	~~47.87~~ 53.2
14	25	~~46.94~~ 52.2
15	26	~~46.02~~ 51.3
16	27	~~45.09~~ 50.4
17	28	~~44.17~~ 49.4
18	29	~~43.25~~ 48.5
19	30	~~42.33~~ 47.5
20	31	~~41.41~~ 46.6
21	32	~~40.49~~ 45.7
22	33	~~39.58~~ 44.7
23	34	~~38.67~~ 43.8
24	35	~~37.76~~ 42.9
25	36	~~36.85~~ 42.0
26	37	~~35.95~~ 41.0
27	38	~~35.06~~ 40.1
28	39	~~34.17~~ 39.2
29	40	~~33.29~~ 38.3
30	41	~~32.42~~ 37.4
31	42	~~31.57~~ 36.5
32	43	~~30.72~~ 35.6
33	44	~~29.87~~ 34.7
34	45	~~29.04~~ 33.8
35	46	~~28.21~~ 32.9
36	47	~~27.38~~ 32.0
37	48	~~26.56~~ 31.1
38	49	~~25.76~~ 30.2
39	50	~~24.96~~ 29.3
40	51	~~24.18~~ 28.5
41	52	~~23.40~~ 27.6
42	53	~~22.64~~ 26.8
43	54	~~21.89~~ 25.9
44	55	~~21.15~~ 25.1
45	56	~~20.42~~ 24.3
46	57	~~19.70~~ 23.5
47	58	~~18.99~~ 22.7
48	59	~~18.29~~ 21.9
49	60	~~17.61~~ 21.1
50	61	~~16.94~~ 20.4
51	62	~~16.29~~ 19.7
52	63	~~15.65~~ 18.9
53	64	~~15.02~~ 18.2

65		~~14.40~~ 17.5
66		~~13.79~~ 16.8
67		~~13.20~~ 16.1
68		~~12.61~~ 15.5
69		~~12.04~~ 14.8
70		~~11.48~~ 14.2
71		~~10.93~~ 13.5
72		~~10.39~~ 12.9
73		~~9.86~~ 12.3
74		~~9.35~~ 11.7
75		~~8.84~~ 11.2
76		~~8.35~~ 10.6
77		~~7.87~~ 10.0
78		~~7.40~~ 9.5
79		~~6.96~~ 9.0
80		~~6.53~~ 8.5
81		~~6.12~~ 8.0
82		~~5.75~~ 7.5
83		~~5.39~~ 7.1
84		~~5.05~~ 6.6
85	and over	~~4.70~~ 6.6
~~86~~		~~4.38~~ 6.2
~~87~~		~~4.08~~
~~88~~		~~3.79~~
~~89~~		~~3.54~~
~~90~~		~~3.30~~
~~91~~		~~3.08~~
~~92~~		~~2.89~~
~~93~~		~~2.72~~
~~94~~		~~2.56~~
~~95~~		~~2.43~~
~~96~~		~~2.32~~
~~97~~		~~2.21~~
~~98~~		~~2.10~~
~~99~~		~~2.01~~
~~100~~		~~1.91~~
~~101~~		~~1.83~~
~~102~~		~~1.75~~
~~103~~		~~1.67~~
~~104~~		~~1.60~~
~~105~~		~~1.53~~
~~106~~		~~1.46~~
~~107~~		~~1.40~~
~~108~~		~~1.35~~
~~109~~		~~1.29~~".

Section 2. G.S. 8-47 reads as rewritten:

"**§ 8-47. Present worth of annuities.**

Whenever it is necessary to establish the present worth or cash value of an annuity to a person, payable annually during ~~his~~ the person's life, such present worth or cash value may be ascertained by the use of the following table in connection with the ~~mortuary~~ mortality tables established by law, the first column representing the

number of years the annuity is to run and the second column representing the present cash value of an annuity of one dollar for such number of years, respectively:

No. of Years Annuity is to Run	Cash Value of the Annuity of $1
1	$ 0.943
2	1.833
3	2.673
4	3.465
5	4.212
6	4.917
7	5.582
8	6.210
9	6.802
10	7.360
11	7.887
12	8.384
13	8.853
14	9.295
15	9.712
16	10.106
17	10.477
18	10.828
19	11.158
20	11.470
21	11.764
22	12.042
23	12.303
24	12.550
25	12.783
26	13.003
27	13.211
28	13.406
29	13.591
30	13.765
31	13.929
32	14.084
33	14.230
34	14.368
35	14.498
36	14.621
37	14.737
38	14.846
39	14.949
40	15.046

41	15.138
42	15.225
43	15.306
44	15.383
45	15.456
46	15.524
47	15.589
48	15.650
49	15.708
50	15.762
51	15.813
52	15.861
53	15.907
54	15.950
55	15.991
56	16.029
57	16.065
58	16.099
59	16.131
60	16.161
61	16.190
62	16.217
63	16.242
64	16.266
65	16.289
66	16.310
67	16.331

The present cash value of the annuity for a fraction of a year may be ascertained as follows: Multiply the difference between the cash value of the annuities for the preceding and succeeding full years by the fraction of the year in decimals and add the sum to the present cash value for the preceding full year. When a person is entitled to the use of a sum of money for life, or for a given time, the interest thereon for one year, computed at four and one half percent (4 1/2%), may be considered as an annuity and the present cash value be ascertained as herein provided: Provided, the interest rate in computing the present cash value of a life interest in land shall be six percent (6%).

Whenever the ~~mortuary~~ mortality tables set out in G.S. 8-46 are admissible in evidence in any action or proceeding to establish the expectancy of continued life of any person from any period of ~~such~~ the person's life, whether ~~he be~~ the person is living at the time or not, the annuity tables herein set forth shall be evidence, but not conclusive, of the loss of income during the period of life expectancy of ~~such~~ the person."

Section 3. G.S. 46-25 reads as rewritten:

"**§ 46-25. Sale of standing timber on partition; valuation of life estate.**

When two or more persons own, as tenants in common, joint tenants or copartners, a tract of land, either in possession, or in remainder or reversion, subject to a life estate, or where one or more persons own a remainder or reversionary interest in a tract of land, subject to a life estate, then in any such case in which there is standing timber upon any such land, a sale of said timber trees, separate from the land, may be had upon the petition of one or more of said owners, or the life tenant, for partition among the owners thereof, including the life tenant, upon such terms as the court may order, and under like proceedings as are now prescribed by law for the sale of land for partition: Provided, that when the land is subject to a life estate, the life tenant shall be made a party to the proceedings, and shall be entitled to receive his or her portion of the net proceeds of sales, to be ascertained under the ~~mortuary~~ mortality tables established by law: Provided further, that prior to a judgment allowing a life tenant to sell the timber there must be a finding that the cutting is in keeping with good husbandry and that no substantial injury will be done to the remainder interest."

Section 4. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

S 2

SENATE BILL 118
Pensions & Retirement and Insurance Committee Substitute Adopted 4/24/97

Short Title: Accident Preven. Course Reduction. (Public)

Sponsors:

Referred to:

February 17, 1997

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR AUTOMOBILE INSURANCE PREMIUM DISCOUNTS OF AT LEAST TEN PERCENT FOR CERTAIN PERSONS WHO COMPLETE ACCIDENT PREVENTION COURSES.

The General Assembly of North Carolina enacts:

Section 1. Article 36 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-36-66. Private passenger motor vehicle insurance premium rate reduction for completion of accident prevention course.**

(a) The classification plan promulgated pursuant to G.S. 58-36-65 shall provide for a reduction in premium rates of at least ten percent (10%) for liability and physical damage coverages to those insureds 55 years of age or older who successfully complete motor vehicle accident prevention courses approved by the Commissioner of Motor Vehicles. Those insureds shall qualify for the reduction for a three-year period after the policy issuance or renewal that follows the completion of the course. Each insured shall successfully complete an approved course every three years to be eligible for the reduction.

(b) Upon successfully completing an approved course, each insured shall be issued a completion certificate by the course's sponsor, on a form approved by the Commissioner of Motor Vehicles, which shall be the only acceptable evidence of qualification for the reduction in rates.

No reduction in rates shall be allowed for:

(1) Self-instructed courses;

(2) Courses that do not provide actual classroom instruction for the minimum number of hours prescribed by the Commissioner of Motor Vehicles; or

(3) Any course required to be taken by:

a. A court order;

b. A Division of Motor Vehicles order or regulation; or

c. A statutory mandate.

(c) An insured who has more than two Safe Driver Incentive Plan points assessed against him or her is not eligible for the reduction in premium rates provided for in this section. The insured's ineligibility shall continue until the insured no longer has more than two Safe Driver Incentive Plan points and the insured successfully completes an approved course.

(d) Insurers that write nonfleet private passenger motor vehicle insurance may deviate from the reduction promulgated by the Bureau and approved by the Commissioner to provide a greater discount as approved by the Commissioner.

(e) The provisions of this section shall not apply to rates used on motor vehicle insurance policies reinsured by the North Carolina Motor Vehicle Reinsurance Facility under Article 37 of this Chapter."

Section 2. The North Carolina Rate Bureau shall promulgate a revision to the classification plan to reflect the provisions of this act. The Bureau shall file the revision with the Commissioner no later than September 1, 1997, and the revision shall become effective January 1, 1998.

Section 3. Sections 2 and 3 of this act are effective when it becomes law. The remainder of this act becomes effective January 1, 1998, and applies only to nonfleet private passenger motor vehicle insurance policies that are issued or renewed on and after January 1, 1998.

VISITOR REGISTRATION SHEET

Name of Committee

3/19 19
Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Ken Eudy	Capital Strategies
David Anders	PFFNC
Paul Smith	PFFNC
J Craig Lewis	PCMA
[illegible]	NCBA
Eugene Hafer	CAPIA

VISITOR REGISTRATION SHEET

Name of Committee

Date 3/19/1997

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Lynn Duncan	Womble Carlyle
Rachael Propes	NC DOI
Julian Philpott	NCFB
Dave Horn	Smith Helms
Steve Keen	NCAIS
Tom Keesee	Moore & Van Allen
Ken Wright	BCBSNC
Robert Powell	Blue Cross Life Ins Co
Evelyn Hawthorne	NC HCA
Will Jay	NCAHC
Lucia Peel	NC Medical Society
A. Clark Gaither, M.D.	Doctor of the Day Goldsboro Fam. Physicians, Goldsboro, NC

Pensions & Ret/Ins, 3-19-97

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Rich Whitcomb	AAA Carolinas, Traffic Safety 720 E. Morehead St. Charlotte, NC.
Richard C Hatch	AARP 217 Beaches Brook Ln Cary, NC 27511
Wilbur Holt	AARP 105 Downs Brook Dr Roanoke Rapids NC 27870
IRENE BRIGGAMAN	VOLUNTEER AARP 524 REDBUD RD CHAPEL HILL, NC 27514
Hugh D. Moon	AARP S.L.C. 15 PAR Three Drive Sylva NC, 28779
Mattie Delaney	AARP/SLC 4809 Sara Drive Greensboro NC 27410
Charles Frazier	AARP/SLC 209 Poplar Ground Franklin NC 287
Albert M. LYLES	AARP/SLC 5041 WEDGEWOOD DR CHARLOTTE NC 28210
Priscilla Swindell	AARP/CCTF 2993 Dillinghast Trail Raleigh, NC 27613
Polly Williams	AARP/CCTF 622 Woodburn Rd Raleigh NC 27605
Bill Wilson	NCAE

VISITOR REGISTRATION SHEET

Pension & Ret/INS. 3-19-97

Name of Committee Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Amy Rinder	Hunton & Williams
Amy Jo Bain	Smith Anderson
Pam Seamans	United Way of NC / Covenant w/ NC's Children
John Jordan	ASSN. of N.C. Life Cos
Ed Clarson	Safety & Health Council of N.C.
Ken McKellar III	Moore & Van Allen
Daschle Boyce	NC Dept. of Ins.
[illegible]	Capital Strategies
✓ Cliz Crandell	AARP, Carrboro, NC
Lamar Whittle	AARP - Red Springs, NC
Richard C Hutch	AARP - Cary, NC
Adam Searing	NC Health Access

VISITOR REGISTRATION SHEET

Pension & Ret Ins. — Name of Committee

3-19-97 — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Gretchen Batra	AARP 225 Hillsborough St #440 Raleigh 27603
Dorothy Crawford	AARP Health Advocacy P.O Box 149 Franklin NC 28744
Thomas S. Dunham	Dunckel & Dunham, PC PO Box 33366 Raleigh NC 27636
Worth McDonald	Safety & Health Council of NC
Scott M. Clark, CSP, ETP	SAFETY + Hlth Council of NC - Raleigh
Sheila H. McKenney	N. C. Dept. of Ins.
Dan Proper	NC Dept. of Ins
Bill Hale	N. C Dept. of Ins.
Jill Miller	NCATL
Amanda Digby	NCATL
Wayne Goodwin	State Representative

VISITOR REGISTRATION SHEET

Pension & Ret/Ins. — Name of Committee

3-19-97 — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Ted & Lee Caldwell	Safety & Health Council, Charlotte
John McMillan	Manning, Fulton & Skinner P.A.
Susan Valenti	NAHanda
Burnett PASchal	Young, Moore & Henderson, P.A.
Chip McDonald	Safety and Health Council of North Carolina
Bob Mussat	Safety and Health Council of North Carolina
Jim Hardt	AARP
Charles Cramer	NCATL
Dick Zoll	NCATL
John Roski	Hunton & Williams
Mike Hile	NC Dept of Insurance
Otis Carter	Carter & Assoc.

VISITOR REGISTRATION SHEET

Pension & Ret Ins. — 3-19-97

Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Gilbert Terry	~~Fayetteville, N.C. 28301~~ Chapter 855 AARP P.55 Alma 1413 ~~Fay, N.C 28301~~
R.H. Beatty	Fay. Chapter 855 AARP 1844 Broadell St. Fayetteville NC 28301
Pam Tademeli	OFFICE OF STATE PERSONNEL 116 W. JONES STREET. Raleigh
Mary Jane Abercrombie	Dept. of Human Resources 101 Blair Dr. Raleigh 27603
Benny Scarboro	WSPFRA
George Kean	2405 New Hill Olive Chapel Rd New Hill, NC 27562 55 ALIVE/AARP
Bill Patterson	Horton & Williams P.O. Box 109 Rol. N.C. 27602
Ruffin Bailey	AIA - Bailey & Dixon Raleigh
John J. Johnson	Johnston Corp - Winston-Salem
Alan Miles	Bailey & Dixon LLP
Steve Davis	NC Dept of Human Resources
James Dorsett	

VISITOR REGISTRATION SHEET

Pension & Ret / INS. — 3-19-97

Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Evelyn Hawthorne	NCHA
David Andrews	[illegible]
Paul Smith	[illegible]
PERRI MORGAN	NFIB
Jim Phillips	BPMHR
Eugene Hafer	CAPIA
[illegible]	[illegible]

Pension & Retirement/ Insurance Committee

March 26, 1997

10:00

1124 LB

Sen. Jenkins, Chairman

AGENDA

SB 345 Update Mortality Tables
Sen. Reeves

SB 118 Accident Prevention Course Reduction.
Sen. Perdue

SB 350 Supplemental Insurance Benefits/AB
Sen. Soles

MINUTES

Pensions & Retirement/ Insurance Committee

The Pensions & Retirement /Insurance Committee met March 26,1997 at 10:00 in Room 1124 of the Legislative Building. Sixteen members were present including Senator Jenkins who presided.

Senator Reeves presented SB 345 **Update Mortality Tables.**. He introduced Rep. Wayne Goodwin for further information. After discussion the bill was referred to a Sub-Committee. Chairman Jenkins appointed Senator Reeves chairman of the sub-committee and the following are members: Senator Wellons; Senator Odom; Senator McDaniel: Senator Webster.

Senator Perdue was present to present SB 118 **Accident Prevention. Course Reduction.** Sen Soles moved for favorable report. Speakers for were: Richard Whitcomb, AAA; Clifton Crandell, AARP; Chip McDonald, Safety & Health Council of NC. Speaking against the bill was Susan Valarie, Nationwide Ins. Senator Odom moved an unfavorable report of the original bill, but favorable report of the committee substitute. The motion carried.

Senator Soles presented SB 350, **Supplemental Insurance Benefits/ AB**. Sen. Soles moved for adoption of committee substitute. The motion carried not favorable to Bill, but favorable to Committee Substitute..

The meeting was adjourned.

Senator Tommy Jenkins, Chair

Katy Haynes, clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

PENSIONS & RETIREMENT/ INSURANCE COMMITTEE REPORT

Senator Tommy Jenkins, Chairman

Thursday, April 24, 1997

SENATOR TOMMY JENKINS,
submits the following with recommendations as to passage:

FAVORABLE

S.B. **345** Update Mortality Tables
Sequential Referral: None
Recommended Referral: None

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO C.S. BILL

S.B. **118** Accident Preven. Course Reduction
Draft Number: PCS7642
Sequential Referral: None
Recommended Referral: None
Long Title Amended: No

S.B. **434** National Guard Health Benefits
Draft Number: PCS2732
Sequential Referral: None
Recommended Referral: Appropriations
Long Title Amended: No

TOTAL REPORTED: 3

Committee Clerk Comment: None

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

PENSIONS & RETIREMENT/ INSURANCE COMMITTEE REPORT
Senator Tommy Jenkins, Chairman

Thursday,March 27,1997

SENATOR TOMMY JENKINS,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO C.S. BILL

S.B. **350** Supplemental Insurance Benefits/AB.

Draft Number:	PCS1656
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 1

Committee Clerk Comment:

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

S 2

SENATE BILL 118
Pensions & Retirement and Insurance Committee Substitute Adopted 4/24/97

Short Title: Accident Preven. Course Reduction. (Public)

Sponsors:

Referred to:

February 17, 1997

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR AUTOMOBILE INSURANCE PREMIUM DISCOUNTS OF AT LEAST TEN PERCENT FOR CERTAIN PERSONS WHO COMPLETE ACCIDENT PREVENTION COURSES.

The General Assembly of North Carolina enacts:

Section 1. Article 36 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-36-66. Private passenger motor vehicle insurance premium rate reduction for completion of accident prevention course.**

(a) The classification plan promulgated pursuant to G.S. 58-36-65 shall provide for a reduction in premium rates of at least ten percent (10%) for liability and physical damage coverages to those insureds 55 years of age or older who successfully complete motor vehicle accident prevention courses approved by the Commissioner of Motor Vehicles. Those insureds shall qualify for the reduction for a three-year period after the policy issuance or renewal that follows the completion of the course. Each insured shall successfully complete an approved course every three years to be eligible for the reduction.

(b) Upon successfully completing an approved course, each insured shall be issued a completion certificate by the course's sponsor, on a form approved by the Commissioner of Motor Vehicles, which shall be the only acceptable evidence of qualification for the reduction in rates.

No reduction in rates shall be allowed for:

(1) Self-instructed courses;

(2) Courses that do not provide actual classroom instruction for the minimum number of hours prescribed by the Commissioner of Motor Vehicles; or

(3) Any course required to be taken by:

a. A court order;

b. A Division of Motor Vehicles order or regulation; or

c. A statutory mandate.

(c) An insured who has more than two Safe Driver Incentive Plan points assessed against him or her is not eligible for the reduction in premium rates provided for in this section. The insured's ineligibility shall continue until the insured no longer has more than two Safe Driver Incentive Plan points and the insured successfully completes an approved course.

(d) Insurers that write nonfleet private passenger motor vehicle insurance may deviate from the reduction promulgated by the Bureau and approved by the Commissioner to provide a greater discount as approved by the Commissioner.

(e) The provisions of this section shall not apply to rates used on motor vehicle insurance policies reinsured by the North Carolina Motor Vehicle Reinsurance Facility under Article 37 of this Chapter."

Section 2. The North Carolina Rate Bureau shall promulgate a revision to the classification plan to reflect the provisions of this act. The Bureau shall file the revision with the Commissioner no later than September 1, 1997, and the revision shall become effective January 1, 1998.

Section 3. Sections 2 and 3 of this act are effective when it becomes law. The remainder of this act becomes effective January 1, 1998, and applies only to nonfleet private passenger motor vehicle insurance policies that are issued or renewed on and after January 1, 1998.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

S 2

SENATE BILL 350
Pensions and Retirement and Insurance Committee Substitute Adopted 3/27/97

Short Title: Supplemental Insurance Benefits/AB. (Public)

Sponsors:

Referred to:

March 10, 1997

A BILL TO BE ENTITLED

AN ACT TO AMEND THE LAWS GOVERNING EMPLOYEE INSURANCE COMMITTEES TO ALLOW FOR A CENTRAL EMPLOYEE INSURANCE COMMITTEE IN THE DEPARTMENT OF HUMAN RESOURCES.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-31-60(b) reads as rewritten:

"(b) Appointment of Employee Insurance Committee Members. -- The members of the Employee Insurance Committee shall be appointed by the head of the payroll unit. The Committee shall consist of not less than five or more than nine individuals a majority of whom have been employed in the payroll unit for at least one year. The committee members shall, except where necessary initially to establish the rotation herein prescribed, serve three-year terms with approximately one-third of the terms expiring annually. Committee membership make-up shall fairly represent the work force in the payroll unit and be selected without regard to any political or other affiliations. It shall be the duty of the payroll unit head to assure that the Employee Insurance Committee is completely autonomous in its selection of insurance products and insurance companies and that no member of the Employee Insurance Committee has any conflict of interest in serving on the Committee. A committee on employee benefits elected or appointed by the faculty representative body of a constituent institution of The University of North Carolina shall be deemed constituted and functioning as an employee insurance committee in accordance with this section. Any decision rendered by the Employee Insurance Committee where the autonomy of the Committee or a conflict of interest is questioned shall be subject to appeal pursuant

to the Administrative Procedure Act, or in the case of departments, boards and commissions which are specifically exempt from the Administrative Procedure Act, pursuant to the appeals procedure prescribed for such department, board or commission.

~~All payroll units in existence on May 21, 1985, shall continue to be deemed payroll units, regardless of any subsequent consolidation of such payroll units, for purposes of the appointment of the members of the Employee Insurance Committee in order to assure such units the continuing ability to meet the needs and desires of the employees of such units by having the right to select insurance carriers and insurance products. No Employee Insurance Committee shall be created for employees represented by a previously existing committee. Any such duplicative Employee Insurance Committees are hereby disbanded. In the event of the consolidation of a payroll unit, the head of the former payroll unit shall appoint the members of the Committee in accordance with the provisions of this section.~~"

Section 2. Effective January 1, 1998, the employee insurance committees of the Department of Human Resources are abolished and shall be replaced with a single employee insurance committee, appointed by the Secretary of Human Resources, to represent all employees of that Department.

Section 3. This act becomes effective January 1, 1998.

North Carolina General Assembly
Legislative Services Office

George R. Hall, Legislative Services Officer
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Room 5, Legislative Building
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Terrence D. Sullivan, Director
Research Division
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300 N. Salisbury St.
Raleigh, NC 27603-5925
(919) 733-2578

March 17, 1997

MEMORANDUM

TO: Senator Thomas Jenkins, Chairman
Pensions & Retirement and Insurance Committee

FROM: Linwood Jones, Staff Counsel

RE: SB 350 (Supplemental Insurance Benefits)(Agency Bill)

Senate Bill 350 abolishes the more than twenty different employee insurance committees operating within the Department of Human Resources and replaces them with one employee insurance committee that will serve all of DHR. The change would take effect January 1, 1998.

Employee insurance committees are responsible for evaluating and selecting the types of supplemental insurance products (such as life insurance, cancer insurance, disability insurance, dental insurance, etc.) that are available to State employees through payroll deduction. The committees also select the vendors that provide these products. Other state agencies are each represented by one employee insurance committee. DHR has over twenty different committees representing its various divisions and institutions. (These products are provided separate and apart from other insurance benefits offered through the State's centralized flexible benefits program).

The consolidation of the DHR employee insurance committees was one of several recommendations made by a select Senate study committee on State employee insurance issues to the 1996 legislative session.

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

VISITOR REGISTRATION SHEET

Pension & Retirement & Insurance Committee, 1997 3/26
Name of Committee Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Cliff Crandell	AARP
Richard Hatch	AARP & NC Coalition on Aging
Diana D. Hatch	AARP
Gretchen Batra	AARP
[illegible] Bailey	AIA Bailey & Dixon
Amy Tenderich	Hunton & Williams
LYNN WILSON	SEANC
FRED JOYNER	NCALU
[illegible] Burns	NCALU
[illegible]	NCALU
[illegible]	NALU
[illegible]	NCALU
[illegible]	NCALU
JAMES C STASIOS	NCALU
BOB PAGE	NCALU
[illegible]	same
[illegible] Carter	Carter & Assoc.
[illegible]	pers

Pensions & Retirement/ Insurance Committee

April 2, 1997
10:00
Room 1124 LB

AGENDA

SB 6
Revise School Calendar

SB 254
Genetic Info/ No Discrimination

SB 235
Increase Fire/Rescue Benefits

SB 190
Increase Pension Benefits

MINUTES
Pensions & Retirement/ Insurance Committee

The Senate Pension & Retirement/ Insurance Committee met April 2, 1997 at 10:00 in room 1124 of the Legislative Building. There were seventeen member present including Chairman Tommy Jenkins, who presided.

Senator Leslie Winner presented SB 6, **Revised School Calendar.** After a period of questions and answers from the committee, Senator Odom moved for a favorable report. The motion carried. The bill was referred to Appropriations by Chairman Jenkins.

Senator Odom presented SB 254, **Genetic Info/ No Discrimination.** with committee substitute. Senator Jordan moved for adoption of committee substitute. After a period of discussion , Senator Pyler moved an unfavorable to the original bill, but favorable as committee substitute. The motion carried.

Senator Bob Martin presented SB 235, **Increase Fire/ Rescue Benefits** with committee substitute. After some discussion, Sen. Carpenter moved for an unfavorable as to bill, but favorable as to committee substitute. The motion carried. The bill was referred to Appropriations by Sen. Jenkins.

The meeting was adjourned.

Sen. Jenkins, Chairman

Katy Haynes, Clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

PENSIONS & RETIREMENT/ INSURANCE COMMITTEE REPORT

Senator Tommy Jenkins, Chairman

Monday, April 07, 1997

SENATOR TOMMY JENKINS,
submits the following with recommendations as to passage:

FAVORABLE

S.B. **6** Revise School Calendar
Sequential Referral: None
Recommended Referral: Appropriations

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO C.S. BILL

S.B. **235** Increase Fire/Rescue Benefits
Draft Number: PCSA606
Sequential Referral: None
Recommended Referral: Appropriations
Long Title Amended: No

S.B. **254** Genetic Info/No Discrimation
Draft Number: PSC2658
Sequential Referral: None
Recommended Referral: None
Long Title Amended: No

TOTAL REPORTED: 3

Committee Clerk Comment: None

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

S 2

SENATE BILL 6
Education/Higher Education Committee Substitute Adopted 3/6/97

Short Title: Revise School Calendar. (Public)

Sponsors:

Referred to: Pensions & Retirement and Insurance.

February 3, 1997

A BILL TO BE ENTITLED

AN ACT TO REVISE THE LAWS RELATED TO THE PUBLIC SCHOOL CALENDAR TO PROVIDE LOCAL BOARDS OF EDUCATION AND SCHOOLS GREATER FLEXIBILITY AND LOCAL CONTROL.

The General Assembly of North Carolina enacts:

Section 1. G.S. 115C-84 is repealed.

Section 2. G.S. 115C-84.1 is repealed.

Section 3. Part 2 of Article 8 of Chapter 115C of the General Statutes is amended by adding a new section to read:

"**§ 115C-84.2. School calendar.**

(a) School Calendar. -- Each local board of education shall adopt a school calendar consisting of 220 days all of which must fall within the fiscal year. A school calendar shall include the following:

(1) A minimum of 180 days and 1,000 hours of instruction covering at least nine calendar months. The local board shall designate when the 180 instructional days shall occur. The number of instructional hours in an instructional day may vary according to local board policy and does not have to be uniform among schools in the administrative unit. Local boards may approve school improvement plans that include days with varying amounts of instructional time. If school is closed early due to inclement weather, the day and the scheduled amount of instructional hours may count towards the required minimum. The school calendar

should include a plan for making up days and instructional hours missed when schools are not opened due to inclement weather.

(2) A minimum of 10 annual vacation leave days.

(3) The same or an equivalent number of legal holidays occurring within the school calendar as those designated by the State Personnel Commission for State employees.

(4) Ten days, as designated by the local board, for use as teacher workdays, additional instructional days, or other lawful purposes. A local board may delegate to the individual schools some or all of the 10 days to schedule under subdivision (5) of this subsection. A local board may schedule different purposes for different personnel on any given day and is not required to schedule the same dates for all personnel.

(5) The remaining days shall be scheduled by each individual school in any or all of the following methods: (i) by the school improvement team in consultation with the school's principal, (ii) in the school improvement plan, (iii) by an amendment to the school improvement plan, and (iv) by agreement between the individual teacher and the school's principal. Days may be scheduled for any of the purposes allowed under subdivision (4) of this subsection. Days may be scheduled for different purposes for different personnel and there is no requirement to schedule the same dates for all personnel.

Local boards of education shall consult with parents and the employed public school personnel in the development of the school calendar.

(b) Limitations. -- The following limitations apply when developing the school calendar:

(1) The total number of teacher workdays shall not exceed 200 days.

(2) Teachers may not be required to work during the month of July unless: (i) the school is a year-round school; or (ii) the teacher is employed for a term in excess of 10 months.

(3) School shall not be held on Sundays.

(c) Emergency Conditions. -- During any period of emergency in any section of the State where emergency conditions make it necessary, the State Board of Education may order general, and if necessary, extended recesses or adjournment of the public schools.

(d) Opening and Closing Dates. -- Local boards of education shall determine the dates of opening and closing the public schools under subdivision (a)(1) of this section. A local board may revise the scheduled closing date if necessary in order to comply with the minimum requirements for instructional days or instructional time. Different opening and closing dates may be fixed for schools in the same administrative unit."

Section 4. G.S. 115C-302 is repealed.

Section 5. Article 20 of Chapter 115C of the General Statutes is amended by adding a new section to read:

"**§ 115C-302.1. Salary.**

(a) Prompt Payment. -- Teachers shall be paid promptly when their salaries are due provided the legal requirements for their employment and service have been met. All teachers employed by any local school administrative unit who are to be paid from local funds shall be paid promptly as provided by law and as State-allotted teachers are paid.

(b) Salary Payments. -- State-allotted teachers shall be paid for a term of 10 months. State-allotted months of employment for vocational education to local boards shall be used for the employment of teachers of vocational and technical education for a term of employment to be determined by the local boards of education.

Each local board of education shall establish a set date on which monthly salary payments to State-allotted teachers shall be made. This set pay date may differ from the end of the month of service. The daily rate of pay for teachers shall equal one twenty-second of the monthly rate of pay.

Teachers may be prepaid on the monthly pay date for days not yet worked. A teacher who fails to attend scheduled workdays or who has not worked the number of days for which the teacher has been paid and who resigns, is dismissed, or whose contract is not renewed shall repay to the local board any salary payments received for days not yet worked. A teacher who has been prepaid and continues to be employed by a local board but fails to attend scheduled workdays may be subject to dismissal under G.S. 115C-325 or other appropriate discipline.

Any individual teacher who is not employed in a year-round school may be paid in 12 monthly installments if the teacher so requests on or before the first day of the school year. The request shall be filed in the local school administrative unit which employs the teacher. The payment of the annual salary in 12 installments instead of 10 shall not increase or decrease the teacher's annual salary nor in any other way alter the contract made between the teacher and the local school administrative unit. Teachers employed for a period of less than 10 months may not receive their salaries in 12 installments.

(c) Vacation. -- Included within the 10-month term shall be annual vacation leave at the same rate provided for State employees, computed at one-twelfth of the annual rate for State employees for each month of employment. Local boards shall provide at least 10 days of annual vacation leave at a time when students are not scheduled to be in regular attendance. However, instructional personnel who do not require a substitute may use annual vacation leave on days that students are in attendance. Vocational and technical education teachers who are employed for 11 or 12 months may, with prior approval of the principal, work on annual vacation leave days designated in the school calendar and may use those annual vacation leave days during the eleventh or twelfth month of employment.

On a day that pupils are not required to attend school due to inclement weather, but employees are required to report for a workday, a teacher may elect not to report due to hazardous travel conditions and to take an annual vacation day or to make up

the day at a time agreed upon by the teacher and the teacher's immediate supervisor or principal. On a day that school is closed to employees and pupils due to inclement weather, a teacher shall work on the scheduled makeup day.

All vacation leave taken by the teacher will be upon the authorization of the teacher's immediate supervisor and under policies established by the local board of education. Annual vacation leave shall not be used to extend the term of employment.

Teachers may accumulate annual vacation leave days without any applicable maximum until June 30 of each year. On June 30 of each year, any teacher or other personnel paid on the teacher salary schedule with more than 30 days of accumulated annual vacation leave shall, at the teacher's option, have the excess accumulation converted to either sick leave or pay, so that only 30 days are carried forward to July 1 of the same year.

Upon separation from service due to resignation, dismissal, reduction in force, or death, an employee shall be paid in a lump sum for accumulated annual leave not to exceed a maximum of 30 days. Upon separation from service due to service retirement, any teacher or other personnel paid on the teacher salary schedule with more than 30 days of accumulated annual vacation leave may, at the teacher's option, have some or all of the excess accumulation converted to sick leave for creditable service towards retirement. A retiring teacher's accumulated annual leave, including any excess accumulated annual leave that is not converted to sick leave, shall be paid in a lump sum. Employees going onto term disability may exhaust annual leave rather than be paid in a lump sum.

Notwithstanding any provisions of this subsection to the contrary, no person shall be entitled to pay for any vacation day not earned by that person.

(d) Personal Leave. -- Teachers earn personal leave at the rate of .20 days for each full month of employment not to exceed two days per year. Personal leave may be accumulated to a maximum of five days. Personal leave may be used only upon the authorization of the teacher's immediate supervisor, but if the request is made at least five days in advance, the teacher cannot be required to provide a reason for the request. Unless approved by the principal, a teacher may not take personal leave on the first day the teacher is required to report for the school year, on required teacher workdays, or on the day before or the day after holidays or scheduled vacation days. Teachers may transfer personal leave days between local school administrative units. The local school administrative unit shall credit a teacher who has separated from service and is reemployed within 60 months from the date of separation with all personal leave accumulated at the time of separation. Local school administrative units may not advance personal leave. Teachers using personal leave receive full salary less the required substitute deduction.

(e) Teachers in Year-Round Schools. -- Compensation for teachers employed in year-round schools shall be the same as teachers paid for a 10-month term, but those days may be scheduled over 12 calendar months. Annual leave, sick leave, workdays, holidays, salary, and longevity for teachers who are employed at year-round schools shall be equivalent to those of other teachers employed for the same number of

months, respectively. Teachers paid for a term of 10 months in year-round schools shall receive their salary in 12 equal installments.

(f) Overpayment. -- Each local board of education shall sustain any loss by reason of an overpayment to any teacher paid from State funds.

(g) Social Security. -- All of the foregoing provisions of this section shall be subject to the requirement that at least fifty dollars ($50.00), or other minimum amount required by federal social security laws, of the compensation of each school employee covered by the Teachers' and State Employees' Retirement System or otherwise eligible for social security coverage shall be paid in each of the four quarters of the calendar year.

(h) Service in Armed Forces. -- The State Board of Education, in fixing the State standard salary schedule of teachers as authorized by law, shall provide that teachers who entered the armed or auxiliary forces of the United States after September 16, 1940, and who left their positions for such service shall be allowed experience increments for the period of such service as though the same had not been interrupted thereby, in the event such persons return to the position of teachers, principals, and superintendents in the public schools of the State after having been honorably discharged from the armed or auxiliary forces of the United States.

(i) Teachers Paid From Other Funds. -- Every local board of education may adopt, as to teachers not paid out of State funds, a salary schedule similar to the State salary schedule, but it likewise shall recognize a difference in salaries based on different duties, training, experience, professional fitness, and continued service in the same school system. If a local board of education does not adopt a local salary schedule, the State salary schedule shall apply. No teacher shall receive a salary higher than that provided in the salary schedule, unless by action of the board of education a higher salary is allowed for special fitness, special duties, or under extraordinary circumstances.

Whenever a higher salary is allowed, the minutes of the board shall show what salary is allowed and the reason. A board of education may authorize the superintendent to supplement the salaries of all teachers from local funds, and the minutes of the board shall show what increase is allowed each teacher.

(j) Longevity Pay. -- Longevity pay shall be based on the annual salary on the employee's anniversary date.

(k) Parental Leave. -- A teacher may use annual leave, personal leave, or leave without pay to care for a newborn child or for a child placed with the teacher for adoption or foster care. The leave may be for consecutive workdays during the first 12 months after the date of birth or placement of the child, unless the teacher and local board of education agree otherwise."

Section 6. G.S. 115C-272(b)(1) reads as rewritten:

"(1) Each local board of education shall establish a set date on which monthly salary payments to superintendents shall be made. This set pay date may differ from the end of the calendar month of service. Superintendents shall only be paid for the days employed as of the set pay date. Payment for a full month when days employed are

less than a full month is prohibited as this constitutes prepayment. The daily rate of pay shall equal the number of weekdays in the pay period. Included within their term of employment shall be annual vacation leave at the same rate provided for State employees. Included within the 12 months' employment each local board of education shall designate the same or an equivalent number of legal holidays as those designated by the State Personnel Commission for State employees."

Section 7. G.S. 115C-285(b)(1) reads as rewritten:

"(1) Classified principals and State-allotted supervisors shall be employed for a term of 12 calendar months. Each local board of education shall establish a set date on which monthly salary payments to classified principals and State-allotted supervisors shall be made. This set pay date may differ from the end of the calendar month of service. Classified principals and State-allotted supervisors shall only be paid for the days employed as of the set pay date. Payment for a full month when days employed are less than a full month is prohibited as this constitutes prepayment. The daily rate of pay shall equal the number of weekdays in the pay period. They shall earn annual vacation leave at the same rate provided for State employees. On a day that employees are required to report for a workday but pupils are not required to attend school due to inclement weather, an employee may elect not to report due to hazardous travel conditions and to take one of ~~his~~ the employee's annual vacation days or to make up the day at the time agreed upon by the employee and ~~his~~ the employees's immediate supervisor. They shall be provided by the board the same or an equivalent number of legal holidays as those designated by the State Personnel Commission for State employees."

Section 8. G.S. 115C-316(a)(1) reads as rewritten:

"(1) Employees Other than Superintendents, Supervisors and Classified Principals on an Annual Basis. -- Each local board of education shall establish a set date on which monthly salary payments to employees other than superintendents, supervisors, and classified principals employed on an annual basis, shall be made. This set pay date may differ from the end of the calendar month of service. ~~These employees shall only be paid for the days employed as of the set pay date. Payment for a full month when days employed are less than a full month is prohibited as this constitutes prepayment.~~ Employees may be prepaid on the monthly pay date for days not yet worked. An employee who fails to attend scheduled workdays or who has not worked the number of days for which the employee has been paid and who resigns or is dismissed shall repay to the local board any salary payments

received for days not yet worked. An employee who has been prepaid and who continues to be employed by a local board but fails to attend scheduled workdays may be subject to dismissal or other appropriate discipline. The daily rate of pay shall equal the number of weekdays in the pay period. Included within their term of employment shall be annual vacation leave at the same rate provided for State employees, computed at one-twelfth (1/12) of the annual rate for state employees for each calendar month of employment. On a day that employees are required to report for a workday but pupils are not required to attend school due to inclement weather, an employee may elect not to report due to hazardous travel conditions and to take one of ~~his~~ the employee's annual vacation days or to make up the day at a time agreed upon by the employee and ~~his~~ the employee's immediate supervisor or principal. On a day that school is closed to employees and pupils due to inclement weather, an employee shall work on the scheduled makeup day. Included within their term of employment each local board of education shall designate the same or an equivalent number of legal holidays as those designated by the State Personnel Commission for State employees."

Section 9. G.S. 115C-316(a)(2) reads as rewritten:

"(2) School Employees Paid on an Hourly or Other Basis. -- Salary payments to employees other than those covered in G.S. 115C-272(b)(1), 115C-285(a)(1) and (2), ~~115C-302(a)(1) and (2),~~ 115C-302.1(b), and 115C-316(a)(1) shall be made at a time determined by each local board of education. Expenditures for the salary of these employees from State funds shall be within allocations made by the State Board of Education and in accordance with rules and regulations approved by the State Board of Education concerning allocations of State funds: Provided, that school employees employed for a term of 10 calendar months in year-round schools shall be paid in 12 equal installments: Provided further, that any individual school employee employed for a term of 10 calendar months who is not employed in a year-round school may be paid in 12 monthly installments if the employee so requests on or before the first day of the school year. Such request shall be filed in the administrative unit which employs the employee. The payment of the annual salary in 12 installments instead of 10 shall not increase or decrease said annual salary nor in any other way alter the contract between the employee and the said administrative unit. Employees may be prepaid on the set pay date for days not yet worked. An employee who fails to attend scheduled workdays or who has not worked the number of days for which the employee has been paid and who resigns or is dismissed shall repay to the

local board any salary payments received for days not yet worked. An employee who has been prepaid and who continues to be employed by a local board but fails to attend scheduled workdays may be subject to dismissal or other appropriate discipline. The daily rate of pay shall equal the number of weekdays in the pay period. Included within the term of employment shall be provided for full-time employees annual vacation leave at the same rate provided for State employees, computed at one-twelfth (1/12) of the annual rate for State employees for each calendar month of employment, to be taken under policies determined by each local board of education. On a day that employees are required to report for a workday but pupils are not required to attend school due to inclement weather, an employee may elect not to report due to hazardous travel conditions and to take one of his annual vacation days or to make up the day at a time agreed upon by the employee and his immediate supervisor or principal. On a day that school is closed to employees and pupils due to inclement weather, the employee shall work on the scheduled makeup day. Included within their term of employment, each local board of education shall designate the same or an equivalent number of legal holidays occurring within the period of employment as those designated by the State Personnel Commission for State employees."

Section 10. G.S. 115C-47(5) reads as rewritten:

"(5) To Fix Time of Opening and Closing Schools. -- The time of opening and closing the public schools shall be fixed ~~pursuant to the provisions of G.S. 115C-84(c).~~ under G.S. 115C-84.2."

Section 11. G.S. 115C-47(11) reads as rewritten:

"(11) To Determine the ~~Length of the School Day, the School Month and the School Term.~~ School Calendar. -- Local boards of education shall determine the school calendar under G.S. 115C-84.2. ~~length of the school day, the school month and the school term pursuant to the provisions of G.S. 115C-84(a) through (c).~~"

Section 12. G.S. 115C-47(21) reads as rewritten:

"(21) It is the duty of every local board of education to provide for the prompt monthly payment of all salaries due teachers and other school officials and employees, and of all current bills and other necessary operating expenses. All salaries and bills shall be paid as provided by law for disbursing State and local funds.

The local board shall determine salary schedules of employees pursuant to the provisions of G.S. 115C-273, 115C-285(b), ~~115C-302(c),~~ 115C-302.1(i), and 115C-316(b).

The authority for boards of education to issue salary vouchers to all school employees, whether paid from State or local funds,

shall be a monthly payroll prepared on forms approved by the State Board of Education and containing all information required by the State Board of Education. This monthly payroll shall be signed by the principal of each school."

Section 13. By October 31, 1997, the State Board of Education shall review and revise its rules, policies, and guidelines to make them consistent with this act. The State Board may use its authority under G.S. 150B-21.1 regarding the adoption of temporary rules consistent with this act.

Section 14. This act becomes effective July 1, 1998, contingent upon the appropriation of funds to implement the act for the 1998-99 school year. Nothing in this act shall require the General Assembly to appropriate any funds to implement it. Local school administrative units may begin planning for the implementation of this act for the 1998-99 school year on or after the date this act becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
1997 SESSION

S.L. 1997-350
SENATE BILL 254

AN ACT TO PROHIBIT DISCRIMINATION IN HEALTH INSURANCE AND EMPLOYMENT BASED ON GENETIC INFORMATION.

The General Assembly of North Carolina enacts:

Section 1. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-215. Genetic information in health insurance.**

(a) Definitions. -- As used in this section:

(1) 'Genetic information' means information about genes, gene products, or inherited characteristics that may derive from an individual or a family member. 'Genetic information' does not include the results of routine physical measurements, blood chemistries, blood counts, urine analyses, tests for abuse of drugs, and tests for the presence of human immunodeficiency virus.

(2) 'Health benefit plan' means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by any waiver of or other exception to that Act provided under federal law or regulation. 'Health benefit plan' does not mean any plan implemented or administered through the Department of Human Resources or its representatives. 'Health benefit plan' also does not mean any of the following kinds of insurance:

a. Accident
b. Credit
c. Disability income
d. Long-term or nursing home care
e. Medicare supplement
f. Specified disease
g. Dental or vision
h. Coverage issued as a supplement to liability insurance
i. Workers' compensation
j. Medical payments under automobile or homeowners
k. Hospital income or indemnity
l. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance

m. Blanket accident and sickness.

(3) 'Insurer' means an insurance company subject to this Chapter; a service corporation organized under Article 65 of this Chapter; a health maintenance organization organized under Article 67 of this Chapter; or a multiple employer welfare arrangement subject to Article 49 of this Chapter.

(b) For the purpose of this section, routine physical measurements, blood chemistries, blood counts, urine analyses, tests for abuse of drugs, and tests for the presence of human immunodeficiency virus are not to be considered genetic tests.

(c) No insurer shall:

(1) Raise the premium or contribution rates paid by a group for a group health benefit plan on the basis of genetic information obtained about an individual member of the group.

(2) Refuse to issue or deliver a health benefit plan because of genetic information obtained about any person to be insured by the health benefit plan.

(3) Charge a higher premium rate or charge for a health benefit plan because of genetic information obtained about any person to be insured by the health benefit plan."

Section 2. Article 3 of Chapter 95 of the General Statutes is amended by adding the following new section to read:

"**§ 95-28.1A. Discrimination against persons based on genetic testing or genetic information prohibited.**

(a) No person, firm, corporation, unincorporated association, State agency, unit of local government, or any public or private entity shall deny or refuse employment to any person or discharge any person from employment on account of the person's having requested genetic testing or counseling services, or on the basis of genetic information obtained concerning the person or a member of the person's family. This section shall not be construed to prevent the person from being discharged for cause.

(b) As used in this section, the term 'genetic test' means a test for determining the presence or absence of genetic characteristics in an individual or a member of the individual's family in order to diagnose a genetic condition or characteristic or ascertain susceptibility to a genetic condition. The term 'genetic characteristic' means any scientifically or medically identifiable genes or chromosomes, or alterations or products thereof, which are known individually or in combination with other characteristics to be a cause of a disease or disorder, or determined to be associated with a statistically increased risk of development of a disease or disorder, and which are asymptomatic of any disease or disorder. The term 'genetic information' means information about genes, gene products, or inherited characteristics that may derive from an individual or a family member."

Section 3. G.S. 95-241(a), as rewritten by S.L. 1997-153, reads as rewritten:

"(a) No person shall discriminate or take any retaliatory action against an employee because the employee in good faith does or threatens to do any of the following:

(1) File a claim or complaint, initiate any inquiry, investigation, inspection, proceeding or other action, or testify or provide information to any person with respect to any of the following:

a. Chapter 97 of the General Statutes.

b. Article 2A or Article 16 of this Chapter.

c. Article 2A of Chapter 74 of the General Statutes.

d. G.S. 95-28.1.

e. Article 16 of Chapter ~~127A.~~ 127A of the General Statutes.
f. G.S. 95-28.1A.

(2) Cause any of the activities listed in subdivision (1) of this subsection to be initiated on an employee's behalf.

(3) Exercise any right on behalf of the employee or any other employee afforded by Article 2A or Article 16 of this Chapter or by Article 2A of Chapter 74 of the General Statutes."

Section 4. Nothing in this act applies to specified accident, specified disease, hospital indemnity, disability, or long-term care health insurance policies.

Section 5. This act is effective when it becomes law.

In the General Assembly read three times and ratified this the 22nd day of July, 1997.

s/ Dennis A. Wicker
President of the Senate

s/ Harold J. Brubaker
Speaker of the House of Representatives

s/ James B. Hunt, Jr.
Governor

Approved 3:59 p.m. this 1st day of August, 1997

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

S 2

SENATE BILL 235*
Pension & Retirement and Insurance Committee Substitute Adopted 4/3/97

Short Title: Increase Fire/Rescue Benefits. (Public)

Sponsors:

Referred to: Appropriations.

February 25, 1997

A BILL TO BE ENTITLED

AN ACT TO INCREASE THE MONTHLY BENEFITS FROM THE NORTH CAROLINA FIREMEN'S AND RESCUE SQUAD WORKERS' PENSION FUND.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-86-55 reads as rewritten:

"**§ 58-86-55. Monthly pensions upon retirement.**

Any member who has served 20 years as an 'eligible fireman' or 'eligible rescue squad worker' in the State of North Carolina, as provided in G.S. 58-86-25 and G.S. 58-86-30, and who has attained the age of 55 years is entitled to be paid a monthly pension from this fund. The monthly pension shall be in the amount of ~~one hundred thirty-five dollars ($135.00)~~ one hundred forty-one dollars ($141.00) per month. Any retired fireman receiving a pension ~~of one hundred ten dollars ($110.00) per month~~ shall, effective July 1, ~~1995,~~ 1997, receive a pension of ~~one hundred thirty-five dollars ($135.00)~~ one hundred forty-one dollars ($141.00) per month.

Members shall pay ten dollars ($10.00) per month as required by G.S. 58-86-35 and G.S. 58-86-40 for a period of no longer than 20 years. No 'eligible rescue squad member' shall receive a pension prior to July 1, 1983. No member shall be entitled to a pension hereunder until the member's official duties as a fireman or rescue squad worker for which the member is paid compensation shall have been terminated and the member shall have retired as such according to standards or rules fixed by the board of trustees.

A member who is totally and permanently disabled while in the discharge of the member's official duties as a result of bodily injuries sustained or as a result of extreme exercise or extreme activity experienced in the course and scope of those official duties and who leaves the fire or rescue squad service because of this disability shall be entitled to be paid from the fund a monthly benefit in an amount of ~~one hundred thirty-five dollars ($135.00)~~ one hundred forty-one dollars ($141.00) per month beginning the first month after the member's fifty-fifth birthday. All applications for disability are subject to the approval of the board who may appoint physicians to examine and evaluate the disabled member prior to approval of the application, and annually thereafter. Any disabled member shall not be required to make the monthly payment of ten dollars ($10.00) as required by G.S. 58-86-35 and G.S. 58-86-40.

A member who is totally and permanently disabled for any cause, other than line of duty, who leaves the fire or rescue squad service because of this disability and who has at least 10 years of service with the pension fund, may be permitted to continue making a monthly contribution of ten dollars ($10.00) to the fund until the member has made contributions for a total of 240 months. The member shall upon attaining the age of 55 years be entitled to receive a pension as provided by this section. All applications for disability are subject to the approval of the board who may appoint physicians to examine and evaluate the disabled member prior to approval of the application and annually thereafter.

A member who, because his residence is annexed by a city under Part 2 or Part 3 of Article 4 of Chapter 160A of the General Statutes, or whose department is closed because of an annexation by a city under Part 2 or Part 3 of Article 4 of Chapter 160A of the General Statutes, and because of such annexation is unable to perform as a fireman of any status, and if the member has at least 10 years of service with the pension fund, may be permitted to continue making a monthly contribution of ten dollars ($10.00) to the fund until the member has made contributions for a total of 240 months. The member upon attaining the age of 55 years and completion of such contributions shall be entitled to receive a pension as provided by this section. Any application to make monthly contributions under this section shall be subject to a finding of eligibility by the Board of Trustees upon application of the member.

The pensions provided shall be in addition to all other pensions or benefits under any other statutes of the State of North Carolina or the United States, notwithstanding any exclusionary provisions of other pensions or retirement systems provided by law."

Section 2. It is the intent of the General Assembly to provide cost-of-living increases to members and retirees of the Firemen's and Rescue Squad Workers' Pension Fund at a rate equal to any cost-of-living increases provided to beneficiaries of the Teachers' and State Employees' Retirement System, to the extent that funds are available.

Section 3. This act becomes effective July 1, 1997.

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April 2, 1997

MEMORANDUM

TO: Senator Thomas Jenkins, Chairman,
Senate Pensions, Retirement and Insurance Committee

FROM: Karen Cochrane Brown, Committee Co-Counsel KCB

RE: **Senate Bill 6 - Revise School Calendar (2d Edition)**

Senate Bill 6 makes a variety of changes to the laws governing the public school calendar year including leave options for teachers. Only one provision of the bill relates to retirement. Section 5 of the bill contains a provision that would allow teachers who accumulate more than 30 days of annual leave by July 1 of each year to either convert the leave to sick leave or receive it as pay.

Under the present law, teachers earn annual leave based on the following table according to years of service:

Less than 2 years	1.00 Days
2 to 4 years	1.15 Days
5 to 9 years	1.40 Days
10 to 14 years	1.65 Days
15 to 19 years	1.90 Days
20 or more years	2.15 Days

Annual leave may be accumulated up to 30 day as of July 1 of each year with any leave over 30 days being converted to sick leave.. If a teacher terminates employment, dies or retires, they are paid a lump sum payment for up to 30 days. Any teacher retiring can use their sick leave to increase their service for retirement purposes. One month of service is allowed for each 20 days of sick leave.

This bill will allow a teacher who continues employment to either convert annual leave over 30 days to sick leave or receive a lump sum payment for those days over 30. Also, the bill allows a retiring teacher with annual leave in excess of 30 days to convert all or part over 30 days to sick leave and receive salary for the balance in addition to receiving salary for the 30 days of annual leave. This will allow a retiring teacher to increase the salary in the four years prior to retirement by 5.5%, which would be used in determining the Average Final Compensation, resulting in an increase of retirement benefit of 5.5%.

The bill is not effective until July 1, 1998 so the cost is reflected in the 1998-99 year.

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

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April 2, 1997

MEMORANDUM

TO: Senator Thomas Jenkins, Chairman,
Senate Pensions and Retirement and Insurance Committee

FROM: Karen Cochrane Brown, Committee Counsel KCB

RE: **Senate Bill 190 - Increase Pension Benefits.**
Senate Bill 235 - Increase Fire/Rescue Benefits.

Senate Bills 190 and 235 both increase the monthly benefits paid to retirees of the North Carolina Firemen's and Rescue Squad Workers' Pension Fund. Senate Bill 190 increases the benefits from $135.00 to $150.00, and Senate Bill 235 increases benefits from $135.00 to $155.00.

In order to be eligible for the benefit, members must pay $10.00 per month for a period of 20 years, be at least 55 years of age and have obtained at least 20 years of service. The benefit would be increased for those already retired and those who retire in the future. In addition, the bill makes an identical increase in the benefit paid to members who become totally and permanently disabled in the line of duty. These benefits were previously increased, effective July 1, 1995, from $110.00 to $135.00.

This act would become effective July 1, 1997.

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March 11, 1997

MEMORANDUM

To: Senate Insurance Committee

From: M. Lynn Marshbanks, Committee Counsel MLM

Re: Senate Bill 254: Genetic Info/No Discrimination

Senate Bill 254 would prohibit discrimination in health insurance and in employment based on "genetic information", defined as "information about genes, gene products, or inherited characteristics that may derive from an individual or a family member". The sections of the bill do the following:

Sections 1, 2, 4, 6, and 8: Provide that in a health plan, genetic information may not be treated as a preexisting condition unless there has been a diagnosis of the condition that is related to the genetic information. Also add to the definition of "preexisting condition" those conditions for which medical diagnosis or care (currently, only medical advice or treatment) was received or recommended.

Sections 3, 5, and 7: Provide that health plans shall not set eligibility rules for an individual to enroll under the plan based on certain health status-related factors relating to the individual or a dependent, including health status, medical conditions (both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), and disability. Also, the company may not require an individual to pay a greater premium or contribution than that charged to a similarly-situated individual on the basis of any health status-related factor or raise a group's rates based on genetic information obtained about an individual in the group.

Section 9: Adds new G.S. 58-51-45A to provide that no licensed insurance company may deny coverage for health benefits based on genetic information obtained about the person to be insured, nor may it charge a higher premium because of the genetic information.

Section 10: Adds new G.S. 95-28.2A to provide that no person, business, agency, or government entity may refuse employment or discharge any person for having requested genetic testing or counseling services or on the basis of genetic information obtained about the person or a member of the person's family.

Section 11: States that the act does not apply to specified accident, specified disease, hospital indemnity, disability, or long-term care health insurance policies.

Section 12: Effective date is July 1, 1997.

S254-SMRS-001

VISITOR REGISTRATION SHEET

Pensions & Retirement and Insurance — Name of Committee

April 2, 1997 — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
LORRAINE GRAEFENSTEIN	MAGELLAN CHARTER SCHOOL
Megan Carney	BSW Student - Meredith College
Sandy Barker	NC Nurses Association
Gordon A Jogan	NCAAPSMS
T MAX WESSON	NC AHEC
John Tate	MIAI NC
Tommy Worth	CHS
John Jackson	Watson Corp
Robert Pierce	Dept. NC Ag. Ins. Com.
Otis Carter	Carter & Assoc
Susan Valauri	Nationwide
Ron Thompson	DPT
Cynthia	NCAHA
A Seaming	NC Health Access

Pension &Retirement/ Insurance Committee

April 9,1997
10:00
1124 LOB

Sen. Jenkins, Chairman

AGENDA

SB 299 Long-Term Care Benefit
Sen. Bob Martin

SB 609 Insurance Audit Recommendations
Sen. Miller

SB 612 Insurer Financial Operations
Sen. Miller

Pensions & Retirement/ Insurance Committee Meeting

MINUTES

The Pension & Retirement/ Insurance Committee met April 9, 1997 at 10:00 in room 1124 of the Legislative Building. There were seventeen members in attendance including Sen. Jenkins, who presided. The following bills were acted upon:

SB 299 **Long-Term Care Benefits.** The bill was explained by Sen. Bob Martin. Sen. Martin sent forth 2 amendments which were approved and rolled into a committee substitute. Sen. Larry Shaw moved for a unfavorable as to the original bill, but favorable as to committee substitute. The motion carried. Sen. Jenkins referred the bill to Appropriations.

SB 609 **Insurance Audit Recommendations.** The bill was explained by Sen. Miller. Sen. Carpenter moved for a favorable report. The motion carried.

SB 612 **Insurer Financial Operations.** Sen. Miller explained the committee substitute bill. Sen. Larry Shaw moved for an unfavorable as to the original bill, but favorable as to committee substitute bill. The motion carried.

The meeting was adjourned.

Sen. Jenkins, Chairman

Katy Haynes, Clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

PENSIONS & RETIREMENT/ INSURANCE COMMITTEE REPORT
Senator Tommy Jenkins, Chairman

Thursday, April 10, 1997

SENATOR TOMMY JENKINS,
submits the following with recommendations as to passage:

FAVORABLE

S.B. **609** Insurance Dept. Audit Recommendations
Sequential Referral: None
Recommended Referral: None

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO C.S. BILL

S.B. **299** Long Term Benefits.
Draft Number: PCSA680
Sequential Referral: None
Recommended Referral: Appropriations
Long Title Amended: No

S.B. **612** Insurer Financial Operations.
Draft Number: PCS6629
Sequential Referral: None
Recommended Referral: None
Long Title Amended: No

TOTAL REPORTED: 3

Committee Clerk Comment: None

GENERAL ASSEMBLY OF NORTH CAROLINA
1997 SESSION

SESSION LAW 1997-468
SENATE BILL 299

AN ACT TO PROVIDE LONG-TERM CARE BENEFITS FOR QUALIFIED EMPLOYEES, RETIRED EMPLOYEES, AND THEIR DEPENDENTS UNDER THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN.

The General Assembly of North Carolina enacts:

Section 1. G.S. 135-38(c) reads as rewritten:

"(c) The Committee shall review programs of hospital, medical and related care provided by Part 3 of this Article and programs of long-term care benefits provided by Part 4 of this Article as recommended by the Executive Administrator and Board of Trustees of the Plan. The Executive Administrator and the Board of Trustees shall provide the Committee with any information or assistance requested by the Committee in performing its duties under this Article."

Section 2. G.S. 135-39.5(22) reads as rewritten:

"(22) ~~Providing to the Industrial Commission the schedule of allowable charges under the Plan for each participating hospital and other information deemed necessary by the Commission to fulfill its duties under G.S. 97-26.~~ Implementing and administering a program of long-term care benefits pursuant to Part 4 of this Article."

Section 3. G.S. 135-39.6 reads as rewritten:

"**§ 135-39.6. Special funds created.**

(a) There are hereby established two special funds, to be known as the Public Employee Health Benefit Fund and the Health Benefit Reserve ~~Fund.~~ Fund for the payment of hospital and medical benefits.

All premiums, fees, charges, rebates, refunds or any other receipts including, but not limited to, earnings on investments, occurring or arising in connection with health benefits programs established by this Article, shall be deposited into the Public Employee Health Benefit Fund. Disbursements from the Fund shall include any and all amounts required to pay the benefits and administrative costs of such programs as may be determined by the Executive Administrator and Board of Trustees.

Any unencumbered balance in excess of prepaid premiums or charges in the Public Employee Health Benefit Fund at the end of each fiscal year shall be used first, to provide an actuarially determined Health Benefit Reserve Fund for incurred but unpresented claims, second, to reduce the premiums required in providing the benefits of the health benefits programs, and third to improve the plan, as may be provided by the General Assembly. The balance in the Health Benefits Reserve Fund may be transferred from time to time to the Public Employee Health Benefit Fund to provide for any deficiency occurring therein.

The Public Employee Health Benefit Fund and the Health Benefit Reserve Fund shall be deposited with the State Treasurer and invested as provided in G.S. 147-69.2 and 147-69.3.

(b) Disbursement from the Public Employee Health Benefit Fund may be made by warrant drawn on the State Treasurer by the Executive Administrator, or the Executive Administrator and Board of Trustees may by contract authorize the Claims Processor to draw the warrant.

(c) Separate and apart from the special funds authorized by subsections (a) and (b) of this section, there shall be a Public Employee Long-Term Care Benefit Fund if the long-term care benefits provided by Part 4 of this Article are administered on a self-insured basis."

Section 4. G.S. 135-39.6A reads as rewritten:

"**§ 135-39.6A. Premiums set.**

(a) The Executive Administrator and Board of Trustees shall, from time to time, establish premium rates for the Comprehensive Major Medical Plan except as they may be established by the General Assembly in the Current Operations Appropriations Act, and establish regulations for payment of the premiums. Premium rates shall be established for coverages where Medicare is the primary payer of health benefits separate and apart from the rates established for coverages where Medicare is not the primary payer of health benefits.

(b) The Executive Administrator and Board of Trustees shall establish separate premium rates for the long-term care benefits provided by Part 4 of this Article if the benefits are administered on a self-insured basis."

Section 5. G.S. 135-39.8 reads as rewritten:

"**§ 135-39.8. Rules and regulations.**

The Executive Administrator and Board of Trustees may issue rules and regulations to implement Parts ~~2 and 3~~ 2, 3, and 4 of this Article. Rules and regulations of the Board of Trustees shall remain in effect until amended or repealed by the Executive Administrator and Board of Trustees. The Executive Administrator and Board of Trustees shall provide a written description of the rules and regulations issued under this section to all employing units, all health benefit representatives, the oversight team provided for in G.S. 135-39.3, all relevant health care providers affected by a rule or regulation, and to any other parties requesting a written description and approved by the Executive Administrator and Board of Trustees to receive a description on a timely basis."

Section 6. G.S. 135-40.7 is amended by adding a new subdivision to read:

"(19) Charges for services covered by the long-term care benefit provisions of Part 4 of this Article."

Section 7. Article 3 of Chapter 135 of the General Statutes is amended by adding a new Part to read:

"Part 4. Long-Term Care Benefits.

"**§ 135-41. Undertaking.**

(a) The State of North Carolina undertakes to make available an optional program of long-term care benefits for the benefit of its qualified employees, retired employees, and their dependents which will pay benefits in accordance with the terms hereof. Retired employees of the Local Governmental Employees' Retirement System pursuant to Article 3 of Chapter 128 of the General Statutes and their dependents are also eligible to be qualified for the benefits provided by this Part.

(b) The long-term care benefits provided by this Part shall be made available through the Teachers' and State Employees' Comprehensive Major Medical Plan pursuant to Articles 2 and 3 of this Chapter (hereinafter called the 'Plan') and administered by the Plan's Executive Administrator and Board of Trustees. In administering the benefits provided by this Part, the Executive Administrator and

Board of Trustees shall have the same type of powers and duties that are provided under Part 3 of this Article for hospital and medical benefits. The benefits provided by this Part may be offered by the Plan on a self-insured basis, in which case a third-party claims processor shall be chosen through competitive bids in accordance with State law, or through a contract of insurance, in which case a carrier licensed to do business in North Carolina shall be selected on a competitive bid basis in accordance with State law.

(c) The benefits authorized by this Part are available only to qualified employees and retired employees who voluntarily elect to provide such benefits for themselves and their qualified dependents. Payroll deductions shall be available from employee salary and disability benefit payments and from retired employee retirement benefit payments for fully contributory premium amounts.

(d) The Executive Administrator and Board of Trustees of the Plan shall insure insofar as possible that the long-term care benefits provided by this Part shall be tax-qualified under federal law.

"**§ 135-41.1. Long-term care benefits.**

Long-term care benefits provided by this Part are subject to elimination periods, coinsurance provisions, and other limitations separate and apart from those provided for in Part 3 of this Article. No limitation on out-of-pocket expenses are provided for the benefits covered by this section. Long-term care benefits are as follows:

(1) Nursing Home Benefits. -- The Plan will pay a fixed amount of the reasonable and customary daily charges allowed for nursing facilities providing skilled nursing care and intermediate nursing care up to a maximum amount per day for each day after a fixed number of consecutive days for each nursing home stay. Such daily charges shall be inclusive of semiprivate room and board; skilled and semiskilled nursing services; routine laboratory tests and examinations; physical, occupational, and speech therapy; respiratory and other gas therapy; and drugs, injections, biologicals, fluids, solutions, dietary aids and supplements, and other routine medical supplies and equipment. Readmission to a nursing home within 180 days, exclusive of hospital stays, for the same or related cause or causes shall be considered a single nursing home stay for the purposes of this section. Benefits payable under this subdivision are contingent upon compliance with the following conditions and will, in no instance, be paid under this section without compliance with each of the following conditions:

a. Confinement to a nursing home is medically appropriate due to an illness, disease, or injury upon recommendation of an admitting physician other than a proprietor, employee, or agent of the nursing home;

b. Confinement to a nursing home is for any overnight stay for which a charge for a day's stay is due and payable; and

c. Prior to confinement, the admitting physician secures approval certification from the Plan for confinement.

As used in this section, a nursing home is a facility or a part of a facility which is (i) operated under State law and which is qualified as a skilled nursing or intermediate nursing facility under Medicare; or is (ii) a facility meeting the requirements for licensure under Chapter 131E of the General Statutes.

(2) Custodial Benefits. -- The Plan will pay a fixed percentage of the fixed amount of reasonable and customary daily charges allowed by the Plan in subdivision (1) of this section for assisted living facilities, for adult day care facilities, and for home care agencies

up to a maximum amount per day for each day after a fixed number of consecutive days that such custodial care is provided. Benefits payable under this subdivision are contingent upon compliance with the following conditions and will, in no instance, be paid under this subdivision without compliance with each of the following conditions:

a. Use of such custodial benefits is medically appropriate in a treatment plan established and certified initially and at least once every six months by an attending physician or other allied health professionals other than a proprietor, employee, or agent of one or more of the aforementioned facilities and agencies;

b. Confinement to a nursing home would be medically appropriate without custodial care proposed to be rendered by one or more of the aforementioned facilities or agencies; and

c. Prior to use of such custodial benefits, an attending physician or other allied health professional secures approval from the Plan for the use of the benefits.

As used in this section, an assisted living facility is a facility which (i) is operated under State law to provide residential care for the aged or disabled whose principal need is a home which provides personal care appropriate to their age or disability; or (ii) meets the requirements for licensure under Chapter 131D of the General Statutes. As used in this section, an adult care facility is a facility which (i) is operated under State law to provide group care for the aged and disabled in a setting away from their residence on a less than 24-hour basis when such aged or disabled would otherwise be in need of full-time personal care away from their residence; or (ii) meets the requirements for certification under Chapter 131D of the General Statutes. As used in this section, a home care agency is a residential care agency which is (i) operated under State law and which is qualified as a home health care agency under Medicare; or (ii) an agency meeting the requirements for licensure as a home care agency under Chapter 131E of the General Statutes.

(3) Other Benefits. -- Upon prior approval of the Plan, other care, services, supplies, and equipment may be used as more cost-effective alternatives to the benefits provided by this section when directed by an attending physician.

(4) The Executive Administrator and Board of Trustees of the Plan shall establish the payment percentages, maximum daily payment rates, benefit periods, elimination periods, and maximum lifetime benefits payable for each covered individual for the nursing home and custodial benefits provided by this section. The Executive Administrator and Board of Trustees shall provide for inflationary increases in the maximum daily payment rates and the maximum lifetime benefits payable for each covered individual.

(5) The Executive Administrator and Board of Trustees of the Plan shall provide a bed reservation benefit whenever Plan members are hospitalized during a stay in a nursing home or an assisted living facility.

(6) The Executive Administrator and Board of Trustees of the Plan shall provide for a waiver of premiums involving minimum lengths of stay in a nursing home or an assisted living facility. In addition, the Executive Administrator and Board of Trustees shall allow coverage to be reinstated upon failure to pay premiums, provided

certain grace periods are not exceeded and retroactive premium payments are made.

(7) Limitations and Exclusions to Long-Term Care Benefits. -- The benefits provided by this section are for the purpose of meeting the requirements for assistance from the loss of functional capacity associated with a chronic illness, disease, or disabling injury for extended periods of time; and are, in no way, intended to duplicate the benefits provided for acute and other medical care provided by Medicare or Part 3 of this Article. A loss of functional capacity can occur from: (i) an illness, disease, or disabling injury resulting in a physical incapacity to perform the activities of daily living; or (ii) an irreversible organic mental impairment resulting in a mental incapacity. Activities of daily living consist of routine functions involving personal care and mobility.

"**§ 135.41.2. Conversion.**

Upon cessation of group coverage under this Part, an employee, retired employee, or dependent shall be entitled to a conversion to a nongroup plan of long-term care benefits. The Executive Administrator and Board of Trustees of the Plan shall determine how the conversion rights authorized by this Part shall be administered.

"**§ 135.41.3. Right to alter, amend, or repeal.**

The General Assembly reserves the right to alter, amend, or repeal this Part."

Section 8. This act becomes effective January 1, 1998.

In the General Assembly read three times and ratified this the 21st day of August, 1997.

s/ Marc Basnight
President Pro Tempore of the Senate

s/ Harold J. Brubaker
Speaker of the House of Representatives

s/ James B. Hunt, Jr.
Governor

Approved 4:16 p.m. this 1st day of September, 1997

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

S 1

SENATE BILL 609

Short Title: Insurance Dept. Audit Recommendations. (Public)

Sponsors: Senator Miller.

Referred to: Pensions & Retirement and Insurance.

April 1, 1997

A BILL TO BE ENTITLED

AN ACT TO ALLOW MONEY CREDITED TO THE CONSUMER PROTECTION FUND TO BE USED TO RETAIN EXPERTS FOR HEARINGS AND TO REQUIRE THAT MONEY RECOVERED FROM DELINQUENCY PROCEEDINGS OR CIVIL ACTIONS AGAINST THE COMMISSIONER BE CREDITED TO THE FUND.

The General Assembly of North Carolina enacts:

Section 1. G. S. 58-2-215 reads as rewritten:

"**§ 58-2-215. Consumer Protection Fund.**

(a) A special fund is created in the Office of the State Treasurer, to be known as the Department of Insurance Consumer Protection Fund. The Fund shall be placed in an interest bearing account and any interest or other income derived from the Fund shall be credited to the Fund. Moneys in the Fund shall only be spent pursuant to warrants drawn by the Commissioner on the Fund through the State Treasurer. The Fund shall be subject to the provisions of the Executive Budget Act; except that the provisions of Article 3C of Chapter 143 of the General Statutes do not apply to subdivision (b)(1) of this section.

(b) All moneys credited to the Fund shall be used only to pay the following expenses incurred by the Department:

(1) For the purpose of retaining outside actuarial and economic consultants, legal counsel, and court reporting services in the review and analysis of rate filings, in conducting all hearings, and through any final adjudication.

(1a) For the purpose of retaining meteorologists, statisticians, and other kinds of professionals and experts needed to analyze or respond to averments, testimony, allegations, or other statements made by other experts or professionals in a rate-making matter or to analyze evidence or exhibits filed or offered by an opposing party in a rate-making matter.

(2) In connection with any delinquency proceeding under Article 30 of this Chapter, for the purpose of locating and recovering the assets of or any other obligations or liabilities owed to or due an insurer that has been placed under such proceeding.

(3) In connection with any civil litigation, other than under Chapter 150B of the General Statutes or any appeal from an order of the Commissioner or his deputies, that is commenced against the Commissioner or his deputies and that arises out of the performance of their official duties, for the purpose of retaining outside consultants, legal counsel, and court reporting services to defend such litigation.

(c) Moneys appropriated by the General Assembly shall be deposited in the Fund and shall become a part of the continuation budget of the Department of Insurance. Such continuation budget amount shall equal the actual expenditures drawn from the Fund during the prior fiscal year plus the official inflation rate designated by the Director of the Budget in the preparation of the State Budget for each ensuing fiscal year; provided that if interest income on the Fund exceeds the amount yielded by the application of the official inflation rate, such continuation budget amount shall be the actual expenditures drawn from the Fund, except that the appropriation for the 1995-96 fiscal year shall not exceed the sum of seven hundred fifty thousand dollars ($750,000) and for the 1996-97 fiscal year shall not exceed the sum of two hundred fifty thousand dollars ($250,000). In the event the amount in the Fund exceeds two hundred fifty thousand dollars ($250,000) at the end of any fiscal year, beginning with the 1995-96 fiscal year, such excess shall revert to the General Fund.

(d) Repealed by Session Laws 1995, c. 507, s. 11A(b).

(e) From any moneys received as recoveries by the estate of an insurer that is the subject of a delinquency proceeding as to which expenses have been incurred under subdivision (b)(2) of this section, there shall be credited to the Fund from the estate any amounts drawn from the Fund to pay the expenses incurred under subdivision (b)(2) of this section in connection with that estate. From any moneys received as recoveries of counterclaims, cross-claims, or any other action in connection with litigation under subdivision (b)(3) of this section, there shall be credited to the Fund any amounts drawn from the Fund to pay the expenses incurred under subdivision (b)(3) of this section."

Section 2. This act becomes effective October 1, 1997.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

S 3

SENATE BILL 612
Pensions & Retirement and Insurance Committee Substitute Adopted 4/10/97
Third Edition Engrossed 4/16/97

Short Title: Insurer Financial Operations. (Public)

Sponsors:

Referred to:

April 1, 1997

A BILL TO BE ENTITLED

AN ACT TO MAKE SUBSTANTIVE CHANGES IN THE LAWS GOVERNING THE FINANCIAL OPERATIONS OF INSURANCE COMPANIES AND THE ROLE OF THE DEPARTMENT OF INSURANCE IN MONITORING THE SOLVENCY OF INSURANCE COMPANIES.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-3-100 reads as rewritten:

"**§ 58-3-100. Revocation, ~~suspension~~ suspension, restriction, ~~and~~ or refusal to renew license.**

(a) ~~The Commissioner may revoke, suspend, or refuse to renew the license of any insurer if:~~ The Commissioner may, after notice and opportunity for a hearing, revoke, suspend, restrict, or refuse to renew the license of any insurer if:

(1) The insurer fails or refuses to comply with any law, order or rule applicable to the insurer.

(2) The insurer's financial condition is unsound, or its assets above its liabilities, exclusive of capital, are less than the amount of its capital or required minimum surplus.

(3) The insurer has published or made to the Department or to the public any false statement or report.

(4) The ~~insurer refuses~~ insurer or any of the insurer's officers, directors, employees, agents, or other representatives refuse to

submit to any examination authorized by ~~law.~~ law or refuse to perform any legal obligation in relation to an examination.

(5) The insurer is found to make a practice of unduly engaging in litigation or of delaying the investigation of claims or the adjustment or payment of valid claims.

(b) Any suspension, revocation or refusal to renew an insurer's license under this section may also be made applicable to the license or registration of any ~~natural person~~ individual regulated under this Chapter who is a party to any of the causes for licensing sanctions listed in subsection (a) of this section.

(c) The Commissioner may impose a civil penalty under G.S. 58-2-70 if an insurer fails to acknowledge a claim within 30 days after receiving written notice of the claim, but only if the notice contains sufficient information for the insurer to identify the specific coverage involved. Acknowledgement of the claim shall be made to the claimant or his legal representative advising that the claim is being investigated; or shall be a payment of the claim; or shall be a bona fide written offer of settlement; or shall be a written denial of the claim.

(d) If a foreign insurance company's license is suspended or revoked, the Commissioner shall give written notification of the revocation or suspension to all of the company's agents in this State. Until the Commissioner restores the company's license and authority to do business in this State, the company shall not write any new business in this State.

(e) The Commissioner may, after considering the standards under G.S. 58-30-60(b), restrict an insurer's license by prohibiting or limiting the kind or amount of insurance written by that insurer. For a foreign insurer, this restriction relates to the insurer's business conducted in this State. The Commissioner shall remove any restriction under this subsection once the Commissioner determines that the operations of the insurer are no longer hazardous to the public or to the insurer's policyholders or creditors."

Section 2. Article 7 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-7-37. Background of incorporators and proposed management personnel.**

(a) Before a license is issued to a new domestic insurance company, each key person must furnish the Commissioner a complete set of the applicant's fingerprints and a recent passport-size, full-face photograph of the applicant. The applicant's fingerprints shall be certified by an authorized law enforcement officer. The fingerprints of every applicant shall be forwarded to the State Bureau of Investigation for a search of the applicant's criminal history record file, if any. If warranted, the State Bureau of Investigation shall forward a set of the fingerprints to the Federal Bureau of Investigation for a national criminal history record check. An applicant shall pay the cost of the State and any national criminal history record check of the applicant.

(b) As used in this section, 'key person' means a proposed officer, director, or any other individual who will be in a position to influence the operating decisions of a domestic insurance company.

(c) The Commissioner may refuse to approve the formation or initial license of a new domestic insurance company under this Article if, after notice to the applicant and an opportunity for a hearing, the Commissioner finds as to the incorporators or other key person any one or more of the following conditions:

(1) Any untrue material statement regarding the background or experience of any incorporator or other key person.

(2) Violation of or noncompliance with any insurance laws or any rule or order of the Commissioner or of the insurance regulator of another state by any incorporator or other key person.

(3) Obtaining or attempting to obtain any license through misrepresentation or fraud.

(4) An incorporator or other key person has been convicted of a felony.

(5) An incorporator or other key person has been found to have committed any unfair trade practice or fraudulent act or omission.

(6) An incorporator or other key person has used fraudulent, coercive, or dishonest practices; or has acted in a manner that is incompetent, untrustworthy, or financially irresponsible.

(7) An incorporator or other key person has held such a position in another insurance company that has had its license suspended or revoked by any state.

(d) If the Commissioner disapproves a company formation or initial license, the Commissioner shall notify the applicant and advise the applicant in writing of the reasons for the disapproval. Within 30 days after date of receipt of the written disapproval, the applicant may make a written request for a hearing, which shall be scheduled within 30 days after the date of receipt of the request.

(e) For investigations under this section, the Commissioner has all of the authority in G.S. 58-3-125.

(f) The Commissioner may adopt rules to set standards for obtaining background information on each incorporator or other key person of a proposed new domestic insurance company."

Section 3. G.S. 58-7-55(3)d. reads as rewritten:

"d. That if at any time the Commissioner finds that the conditions justifying the maintenance of such offices, records, and assets outside of this State no longer exist, or that the insurer has willfully and knowingly violated any of the conditions stated in sub-subdivisions b. and c., the Commissioner may order the return of such offices, records, and assets to this State within such reasonable time, not less than six months, as may be specified in the order; ~~and that for failure to comply with such order, as thereafter modified or extended, if any, the Commissioner shall suspend or revoke the insurer's certificate of authority.~~ and the

Commissioner may, for good cause shown, extend the time for compliance in the order."

Section 4. G.S. 58-7-130 reads as rewritten:

"§ 58-7-130. ~~Payment of dividends impairing financial soundness of company or detrimental to policyholders.~~ Dividends and distributions to stockholders.

(a) Each domestic insurance company in North Carolina shall be restricted by the Commissioner from the payment of any dividends or other distributions to its stockholders whenever the Commissioner determines from examination of such company's financial condition that the payment of future dividends or other distributions would cause a hazardous financial condition, impair the financial soundness of the company or be detrimental to its policyholders, and ~~such~~ those restrictions shall continue in force until ~~such future date when~~ the Commissioner ~~may~~ specifically ~~permit~~ permits the payment of dividends or other distributions to stockholders by the company through a written authorization. ~~Nothing contained in this section and no action taken by the Commissioner shall in any way restrict the liability of stockholders under G.S. 58-7-125.~~

(b) No domestic stock insurance company shall declare dividends to its stockholders except from the unassigned surplus of the company as reflected in the company's most recent financial statement filed with the Commissioner under G.S. 58-2-165.

(c) A transfer out of paid-in and contributed surplus to common or preferred capital stock will be permitted on a case-by-case basis, with the Commissioner's prior approval, depending on the necessity for a company to make the transfer.

(d) Nothing in this section and no action taken by the Commissioner in any way restricts the liabilities of stockholders under G.S. 58-7-125.

(e) Dividends and other distributions paid to stockholders are subject to the requirements and limitations of G.S. 58-19-25(d) and G.S. 58-19-30(c)."

Section 5. G.S. 58-7-170(c) reads as rewritten:

"(c) ~~The cost of investments made by insurers in mortgage loans, authorized by G.S. 58-7-179, with any one person shall not exceed the lesser of five percent (5%) of the insurer's admitted assets or ten percent (10%) of the insurer's capital and surplus. An insurer shall not invest in additional mortgage loans without the Commissioner's consent if the admitted value of all mortgage loans held by the insurer exceeds an aggregate of sixty percent (60%) of the admitted assets of the insurer, if (i) the admitted value of all mortgage pass-through securities permitted by G.S. 58-7-173(17) does not exceed twenty-five percent (25%) of the admitted assets of the insurer and (ii) the admitted value of other mortgage loans permitted by G.S. 58-7-179 does not exceed forty percent (40%) of the admitted assets of the insurer.~~

~~An insurer that, as of October 1, 1993, has mortgage investments that exceed the aggregate limitation specified in this subsection shall submit to the Commissioner no later than January 31, 1994, a plan to bring the amount of mortgage investments into compliance with the limitations by January 1, 2001.~~ The cost of investments made by an insurer in mortgage loans authorized by G.S. 58-7-179, with any one person, or in mortgage pass-through securities and derivatives of mortgage pass-through securities

authorized by G.S. 58-7-173(1), (2), (8), or (17), backed by a single collateral package, shall not exceed three percent (3%) of the insurer's admitted assets. An insurer shall not invest in additional mortgage loans or mortgage pass-through securities and derivatives of mortgage pass-through securities without the Commissioner's consent if the admitted value of all such investments held by the insurer exceeds an aggregate of sixty percent (60%) of the admitted assets of the insurer. Within the aggregate sixty percent (60%) limitation, the admitted value of all mortgage pass-through securities and derivatives of mortgage pass-through securities permitted by G.S. 58-7-173(17) shall not exceed twenty-five percent (25%) of the admitted assets of the insurer. The admitted value of other mortgage loans permitted by G.S. 58-7-179 shall not exceed forty percent (40%) of the admitted assets of the insurer. Mortgage pass-through securities authorized by G.S. 58-7-173(1), (2), or (8) shall only be subject to the single collateral package limitation and the sixty percent (60%) aggregate limitation. An insurer that has mortgage investments that exceed the limitations specified in this subsection shall submit to the Commissioner no later than January 31, 1998, a plan to bring the amount of mortgage investments into compliance with the limitations by January 1, 2003."

Section 6. G.S. 58-7-185(a) reads as rewritten:

"(a) In addition to investments excluded under other provisions of this Chapter, except with prior approval by the Commissioner, an insurer shall not directly or indirectly invest in or lend its funds upon the security of:

(1) Issued shares of its own capital stock, except in connection with a plan for purchase of the shares by the insurer's officers, employees, or agents. No such stock shall, however, constitute an asset of the insurer in any determination of its financial condition.

(2) Except with the Commissioner's consent, securities issued by any corporation or enterprise, the controlling interest of which is or will after acquisition by the insurer be held directly or indirectly by the insurer or any combination of the insurer and the insurer's directors, officers, parent corporation, subsidiaries, or controlling stockholders. Investments in subsidiaries under G.S. 58-7-177 are not subject to this provision.

~~(3) Any note or other evidence of indebtedness of any director, officer, or controlling stockholder of the insurer, except as to policy loans authorized under G.S. 58-7-175 and loans authorized under G.S. 58-7-200(c).~~"

Section 7. G.S. 58-7-187(c) reads as rewritten:

"(c) ~~An insurer may acquire and hold real property for investment, subject to the following conditions:~~ An insurer may, subject to the limitations and conditions set out in subdivisions (1) through (4) of this subsection, acquire, improve, develop, manage, lease, mortgage, and dispose of real estate, other than real estate to be used primarily for mining or development of oil or mineral resources, situated in any state of the United States or province of Canada either directly or indirectly through limited partnership interest, general partnership interests, provided that in the case of general

partnership interests, all other partners in the partnership are subsidiaries of the insurer, limited liability companies, joint ventures, stock of an investment subsidiary, trust certificates, or other similar instruments. The real estate shall be income-producing or to be improved or developed for investment purposes under an existing program, in which case the property shall be deemed to be income-producing. The real estate may be subject to mortgages, liens, or other encumbrances, the amount of which shall, to the extent that the obligations secured by the mortgages, liens, or encumbrances are without recourse to the insurer, be deducted from the amount of the investment of the insurer in the real estate for purposes of determining compliance with this subsection and G.S. 58-7-187(d). As used in this subsection, 'investment subsidiary' means a subsidiary of an insurer engaged or organized to engage exclusively in real estate investments authorized in this subsection.

(1) The amount shall not exceed in the aggregate the lesser of five percent (5%) of the insurer's admitted assets or fifteen percent (15%) of the insurer's capital and surplus.

(2) The amount in any one property shall not exceed one percent (1%) of the insurer's admitted assets.

(3) The amount in unimproved land shall not exceed one-half of one percent (0.5%) of the insurer's admitted assets.

(4) There shall be no time limit for the disposal of investment real estate."

Section 8. G.S. 58-7-200(c) reads as rewritten:

"(c) ~~No insurer shall make any direct or indirect loan to any of its directors, officers, or controlling stockholders; nor shall the insurer make any loan to any other person in which the officer, director, or stockholder is substantially interested; nor shall any such director, officer, or stockholder directly or indirectly accept any such loan.~~ No insurer shall directly or indirectly invest in or lend its funds to any of its directors, officers, stockholders, or any other person in which an officer, director, or stockholder is interested substantially, nor shall any director, officer, or stockholder directly or indirectly accept such funds."

Section 9. G.S. 58-8-10 reads as rewritten:

"**§ 58-8-10. Policyholders are members of mutual companies.**

Every person insured by a mutual insurance company is a member while ~~his~~ that person's policy is in force, is entitled to one vote for each policy ~~he~~ that person holds, and must be notified of the time and place of holding its meetings by a written notice or by an imprint upon the back of each policy, receipt, or certificate of renewal, as follows:

> The insured is hereby notified that by virtue of this policy ~~he~~ the insured is a member of the ..... insurance company, and that the annual meetings of the company are held at its home office on the ..... day of ....., in each year, at ..... o'clock.

The blanks shall be duly filled in print and are a sufficient notice. A corporation ~~which~~ that becomes a member of ~~such~~ a mutual insurance company may authorize any person to represent ~~it,~~ the corporation; and this representative has all the rights

of an individual member. A person holding property in trust may insure it in ~~such~~ a mutual insurance company, and as trustee assume the liability and be entitled to the rights of a ~~member,~~ member; but that person is not personally liable upon the contract of insurance. Members may vote by proxies, dated and executed within three ~~months,~~ months after receipt, and returned and recorded on the books of the company three days or more before the meeting at which they are to be ~~used; but no person as proxy or otherwise may cast more than 20 votes.~~ used."

Section 10. Article 10 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-10-10. Conversion to stock insurer.**

(a) A domestic mutual insurer may convert to a domestic stock insurer under a plan that is approved in advance by the Commissioner.

(b) The Commissioner shall not approve the plan unless:

(1) It is fair and equitable to the insurer's policyholders.

(2) It is adopted by the insurer's board of directors in accordance with the insurer's bylaws and approved by a vote of not less than two-thirds of the insurer's members voting on it in person, by proxy, or by mail at a meeting called for the purpose of voting on the plan, pursuant to reasonable notice and procedure as approved by the Commissioner. If the company is a life insurer, the right to vote may be limited, as its bylaws provide, to members whose policies are other than term or group policies and have been in effect for more than one year.

(3) Each policyholder's equity in the insurer is determinable under a fair and reasonable formula approved by the Commissioner. The equity shall be based upon the insurer's entire statutory surplus after deducting certificates of contribution, guaranty capital certificates, and similar evidences of indebtedness included in an insurer's statutory surplus.

(4) The policyholders entitled to vote on the plan and participate in the purchase of stock or distribution of assets include all policyholders on the date the plan was adopted by the insurer's board of directors.

(5) The plan provides that each policyholder specified in subdivision (4) of this subsection receives a preemptive right to acquire a proportionate part of all of the proposed capital stock of the insurer or of all of the stock of a corporation affiliated with the insurer within a designated reasonable period as the part is determinable under the plan of conversion; and to apply toward the purchase of the stock the amount of the policyholder's equity in the insurer under subdivision (3) of this subsection. The plan must provide for an equitable distribution of fractional interests.

(6) The plan provides for payment to each policyholder of the policyholder's entire equity in the insurer; with that payment to be

applied toward the purchase of stock to which the policyholder is entitled preemptively or to be made in cash, or both. The cash payment may not exceed fifty percent (50%) of each policyholder's equity. The stock purchased, together with the cash payment, if any, shall constitute full payment and discharge of the policyholder's equity as an owner of the mutual insurer.

(7) Shares are to be offered to policyholders at a price not greater than that of shares to be subsequently offered to others.

(8) The Commissioner finds that the insurer's management has not, through reduction of volume of new business written, through policy cancellations, or through any other means, sought to (i) reduce, limit, or affect the number or identity of the insurer's members entitled to participate in the plan or (ii) secure for the individuals constituting management any unfair advantage through the plan.

(9) The plan, when completed, provides that the insurer's capital and surplus are not less than the minimum required of a domestic stock insurer transacting the same kinds of insurance, are reasonable in relation to the insurer's outstanding liabilities, and are adequate to meet its financial needs.

(c) With respect to an insurer with a guaranty capital, the conversion plan shall be approved by a vote of not less than two-thirds of the insurer's guaranty capital shareholders and policyholders as provided for in subdivision (b)(2) of this section. The plan may provide for the issuance of stock in exchange for outstanding guaranty capital shares at their redemption value subject to the conditions in subsection (b) of this section.

(d) The Commissioner may schedule a public hearing on the proposed conversion plan.

(e) The Commissioner may retain, at the mutual insurer's expense, any attorneys, actuaries, economists, accountants, or other experts not otherwise a part of the Commissioner's staff as may be reasonably necessary to assist the Commissioner in reviewing the proposed conversion plan.

(f) The corporate existence of the mutual company continues in the stock company created under this section. All assets, rights, franchises, and interests of the former mutual insurer, in and to real or personal property, are deemed to be transferred to and vested in the stock insurer, without any other deed or transfer; and the stock insurer simultaneously assumes all of the obligations and liabilities of the former mutual insurer.

(g) The Commissioner may adopt rules to carry out the provisions of this section."

Section 11. G.S. 58-16-5 reads as rewritten:

"**§ 58-16-5. Conditions of ~~admission.~~ licensure.**

A foreign or alien insurance company may be ~~admitted and authorized~~ licensed to do business when it:

(1) Deposits with the Commissioner a certified copy of its charter or certificate of organization and a statement of its financial condition and business, in ~~such~~ the form and detail ~~as he~~ that the Commissioner requires, signed and sworn to by its president and secretary or other proper officer, and pays for the filing of this statement the sum required by law.

(2) Satisfies the Commissioner that it is fully and legally organized under the laws of its state or government to do the business it proposes to ~~transact,~~ transact as direct insurance or assumed reinsurance and that it has been successful in the conduct of ~~such~~ that business; that it has, if a stock company, a free surplus and a fully paid-up and unimpaired capital, exclusive of stockholders' obligations of any description of an amount not less than that required for the organization of a domestic company writing the same kinds of business; and if a mutual company that its free surplus is not less than that required for the organization of a domestic company writing the same kind of business, and that ~~such~~ the capital, surplus, and other funds are invested in substantial accordance with the requirements ~~of Articles 1 through 64~~ of this Chapter.

(3) Repealed by Session Laws 1995, c. 517, s. 6.

(4) Repealed by Session Laws 1987, c. 629, s. 20.

(5) Files with the Commissioner a certificate that it has complied with the laws of the state or government under which it was organized and is authorized to make contracts of insurance.

(6) Satisfies the Commissioner that it is in substantial compliance with ~~the provisions of~~ G.S. 58-7-21, 58-7-26, 58-7-30, and 58-7-31 and Article 13 of this Chapter.

(7) Satisfies the Commissioner that it is in compliance with the company name requirements of G.S. 58-7-35.

(8) Satisfies the Commissioner that it is in substantial compliance with the requirements of G.S. 58-7-37 pertaining to the background of its officers and directors.

(9) Files with the Commissioner an instrument appointing the Commissioner as the company's agent on whom any legal process under G.S. 58-16-30 may be served. This appointment is irrevocable as long as any liability of the company remains outstanding in this State. A copy of this instrument, certified by the Commissioner, is sufficient evidence of this appointment; and service upon the Commissioner is sufficient service upon the company."

Section 12. G.S. 58-16-6 reads as rewritten:

"**§ 58-16-6. Conditions of continued licensure.**

In order for a foreign insurance company to continue to be licensed, it shall report any changes in the documents filed under ~~G.S. 58-16-5(1) or G.S. 58-16-5(5),~~ G.S. 58-16-5, maintain the amounts of capital and surplus specified in G.S. 58-16-5(2), and remain in substantial compliance with the statutes listed in G.S. 58-16-5(6) ~~and G.S. 58-16-5(7).~~ through G.S. 58-16-5(8)."

Section 13. G.S. 58-19-25(a) reads as rewritten:

"(a) Every insurer that is licensed to do business in this State and that is a member of an insurance holding company system shall register with the Commissioner, except a foreign insurer subject to the registration requirements and standards adopted by statute or regulation in the jurisdiction of its domicile that are substantially similar to those contained ~~in this section and G.S. 58-19-30 or a provision such as the following: Each registered insurer shall keep current the information required to be disclosed in its registration statement by reporting all material changes or additions within 15 days after the end of the month in which it learns of each change or addition. The insurer shall also file a copy of its registration statement and any amendments to the statement in each state in which that insurer is authorized to do business if requested by the insurance regulator of that state.~~ in:

(1) This section.

(2) G.S. 58-19-30(a), 58-19-30(c), and 58-19-30(d).

(3) G.S. 58-19-30(b) or a provision such as the following: Each registered insurer shall keep current the information required to be disclosed in its registration statement by reporting all material changes or additions within 15 days after the end of the month in which it learns of each change or addition. The insurer shall also file a copy of its registration statement and any amendments to the statement in each state in which that insurer is authorized to do business, if requested by the insurance regulator of that state.

Any insurer that is subject to registration under this section shall register within 30 days after it becomes subject to registration, and an amendment to the registration statement shall be filed by March 1 of each year for the previous calendar year; unless the Commissioner for good cause shown extends the time for registration or filing, and then within the extended time. All registration statements shall contain a summary, on a form prescribed by the Commissioner, outlining all items in the current registration statement representing changes from the prior registration statement. The Commissioner may require any insurer that is a member of a holding company system that is not subject to registration under this section to furnish a copy of the registration statement or other information filed by the insurance company with the insurance regulator of its domiciliary jurisdiction."

Section 14. G.S. 58-19-30(b) reads as rewritten:

"(b) The following transactions involving a domestic insurer and any person in its holding company system may not be entered into unless the insurer has notified the Commissioner in writing of its intention to enter into the transaction at least 30 days before the transaction, or such shorter period as the Commissioner permits, and the Commissioner has not disapproved it within that period:

(1) Sales, purchases, exchanges, loans or extensions of credit, guarantees, or investments, provided the transactions equal or exceed: (i) with respect to nonlife insurers, the lesser of three percent (3%) of the insurer's admitted assets or twenty-five percent (25%) of surplus as regards policyholders; (ii) with respect to life insurers, three percent (3%) of the insurer's admitted assets; each as of the preceding December 31.

(2) Loans or extensions of credit to any person who is not affiliated, where the insurer makes the loans or extensions of credit with the agreement or understanding that the proceeds of the transactions, in whole or in substantial part, are to be used to make loans or extensions of credit to, to purchase assets of, or to make investments in, any affiliate of the insurer making the loans or extensions of credit provided the transactions equal or exceed: (i) with respect to nonlife insurers, the lesser of three percent (3%) of the insurer's admitted assets or twenty-five percent (25%) of surplus as regards policyholders; (ii) with respect to life insurers, three percent (3%) of the insurer's admitted assets; each as of the preceding December 31.

(3) Reinsurance agreements or modifications to the agreements in which the reinsurance premium or a change in the insurer's liabilities equals or exceeds five percent (5%) of the insurer's surplus as regards policyholders, as of the preceding December 31, including those agreements that may require as consideration the transfer of assets from an insurer to a nonaffiliate, if an agreement or understanding exists between the insurer and nonaffiliate that any portion of the assets will be transferred to one or more affiliates of the insurer.

(4) All management agreements, service contracts, guarantees, or cost-sharing arrangements.

(4a) Direct or indirect acquisitions or investments in a person that controls the insurer or an affiliate of the insurer in an amount which, together with its present holdings in the investments, exceeds two and one-half percent (2.5%) of the insurer's surplus to policyholders. Direct or indirect acquisitions or investments in subsidiaries acquired under G.S. 58-19-10, or in nonsubsidiary insurance affiliates that are subject to the provisions of this Article, are exempt from this requirement.

(5) Any material transactions, specified by rule, that the Commissioner determines may adversely affect the interests of the insurer's policyholders."

Section 15. G.S. 58-26-25 reads as rewritten:

"**§ 58-26-25. Amount of unearned premium reserve.**

subsection (b) of this section. The Commissioner may prescribe a form to be used to provide notice under this subsection.

(d) Any domestic insurer that has a management contract or custodial agreement shall file a statement on or before March 1 of each year, for the preceding calendar year, disclosing (i) total charges incurred by the insurer under the contract; (ii) any salaries, commissions, or other valuable consideration paid by the insurer directly to any officer, director, or shareholder of the management or custodian firm; and (iii) other information concerning the contract or the management or custodian firm as may be included from time to time in any registration forms adopted or approved by the Commissioner. The Commissioner may prescribe a form to be used to provide the information required by this subsection.

(e) Any domestic insurer that has a management contract may request an exemption from the filing requirements of this section if the contract is for a group of affiliated insurers on a pooled funds basis or service company management basis, where costs to the individual member insurers are charged on an actually incurred or closely estimated basis. The request for an exemption must be in writing, must explain the basis for the exemption, and must be received by the Commissioner on or before the effective date of the contract. As used in this subsection, 'affiliated' has the same meaning as in G.S. 58-19-5(1). Management contracts exempted under this subsection must still be reduced to written form."

Section 18. G.S. 58-34-15 reads as rewritten:

"**§ 58-34-15. Grounds for disapproval.**

(a) The Commissioner must disapprove any management contract or custodial agreement filed under G.S. 58-34-10 if, at any time, the Commissioner finds:

(1) That the service or management charges are based upon criteria unrelated either to the managed insurer's profits or to the reasonable customary and usual charges for ~~such~~ the services or are based on factors unrelated to the value of ~~such~~ the services to the insurer; or

(2) That management personnel or other employees of the insurer are to be performing management functions and receiving any remuneration ~~therefor~~ for those functions through the management or service contract in addition to the compensation by way of salary received directly from the insurer for their services; or

(3) That the contract would transfer substantial control of the insurer or any of the powers vested in the board of directors, by statute, articles of incorporation, or bylaws, or substantially all of the basic functions of the insurance company management; or

(4) That the contract contains provisions that would be clearly detrimental to the best interest of policyholders, stockholders, or members of the insurer; or

(5) That the officers and directors of the management or custodial firm are of known bad character or have been affiliated, directly or indirectly, through ownership, control, management, reinsurance

transactions, or other insurance or business relations with any person known to have been involved in the improper manipulation of assets, accounts, or reinsurance.

(6) That the custodial agreement is not substantially the same as the form adopted by the Commissioner.

(b) If the Commissioner disapproves any management contract or custodial agreement, notice of ~~such action~~ the disapproval shall be given to the insurer assigning the reasons ~~therefor~~ for the disapproval in writing. The Commissioner shall grant any party to the contract a hearing ~~upon request according to G.S. 58-2-50.~~ if the party requests a hearing."

Section 19. G.S. 58-65-95 reads as rewritten:

"**§ 58-65-95. Investments and reserves.**

~~No~~(a) Except as provided in subsection (e) of this section, no corporation subject to this Article shall invest in any securities other than securities permitted ~~by the laws of this State~~ by Article 7 of this Chapter for the investment of ~~assets of life insurance companies, banks, trust companies, executors, administrators and guardians.~~ assets.

(b) Every ~~such~~ corporation ~~after the first full year of doing business after the passage of this Article and Article 66 of this Chapter~~ subject to this Article shall accumulate and maintain, in addition to proper reserves for current administrative liabilities and whatever reserves are deemed to be adequate and proper by the Commissioner ~~of Insurance~~ for unpaid ~~hospital and/or medical and/or~~ hospital, medical, or dental bills, and unearned membership dues, a special contingent surplus or reserve at the following rates annually of its gross annual collections from membership dues, exclusive of receipts from cost plus plans, until ~~said~~ the reserve ~~shall equal~~ equals an amount that is three times its average monthly expenditures for ~~hospital and/or medical and/or dental~~ claims and administrative and selling expenses:

(1) First $200,000 ..... 4%
(2) Next $200,000 ..... 2%
(3) All above $400,000 ..... 1%

(c) Any ~~such~~ corporation subject to this Article may accumulate and maintain a contingent reserve in excess of the ~~reserve hereinabove provided for,~~ reserve required in subsection (b) of this section, not to exceed an amount equal to six times the average monthly expenditures for ~~hospital and/or medical and/or dental~~ claims and administrative and selling expenses.

(d) ~~In the event~~ If the Commissioner ~~of Insurance~~ finds that special conditions exist warranting an increase or decrease in the reserves or schedule of ~~reserves, hereinabove provided for, it may be modified by~~ reserves in subsection (b) of this section, the Commissioner ~~of Insurance accordingly,~~ may modify them accordingly. ~~provided~~ Provided, however, when special conditions exist warranting an increase in ~~said~~ the schedule of reserves, ~~said~~ the schedule shall not be increased by the Commissioner ~~of Insurance~~ until a reasonable length of time ~~shall have~~ has elapsed after the Commissioner gives notice of ~~such~~ the increase.

(e) The cost of investments made by service corporations in mortgage loans, authorized by G.S. 58-7-179, with any one person, shall not exceed the lesser of five

percent (5%) of the service corporation's admitted assets of ten percent (10%) of the service corporation's capital and surplus. A service corporation shall not invest in additional mortgage loans without the Commissioner's consent if the admitted value of all such mortgage loans held by the service corporation exceeds an aggregate of sixty percent (60%) of the admitted assets of the service corporation, if (i) the admitted value of all mortgage pass-through securities permitted by G.S. 58-7-173(17) does not exceed twenty-five percent (25%) of the admitted assets of the service corporation and (ii) the admitted value of other mortgage loans permitted by G.S. 58-7-179 does not exceed forty percent (40%) of the admitted assets of the service corporation. A service corporation that, as of October 1, 1997, has mortgage investments that exceed the aggregate limitation specified in this subsection shall submit to the Commissioner no later than January 31, 1998, a plan to bring the amount of mortgage investments into compliance with the limitations by January 1, 2001."

Section 20. Article 65 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-65-102. Financial statements; examinations.**

(a) Every corporation organized under this Article is subject to G.S. 58-2-165.

(b) Service corporations organized under this Article shall be examined under G.S. 58-2-131, 58-2-132, and 58-2-133."

Section 21. Article 67 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-67-56. Financial statements.**

Every HMO under this Chapter is subject to G.S. 58-2-165."

Section 22. G.S. 58-3-90, 58-65-100, 58-65-105, and 58-67-55 are repealed.

Section 23. This act becomes effective October 1, 1997.

GENERAL ASSEMBLY OF NORTH CAROLINA
1997 SESSION

SESSION LAW 1997-468
SENATE BILL 299

AN ACT TO PROVIDE LONG-TERM CARE BENEFITS FOR QUALIFIED EMPLOYEES, RETIRED EMPLOYEES, AND THEIR DEPENDENTS UNDER THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN.

The General Assembly of North Carolina enacts:

Section 1. G.S. 135-38(c) reads as rewritten:

"(c) The Committee shall review programs of hospital, medical and related care provided by Part 3 of this Article and programs of long-term care benefits provided by Part 4 of this Article as recommended by the Executive Administrator and Board of Trustees of the Plan. The Executive Administrator and the Board of Trustees shall provide the Committee with any information or assistance requested by the Committee in performing its duties under this Article."

Section 2. G.S. 135-39.5(22) reads as rewritten:

"(22) ~~Providing to the Industrial Commission the schedule of allowable charges under the Plan for each participating hospital and other information deemed necessary by the Commission to fulfill its duties under G.S. 97-26.~~ Implementing and administering a program of long-term care benefits pursuant to Part 4 of this Article."

Section 3. G.S. 135-39.6 reads as rewritten:

"**§ 135-39.6. Special funds created.**

(a) There are hereby established two special funds, to be known as the Public Employee Health Benefit Fund and the Health Benefit Reserve ~~Fund.~~ Fund for the payment of hospital and medical benefits.

All premiums, fees, charges, rebates, refunds or any other receipts including, but not limited to, earnings on investments, occurring or arising in connection with health benefits programs established by this Article, shall be deposited into the Public Employee Health Benefit Fund. Disbursements from the Fund shall include any and all amounts required to pay the benefits and administrative costs of such programs as may be determined by the Executive Administrator and Board of Trustees.

Any unencumbered balance in excess of prepaid premiums or charges in the Public Employee Health Benefit Fund at the end of each fiscal year shall be used first, to provide an actuarially determined Health Benefit Reserve Fund for incurred but unpresented claims, second, to reduce the premiums required in providing the benefits of the health benefits programs, and third to improve the plan, as may be provided by the General Assembly. The balance in the Health Benefits Reserve Fund may be transferred from time to time to the Public Employee Health Benefit Fund to provide for any deficiency occurring therein.

The Public Employee Health Benefit Fund and the Health Benefit Reserve Fund shall be deposited with the State Treasurer and invested as provided in G.S. 147-69.2 and 147-69.3.

(b) Disbursement from the Public Employee Health Benefit Fund may be made by warrant drawn on the State Treasurer by the Executive Administrator, or the Executive Administrator and Board of Trustees may by contract authorize the Claims Processor to draw the warrant.

(c) Separate and apart from the special funds authorized by subsections (a) and (b) of this section, there shall be a Public Employee Long-Term Care Benefit Fund if the long-term care benefits provided by Part 4 of this Article are administered on a self-insured basis."

Section 4. G.S. 135-39.6A reads as rewritten:

"**§ 135-39.6A. Premiums set.**

(a) The Executive Administrator and Board of Trustees shall, from time to time, establish premium rates for the Comprehensive Major Medical Plan except as they may be established by the General Assembly in the Current Operations Appropriations Act, and establish regulations for payment of the premiums. Premium rates shall be established for coverages where Medicare is the primary payer of health benefits separate and apart from the rates established for coverages where Medicare is not the primary payer of health benefits.

(b) The Executive Administrator and Board of Trustees shall establish separate premium rates for the long-term care benefits provided by Part 4 of this Article if the benefits are administered on a self-insured basis."

Section 5. G.S. 135-39.8 reads as rewritten:

"**§ 135-39.8. Rules and regulations.**

The Executive Administrator and Board of Trustees may issue rules and regulations to implement Parts ~~2 and 3~~ 2, 3, and 4 of this Article. Rules and regulations of the Board of Trustees shall remain in effect until amended or repealed by the Executive Administrator and Board of Trustees. The Executive Administrator and Board of Trustees shall provide a written description of the rules and regulations issued under this section to all employing units, all health benefit representatives, the oversight team provided for in G.S. 135-39.3, all relevant health care providers affected by a rule or regulation, and to any other parties requesting a written description and approved by the Executive Administrator and Board of Trustees to receive a description on a timely basis."

Section 6. G.S. 135-40.7 is amended by adding a new subdivision to read:

"(19) Charges for services covered by the long-term care benefit provisions of Part 4 of this Article."

Section 7. Article 3 of Chapter 135 of the General Statutes is amended by adding a new Part to read:

"Part 4. Long-Term Care Benefits.

"**§ 135-41. Undertaking.**

(a) The State of North Carolina undertakes to make available an optional program of long-term care benefits for the benefit of its qualified employees, retired employees, and their dependents which will pay benefits in accordance with the terms hereof. Retired employees of the Local Governmental Employees' Retirement System pursuant to Article 3 of Chapter 128 of the General Statutes and their dependents are also eligible to be qualified for the benefits provided by this Part.

(b) The long-term care benefits provided by this Part shall be made available through the Teachers' and State Employees' Comprehensive Major Medical Plan pursuant to Articles 2 and 3 of this Chapter (hereinafter called the 'Plan') and administered by the Plan's Executive Administrator and Board of Trustees. In administering the benefits provided by this Part, the Executive Administrator and

Board of Trustees shall have the same type of powers and duties that are provided under Part 3 of this Article for hospital and medical benefits. The benefits provided by this Part may be offered by the Plan on a self-insured basis, in which case a third-party claims processor shall be chosen through competitive bids in accordance with State law, or through a contract of insurance, in which case a carrier licensed to do business in North Carolina shall be selected on a competitive bid basis in accordance with State law.

(c) The benefits authorized by this Part are available only to qualified employees and retired employees who voluntarily elect to provide such benefits for themselves and their qualified dependents. Payroll deductions shall be available from employee salary and disability benefit payments and from retired employee retirement benefit payments for fully contributory premium amounts.

(d) The Executive Administrator and Board of Trustees of the Plan shall insure insofar as possible that the long-term care benefits provided by this Part shall be tax-qualified under federal law.

"**§ 135-41.1. Long-term care benefits.**

Long-term care benefits provided by this Part are subject to elimination periods, coinsurance provisions, and other limitations separate and apart from those provided for in Part 3 of this Article. No limitation on out-of-pocket expenses are provided for the benefits covered by this section. Long-term care benefits are as follows:

(1) Nursing Home Benefits. -- The Plan will pay a fixed amount of the reasonable and customary daily charges allowed for nursing facilities providing skilled nursing care and intermediate nursing care up to a maximum amount per day for each day after a fixed number of consecutive days for each nursing home stay. Such daily charges shall be inclusive of semiprivate room and board; skilled and semiskilled nursing services; routine laboratory tests and examinations; physical, occupational, and speech therapy; respiratory and other gas therapy; and drugs, injections, biologicals, fluids, solutions, dietary aids and supplements, and other routine medical supplies and equipment. Readmission to a nursing home within 180 days, exclusive of hospital stays, for the same or related cause or causes shall be considered a single nursing home stay for the purposes of this section. Benefits payable under this subdivision are contingent upon compliance with the following conditions and will, in no instance, be paid under this section without compliance with each of the following conditions:

a. Confinement to a nursing home is medically appropriate due to an illness, disease, or injury upon recommendation of an admitting physician other than a proprietor, employee, or agent of the nursing home;

b. Confinement to a nursing home is for any overnight stay for which a charge for a day's stay is due and payable; and

c. Prior to confinement, the admitting physician secures approval certification from the Plan for confinement.

As used in this section, a nursing home is a facility or a part of a facility which is (i) operated under State law and which is qualified as a skilled nursing or intermediate nursing facility under Medicare; or is (ii) a facility meeting the requirements for licensure under Chapter 131E of the General Statutes.

(2) Custodial Benefits. -- The Plan will pay a fixed percentage of the fixed amount of reasonable and customary daily charges allowed by the Plan in subdivision (1) of this section for assisted living facilities, for adult day care facilities, and for home care agencies

up to a maximum amount per day for each day after a fixed number of consecutive days that such custodial care is provided. Benefits payable under this subdivision are contingent upon compliance with the following conditions and will, in no instance, be paid under this subdivision without compliance with each of the following conditions:

a. Use of such custodial benefits is medically appropriate in a treatment plan established and certified initially and at least once every six months by an attending physician or other allied health professionals other than a proprietor, employee, or agent of one or more of the aforementioned facilities and agencies;

b. Confinement to a nursing home would be medically appropriate without custodial care proposed to be rendered by one or more of the aforementioned facilities or agencies; and

c. Prior to use of such custodial benefits, an attending physician or other allied health professional secures approval from the Plan for the use of the benefits.

As used in this section, an assisted living facility is a facility which (i) is operated under State law to provide residential care for the aged or disabled whose principal need is a home which provides personal care appropriate to their age or disability; or (ii) meets the requirements for licensure under Chapter 131D of the General Statutes. As used in this section, an adult care facility is a facility which (i) is operated under State law to provide group care for the aged and disabled in a setting away from their residence on a less than 24-hour basis when such aged or disabled would otherwise be in need of full-time personal care away from their residence; or (ii) meets the requirements for certification under Chapter 131D of the General Statutes. As used in this section, a home care agency is a residential care agency which is (i) operated under State law and which is qualified as a home health care agency under Medicare; or (ii) an agency meeting the requirements for licensure as a home care agency under Chapter 131E of the General Statutes.

(3) Other Benefits. -- Upon prior approval of the Plan, other care, services, supplies, and equipment may be used as more cost-effective alternatives to the benefits provided by this section when directed by an attending physician.

(4) The Executive Administrator and Board of Trustees of the Plan shall establish the payment percentages, maximum daily payment rates, benefit periods, elimination periods, and maximum lifetime benefits payable for each covered individual for the nursing home and custodial benefits provided by this section. The Executive Administrator and Board of Trustees shall provide for inflationary increases in the maximum daily payment rates and the maximum lifetime benefits payable for each covered individual.

(5) The Executive Administrator and Board of Trustees of the Plan shall provide a bed reservation benefit whenever Plan members are hospitalized during a stay in a nursing home or an assisted living facility.

(6) The Executive Administrator and Board of Trustees of the Plan shall provide for a waiver of premiums involving minimum lengths of stay in a nursing home or an assisted living facility. In addition, the Executive Administrator and Board of Trustees shall allow coverage to be reinstated upon failure to pay premiums, provided

certain grace periods are not exceeded and retroactive premium payments are made.

(7) Limitations and Exclusions to Long-Term Care Benefits. -- The benefits provided by this section are for the purpose of meeting the requirements for assistance from the loss of functional capacity associated with a chronic illness, disease, or disabling injury for extended periods of time; and are, in no way, intended to duplicate the benefits provided for acute and other medical care provided by Medicare or Part 3 of this Article. A loss of functional capacity can occur from: (i) an illness, disease, or disabling injury resulting in a physical incapacity to perform the activities of daily living; or (ii) an irreversible organic mental impairment resulting in a mental incapacity. Activities of daily living consist of routine functions involving personal care and mobility.

"**§ 135.41.2. Conversion.**

Upon cessation of group coverage under this Part, an employee, retired employee, or dependent shall be entitled to a conversion to a nongroup plan of long-term care benefits. The Executive Administrator and Board of Trustees of the Plan shall determine how the conversion rights authorized by this Part shall be administered.

"**§ 135.41.3. Right to alter, amend, or repeal.**

The General Assembly reserves the right to alter, amend, or repeal this Part."

Section 8. This act becomes effective January 1, 1998.

In the General Assembly read three times and ratified this the 21st day of August, 1997.

s/ Marc Basnight
President Pro Tempore of the Senate

s/ Harold J. Brubaker
Speaker of the House of Representatives

s/ James B. Hunt, Jr.
Governor

Approved 4:16 p.m. this 1st day of September, 1997

NORTH CAROLINA GENERAL ASSEMBLY
LEGISLATIVE ACTUARIAL NOTE

BILL NUMBER: SB 299

SHORT TITLE: Long-Term Care Benefits

SPONSOR(S): Sen. Bob Martin

SYSTEM OR PROGRAM AFFECTED: Teachers' and State Employees' Comprehensive Major Medical Plan.

FUNDS AFFECTED: Fully Contributory Premium Payments for Coverages Selected by Eligible Employees, Retired Employees, and Their Dependents.

BILL SUMMARY: The bill makes available an optional group program of long-term care benefits for teachers and state employees and retired teachers and state employees who elect to pay for the program by making fully contributory premium payments for themselves and their eligible dependents. Long-term care benefits provide treatment, therapeutic, rehabilitative, maintenance, and personal care help to individuals who are unable to care for themselves because of a prolonged chronic illness, injury, or disability. Eligible dependents can include not only spouses and children, but parents, parents-in-law, and grandparents as well. The program is to be provided through the Teachers' and State Employees' Comprehensive Major Medical Plan. The Plan's Executive Administrator and Board of Trustees are authorized to provide the program either on a self-insured basis or through a competitively bid contract of insurance from a commercial insurer.

Nursing home benefits are provided for skilled and intermediate nursing care when confinement to a nursing home is medically appropriate for an illness, disease, or injury upon recommendation of an admitting physician. Medical appropriateness is based upon a physical inability to perform the activities of daily living or upon mental disorientation. Employees, retired employees, and their dependents can select from a menu of daily amounts that will be paid for nursing home stays, along with the number of days that the daily amount will be paid, which together constitute a lifetime benefit.

Custodial benefits are provided as a percentage of the daily amount chosen by employees, retired employees, and their dependents for nursing home stays when a nursing home stay would otherwise be medically appropriate. The percentage is chosen by employees, retired employees, and their dependents from a menu of options. Benefits would be payable for services provided by assisted living facilities, which include adult care homes, family care homes, group homes for developmentally disabled adults, and multiunit assisted housing services, as well as for services provided by adult day care facilities and home care agencies. Use of custodial benefits is contingent upon recommendation of such services by an attending physician or other allied health professional, such as a registered nurse, licensed clinical social worker, or licensed physical, occupational, respiratory, or speech therapist.

Other alternative long-term care benefits are also available under the bill to employees, retired employees, and their dependents who elect such

benefits. Prior approval of the Plan and an attending physician is required before such benefits will be payable. A menu of other alternative benefits might include caregiver training, rehabilitation equipment, respite services, in-home meals, in-home safety devices, hospice, homemaker services, and chore services. Coordinated care and case management services could also be available to help employees, retired employees, and their dependents choose appropriate levels of care and contain costs.

Employees, retired employees, and their dependents would choose from among several elimination periods before nursing home and custodial benefits are paid. Elimination periods are initial periods of a stay for which benefits are not payable. Inflationary increases to daily benefits and lifetime benefits are also available to those selecting coverage. Such increases may be compounded or be a fixed daily amount. The bill provides a bed reservation benefit when residents of a nursing home or an assisted living facility are hospitalized. Waiver of premiums are provided for minimum lengths of stay in a nursing or assisted living facility. Retroactive premium payments are also included for failure to pay premiums because of functional incapacity. Benefits would include clinically diagnosed cases of Alzheimer's disease and related degenerative and dementing illnesses. Benefits would also be required to be tax-qualified under federal law. As such, age-based premiums would be eligible for federal income tax deductions. Federal qualification would further require that only two activities of daily living (eating, bathing, dressing, transferring, toileting, and continence) qualify for functional incapacity for a duration of at least 90 days. Additional federal measures include guaranteed renewability and the option for nonforfeiture of benefits in which premiums are returned or a reduced amount of paid-up benefits are provided upon cancellation of coverage. Employees, retired employees, and their dependents could convert to a non-group form of long-term care benefits upon a cessation of group benefits provided by the Plan.

Benefits provided under the bill could include most all eligible members of the Teachers' and State Employees' Comprehensive Major Medical Plan on a guaranteed issue basis, in which case exclusions for preexisting health conditions would be required, or medical underwriting criteria could be used for selective enrollments without any preexisting health condition exclusions. The General Assembly's Committee on Employee Hospital and Medical Benefits would have an oversight responsibility on implementation and operation of the long-term care benefits provided under the bill.

EFFECTIVE DATE: January 1, 1998.

ESTIMATED IMPACT ON STATE: The consulting actuary for the Plan, Aon Consulting, and the consulting actuary of the General Assembly's Fiscal Research Division, Dilts, Umstead & Dunn, both estimate that the Plan will incur some administrative expense for implementing and monitoring the payment of the benefits provided by the bill.

This administrative expense is estimated by the Plan to be $115,000 annually plus an additional one-time amount of $45,000 for implementation. However, such expenses are expected to be covered or recovered by premiums paid by employees and retired employees electing to purchase the benefits for themselves and their dependents. The actual claim costs for the benefits provided by the bill will also be paid by those electing to purchase the benefits through fully contributory premiums. Consequently, *no additional claim costs are expected to be borne by the Plan through employer-provided funds.*

ASSUMPTIONS AND METHODOLOGY: The Comprehensive Major Medical Plan for Teachers and State Employees is divided into two programs. From October, 1982, through June, 1986, the Plan had only a self-funded indemnity type of program which covered all employees, retired employees, eligible dependents of employees and retired employees, and eligible former employees and their eligible dependents authorized to continue coverage past a termination of employment other than for retirement or disability purposes. A prepaid program of coverage by health maintenance organizations (HMOs) was offered in July, 1986, as an alternative to the Plan's self-insured indemnity program. The benefits of the self-insured indemnity type of program are spelled out in Part 3 of Article 3 of Chapter 135 of the North Carolina General Statutes (i.e., $250 annual deductible, 20% coinsurance up to $1,000 annually, etc. paid by the program's members). HMOs are required to offer benefits that are comparable to those provided by the self-insured indemnity program. Employer-paid non-contributory premiums are only authorized for the indemnity program's coverage for employees and most retired employees. All other types of premium in the indemnity program are fully contributory. Premiums paid by employers to HMOs are limited to like amounts paid to the indemnity program with employees and retired employees paying any HMO amounts above the indemnity program's non-contributory rates. Both types of coverage continue to be available in the Plan with twelve HMOs currently covering about 25% of the Plan's total population in about 85 of the State's 100 counties. The Plan's employees and retired employees select the type of program that they wish for themselves and their dependents during the months of August and September of each year for coverage beginning in October. The demographics of the Plan as of December 31, 1996, include:

	Self-Insured Indemnity Program	Alternative HMOs	Plan Total
Number of Participants			
Active Employees	186,400	70,400	256,800
Active Employee Dependents	104,700	51,800	156,500
Retired Employees	84,400	5,400	89,800
Retired Employee Dependents	14,400	1,200	15,600
Former Employees & Dependents with Continued Coverage	2,700	800	3,500
Total Enrollments	392,600	129,600	522,200
Number of Contracts			
Employee Only	206,300	51,800	258,100
Employee & Child(ren)	29,900	14,500	44,400
Employee & Family	36,600	10,100	46,700
Total Contracts	272,800	76,400	349,200
Percentage of Enrollment by Age			
29 & Under	27.3%	44.7%	31.6%
30-44	21.6	28.0	23.2
45-54	20.0	17.8	19.5
55-64	13.8	7.1	12.1
65 & Over	17.3	2.4	13.6

Percentage of Enrollment by Sex			
Male	39.8%	40.0%	39.8%
Female	60.2	60.0	60.2

Asssumptions for Long-Term Care Benefits: Long-term care benefits sponsored by employers have been available only since the late 1980's. Based upon a survey by the Health Insurance Association of America, employer-sponsored long-term care plans only numbered 5 in 1988. By 1990, this number had grown to more than 80 and by 1994, almost 1,000 employers were sponsoring long-term care plans. Employee participation in these plans was typically 2-10%, although some employers, like Ford Motor Co., achieved participation rates as high as 15% of salaried workers. Increased life expectancies spawned by medical advances have led to this increased emphasis upon long-term care benefits. The U. S. Bureau of the Census now forecasts that by the year 2050, the average lifespan for males could be almost 80 years with the same average for females exceeding 85 years. Current estimates place the average lifespan for males at a little over 70 years and at almost 80 years for females. As a result, many older citizens will outlive their financial resources. A 1995 study of public-private long-term care partnership programs in Connecticut, Indiana, New York, and California established by the states, commercial insurers, and the Robert Wood Johnson Foundation to stimulate the long-term care benefit market has provided some benchmark data by which to judge the demand for long-term care benefits. Approximately 60% of the purchasers were female. Average ages of purchasers ranged from 59 in Connecticut to 69 in Indiana. The average age for group purchasers was 49 whereas the average age for individual purchasers was 64.

In comparison with the foregoing experiences of other employers and in other states, the Teachers' and State Employees' Comprehensive Major Medical Plan has the following membership data as of December 31, 1996, for Plan members age 40 and over, which is the primary age group for purchasers of long-term care benefits:

	Number of Members by Age				
Plan	40-49	50-59	60-69	70 +	Total
Indemnity Plan					
Employees	68,400	43,900	9,100	500	121,900
Employee Depend.	9,800	7,600	2,200	100	19,700
Tot. Employee Group	78,200	51,500	11,300	600	141,600
Retirees	1,200	10,300	31,300	41,400	84,200
Retiree Depend.	600	2,300	4,900	3,700	11,500
Tot. Retiree Group	1,800	12,600	36,200	45,100	95,700
Tot. Indemnity Plan	80,000	64,100	47,500	45,700	237,300
Average Age					57 Years
Percent Female					63%
HMOs					
Employees	22,900	11,800	1,900	100	36,700
Employee Depend.	3,600	1,700	400	-	5,700
Tot. Employee Group	26,500	13,500	2,300	100	42,400
Retirees	200	1,300	2,500	1,400	5,400
Retiree Depend.	-	200	300	200	700
Tot. Retiree Group	200	1,500	2,800	1,600	6,100
Total HMOs	26,700	15,000	5,100	1,700	48,500
Average Age					50 Years

Percent Female					62%
Total Plan					
Employees	91,300	55,700	11,000	600	158,600
Employee Depend.	13,400	9,300	2,600	100	25,400
Tot. Employee Group	104,700	65,000	13,600	700	184,000
Retirees	1,400	11,600	33,800	42,800	89,600
Retiree Depend.	600	2,500	5,200	3,900	12,200
Tot. Retiree Group	2,000	14,100	39,000	46,700	101,800
Total Plan	106,700	79,100	52,600	47,400	285,800
Average Age					56 Years
Percent Female					63%

Based upon the Plan's population and the experiences of other employers and in other states, it is estimated that some 6,000 long-term care benefit contracts could be purchased through the Plan by the year 2000, provided the Plan has a sufficient number of contacts located throughout the State to service the benefits. In addition, given the increased visibility of long-term care benefits stimulated by the 104th Congress' inclusion of the benefits in the Health Insurance Portability and Accountability Act of 1996, it would not be unreasonable to assume that an additional 2,000 to 3,000 contracts could be issued through the Plan by the year 2000 just from the Act alone.

Currently, the State of North Carolina has licensed or registered the following number of long-term care facilities to serve the 8,000 to 9,000 contracts that could be issued through the Plan:

Nursing Facilities	362
Nursing Facilities in Hospitals	52
Homes for the Aged	481
Family Care Homes	723
Developmentally Disabled Adult Group Homes	211
Multiunit Assisted Housing Services	5
Home Care Agencies	868
Adult Day Care Facilities	73

According to information supplied by the North Carolina Health Care Facilities Association and the North Carolina Association of Long Term Care Facilities, the average daily charge in the State for a private-pay resident in a nursing home is about $100 for skilled and intermediate care and about $50 for a private-pay stay in an assisted living residence. The average statewide charge per visit for home care agencies in the indemnity program of the Comprehensive Major Medical Plan for Teachers and State Employees is about $85 for skilled nursing and physical, speech, and occupational therapy, $110 for clinical social workers, and $50 for home health aides.

Before concluding the assumptions used for long-term care benefits, mention should be made of a previous State effort in offering such coverage. The State Retirement Systems, in May, 1991, began a program of long-term care insurance for retired members of the Teachers' and State Employees' Retirement System, the Consolidated Judicial Retirement System, the Legislative Retirement System, and the Local Governmental Employees' Retirement System. By the end of 1992, some 80 contracts were in effect through monthly retirement payroll deduction of premiums. By the end of 1994, some 240 contracts were in effect through payroll deduction of

premiums. By the end of 1996, some 580 contracts were in effect through monthly retirement payroll deduction of premiums plus another 300 contracts in effect with direct payments of annual premiums. In comparison, the total number of retired members of the several Retirement Systems was about 113,000 at the same time.

SOURCES OF DATA:

-Actuarial Note, Dilts, Umstead & Dunn, Senate Bill 299, March 12, 1997, original of which is on file in the General Assembly's Fiscal Research Division.

-Actuarial Note, Aon Consulting, Senate Bill 299, March 21, 1997, original of which is on file with the Comprehensive Major Medical Plan for Teachers and State Employees and the General Assembly's Fiscal Research Division.

TECHNICAL CONSIDERATIONS: The proposed G. S. 135-41.1(2)c. on page 5 of the bill needs to be amended by adding the words "or other allied health professional" between the words "physician" and "secures".

FISCAL RESEARCH DIVISION
733-4910
PREPARED BY: Sam Byrd
APPROVED BY: Tom L. Covington**TomC**
DATE: April 1, 1997.

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MEMORANDUM

TO: Senator Bob Martin

FROM: Sam Byrd, Fiscal Research Division

DATE: April 1, 1997

SUBJECT: Actuarial Note (Senate Bill 299)

Re: Long-Term Care Benefits Provided under the Teachers' & State Employees' Health Benefit Plan for Employees and Retirees Electing Such Benefits.

In accordance with North Carolina General Statute 120-114 and applicable Rules of the North Carolina Senate and House of Representatives, attached is a certified copy of an original actuarial note on the above subject as prepared by the General Assembly's Consulting Actuary. A certified copy of an original actuarial note on the same subject from the Plan Administrator's Consulting Actuary is also attached for your review.

cc: Sen. Tommy Jenkins, Committee on Pensions & Retirement and Insurance
Principal Clerk, Senate

Attachment(s):
(1) Senate Bill 299.
(2) Actuarial Note, Dilts, Umstead & Dunn, Senate Bill 299, March 12, 1997.
(3) Actuarial Note, Aon Consulting, Senate Bill 299, March 21, 1997.

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

S

SENATE BILL 299

Short Title: Long-term Care Benefits. (Public)

Sponsors: Senators Martin of Pitt; Albertson, Hoyle, Kerr, and Perdue.

Referred to: Pensions & Retirement and Insurance.

March 5, 1997

A BILL TO BE ENTITLED

AN ACT TO PROVIDE LONG-TERM CARE BENEFITS FOR QUALIFIED EMPLOYEES, RETIRED EMPLOYEES, AND THEIR DEPENDENTS UNDER THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN.

The General Assembly of North Carolina enacts:

Section 1. G.S. 135-38(c) reads as rewritten:

"(c) The Committee shall review programs of hospital, medical and related care provided by Part 3 of this Article and programs of long-term care benefits provided by Part 4 of this Article as recommended by the Executive Administrator and Board of Trustees of the Plan. The Executive Administrator and the Board of Trustees shall provide the Committee with any information or assistance requested by the Committee in performing its duties under this Article."

Section 2. G.S. 135-39.5(22) reads as rewritten:

"(22) ~~Providing to the Industrial Commission the schedule of allowable charges under the Plan for each participating hospital and other information deemed necessary by the Commission to fulfill its duties under G.S. 97-26.~~ Implementing and administering a program of long-term care benefits pursuant to Part 4 of this Article."

Section 3. G.S. 135-39.6 reads as rewritten:

"**§ 135-39.6. Special funds created.**

(a) There are hereby established two special funds, to be known as the Public Employee Health Benefit Fund and the Health Benefit Reserve ~~Fund.~~ Fund for the payment of hospital and medical benefits.

All premiums, fees, charges, rebates, refunds or any other receipts including, but not limited to, earnings on investments, occurring or arising in connection with health benefits programs established by this Article, shall be deposited into the Public Employee Health Benefit Fund. Disbursements from the Fund shall include any and all amounts required to pay the benefits and administrative costs of such programs as may be determined by the Executive Administrator and Board of Trustees.

Any unencumbered balance in excess of prepaid premiums or charges in the Public Employee Health Benefit Fund at the end of each fiscal year shall be used first, to provide an actuarially determined Health Benefit Reserve Fund for incurred but unpresented claims, second, to reduce the premiums required in providing the benefits of the health benefits programs, and third to improve the plan, as may be provided by the General Assembly. The balance in the Health Benefits Reserve Fund may be transferred from time to time to the Public Employee Health Benefit Fund to provide for any deficiency occurring therein.

The Public Employee Health Benefit Fund and the Health Benefit Reserve Fund shall be deposited with the State Treasurer and invested as provided in G.S. 147-69.2 and 147-69.3.

(b) Disbursement from the Public Employee Health Benefit Fund may be made by warrant drawn on the State Treasurer by the Executive Administrator, or the Executive Administrator and Board of Trustees may by contract authorize the Claims Processor to draw the warrant.

(c) Separate and apart from the special funds authorized by subsections (a) and (b) of this section there shall be a Public Employee Long-Term Care Benefit Fund if the long-term care benefits provided by Part 4 of this Article are administered on a self-insured basis."

Section 4. G.S. 135-39.6A reads as rewritten:

"**§ 135-39.6A. Premiums set.**

(a) The Executive Administrator and Board of Trustees shall, from time to time, establish premium rates for the Comprehensive Major Medical Plan except as they may be established by the General Assembly in the Current Operations Appropriations Act, and establish regulations for payment of the premiums. Premium rates shall be established for coverages where Medicare is the primary payer of health benefits separate and apart from the rates established for coverages where Medicare is not the primary payer of health benefits.

(b) The Executive Administrator and Board of Trustees shall establish separate premium rates for the long-term care benefits provided by Part 4 of this Article if the benefits are administered on a self-insured basis."

Section 5. G.S. 135-39.8 reads as rewritten:

"**§ 135-39.8. Rules and regulations.**

The Executive Administrator and Board of Trustees may issue rules and regulations to implement Parts ~~2 and 3~~ 2, 3, and 4 of this Article. Rules and

regulations of the Board of Trustees shall remain in effect until amended or repealed by the Executive Administrator and Board of Trustees. The Executive Administrator and Board of Trustees shall provide a written description of the rules and regulations issued under this section to all employing units, all health benefit representatives, the oversight team provided for in G.S. 135-39.3, all relevant health care providers affected by a rule or regulation, and to any other parties requesting a written description and approved by the Executive Administrator and Board of Trustees to receive a description on a timely basis."

Section 6. G.S. 135-40.7 is amended by adding a new subdivision to read:

"(19) Charges for services covered by the long-term care benefit provisions of Part 4 of this Article."

Section 7. Article 3 of Chapter 135 of the General Statutes is amended by adding a new Part to read:

"Part 4. Long-Term Care Benefits.

"**§ 135-41. Undertaking.**

(a) The State of North Carolina undertakes to make available an optional program of long-term care benefits for the benefit of its qualified employees, retired employees, and their dependents which will pay benefits in accordance with the terms hereof.

(b) The long-term care benefits provided by this Part shall be made available through the Teachers' and State Employees' Comprehensive Major Medical Plan pursuant to Articles 2 and 3 of this Chapter (hereinafter called the 'Plan') and administered by the Plan's Executive Administrator and Board of Trustees. In administering the benefits provided by this Part, the Executive Administrator and Board of Trustees shall have the same type of powers and duties that are provided under Part 3 of this Article for hospital and medical benefits. The benefits provided by this Part may be offered by the Plan on a self-insured basis, in which case a third-party claims processor shall be chosen through competitive bids in accordance with State law, or through a contract of insurance, in which case a carrier licensed to do business in North Carolina shall be selected on a competitive bid basis in accordance with State law.

(c) The benefits authorized by this Part are available only to qualified employees and retired employees who voluntarily elect to provide such benefits for themselves and their qualified dependents. Payroll deductions shall be available from employee salary and disability benefit payments and from retired employee retirement benefit payments for fully contributory premium amounts.

(d) The Executive Administrator and Board of Trustees of the Plan shall insure insofar as possible that the long-term care benefits provided by this Part shall be tax-qualified under federal law.

"**§ 135-41.1. Long-term care benefits.**

Long-term care benefits provided by this Part are subject to elimination periods, coinsurance provisions, and other limitations separate and apart from those provided for in Part 3 of this Article. No limitation on out-of-pocket expenses are provided for the benefits covered by this section. Long-term care benefits are as follows:

(1) Nursing Home Benefits. -- The Plan will pay a fixed amount of the reasonable and customary daily charges allowed for nursing facilities providing skilled nursing care and intermediate nursing care up to a maximum amount per day for each day after a fixed number of consecutive days for each nursing home stay. Such daily charges shall be inclusive of semiprivate room and board; skilled and semiskilled nursing services; routine laboratory tests and examinations; physical, occupational, and speech therapy; respiratory and other gas therapy; and drugs, injections, biologicals, fluids, solutions, dietary aids and supplements, and other routine medical supplies and equipment. Readmission to a nursing home within 180 days, exclusive of hospital stays, for the same or related cause or causes shall be considered a single nursing home stay for the purposes of this section. Benefits payable under this subdivision are contingent upon compliance with the following conditions and will, in no instance, be paid under this section without compliance with each of the following conditions:

a. Confinement to a nursing home is medically appropriate due to an illness, disease, or injury upon recommendation of an admitting physician other than a proprietor, employee, or agent of the nursing home;

b. Confinement to a nursing home is for any overnight stay for which a charge for a day's stay is due and payable; and

c. Prior to confinement, the admitting physician secures approval certification from the Plan for confinement.

As used in this section, a nursing home is a facility or a part of a facility which is (i) operated under State law and which is qualified as a skilled nursing or intermediate nursing facility under Medicare; or is (ii) a facility meeting the requirements for licensure under Chapter 131E of the General Statutes.

(2) Custodial Benefits. -- The Plan will pay a fixed percentage of the fixed amount of reasonable and customary daily charges allowed by the Plan in subdivision (1) of this section for assisted living facilities, for adult day care facilities, and for home care agencies up to a maximum amount per day for each day after a fixed number of consecutive days that such custodial care is provided. Benefits payable under this subdivision are contingent upon compliance with the following conditions and will, in no instance, be paid under this subdivision without compliance with each of the following conditions:

a. Use of such custodial benefits is medically appropriate in a treatment plan established and certified initially and at least once every six months by an attending physician or other allied health professionals other than a proprietor,

employee, or agent of one or more of the aforementioned facilities and agencies;

b. Confinement to a nursing home would be medically appropriate without custodial care proposed to be rendered by one or more of the aforementioned facilities or agencies; and

c. Prior to use of such custodial benefits, an attending physician secures approval from the Plan for the use of the benefits.

As used in this section, an assisted living facility is a facility which (i) is operated under State law to provide residential care for the aged or disabled whose principal need is a home which provides personal care appropriate to their age or disability; or (ii) meets the requirements for licensure under Chapter 131D of the General Statutes. As used in this section, an adult care facility is a facility which (i) is operated under State law to provide group care for the aged and disabled in a setting away from their residence on a less than 24-hour basis when such aged or disabled would otherwise be in need of full-time personal care away from their residence; or (ii) meets the requirements for certification under Chapter 131D of the General Statutes. As used in this section, a home care agency is a residential care agency which is (i) operated under State law and which is qualified as a home health care agency under Medicare; or (ii) an agency meeting the requirements for licensure as a home care agency under Chapter 131E of the General Statutes.

(3) Other Benefits. -- Upon prior approval of the Plan, other care, services, supplies, and equipment may be used as more cost-effective alternatives to the benefits provided by this section when directed by an attending physician.

(4) The Executive Administrator and Board of Trustees of the Plan shall establish the payment percentages, maximum daily payment rates, benefit periods, elimination periods, and maximum lifetime benefits payable for each covered individual for the nursing home and custodial benefits provided by this section. The Executive Administrator and Board of Trustees shall provide for inflationary increases in the maximum daily payment rates and the maximum lifetime benefits payable for each covered individual.

(5) The Executive Administrator and Board of Trustees of the Plan shall provide a bed reservation benefit whenever Plan members are hospitalized during a stay in a nursing home or an assisted living facility.

(6) The Executive Administrator and Board of Trustees of the Plan shall provide for a waiver of premiums involving minimum lengths of stay in a nursing home or an assisted living facility. In addition, the Executive Administrator and Board of Trustees shall allow coverage to be reinstated upon failure to pay premiums, provided

certain grace periods are not exceeded and retroactive premium payments are made.

(7) Limitations and Exclusions to Long-Term Care Benefits. -- The benefits provided by this section are for the purpose of meeting the requirements for assistance from the loss of functional capacity associated with a chronic illness, disease, or disabling injury for extended periods of time; and are, in no way, intended to duplicate the benefits provided for acute and other medical care provided by Medicare or Part 3 of this Article. A loss of functional capacity can occur from: (i) an illness, disease, or disabling injury resulting in a physical incapacity to perform the activities of daily living; or (ii) an irreversible organic mental impairment resulting in a mental incapacity. Activities of daily living consist of routine functions involving personal care and mobility.

"**§ 135.41.2. Conversion.**

Upon cessation of group coverage under this Part, an employee, retired employee, or dependent shall be entitled to a conversion to a nongroup plan of long-term care benefits. The Executive Administrator and Board of Trustees of the Plan shall determine how the conversion rights authorized by this Part shall be administered.

"**§ 135.41.3. Right to alter, amend, or repeal.**

The General Assembly reserves the right to alter, amend, or repeal this Part."

Section 8. This act becomes effective January 1, 1998.

DILTS, UMSTEAD & DUNN

ACTUARIAL CONSULTING

MARK V. HARTMAN, FSA, MAAA, MCA, EA

Phone: (910) 731-4038
Fax: (910) 731-2583

668 Link Road
Lexington, NC 27295

ACTUARIAL NOTE
True & Exact Copy of Original
Certified By: Sam Byrd Date: 4-1-97
Legislative Fiscal Research

March 12, 1997

Mr. Sam Byrd
Fiscal Research Division
North Carolina General Assembly
300 N. Salisbury Street
Raleigh, NC 27603-5925

Re: Senate Bill 299: Addition of Long Term Care Benefits to Teachers' and State Employees' Health Benefit Plan

Dear Mr. Byrd:

This bill would modify Article 3 of Chapter 135 of the General Statutes to include a new Part 4 providing long term care benefits through the North Carolina Teachers and State Employees Comprehensive Major Medical Plan, effective January 1, 1998. Benefits would be provided for qualified employees, retired employees, and their dependents on an optional basis. Election to participant in the plan is on a voluntary basis, and those who elect to participant would provide for their benefits through fully contributory premiums.

The bill provides that long term care benefits may be provided on either a self-insured basis or through a contract of insurance. If benefits are provided on a self-insured basis, separate premium rates for long term care benefits would be established by the Executive Administrator and Board of Trustees, and a separate Public Employees Long Term Care Benefit Fund would be established.

Adding long term care benefits would produce additional administrative costs for the plan. However, these costs are expected to be covered by the employee premium rates established. Thus, if this bill is passed, any additional costs to the Health Benefit Plan would be negligible.

If you have any questions, give me a call.

Sincerely,

Mark Hartman

Mark V. Hartman, FSA, MAAA, MCA, EA
Consulting Actuary

MVH/jj

NORTH CAROLINA TEACHERS' & STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN

• • •

SENATE BILL 299
Long Term Care Benefits

ACTUARIAL NOTE

True & Exact Copy of Original

Certified By: _____ **Date:** 4-1-97

Legislative Fiscal Research

Prepared by:

Aon Consulting
One Piedmont Center
3565 Piedmont Road, N.E.
Atlanta, Georgia 30363

March 1997

Alexander & Alexander
Consulting Group

ACTUARIAL STATEMENT

The State of North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan (Plan) has requested that Aon Consulting prepare an Actuarial Note in response to an Actuarial Note Request entitled An Act to Provide Long-Term Care Benefits for Qualified Employees, Retired Employees, and their Dependents Under the Teachers' and State Employees' Comprehensive Major Medical Plan.

The Actuarial Note was prepared according to generally accepted actuarial principles and practices, in compliance with General Statute 120-114, and within the confidentiality requirements of General Statute 120-129 through 120-134. As required by statute, the Note includes an explanatory statement of the proposed change(s) and, to the extent possible, an estimate of the financial and actuarial effect of the proposed change(s) on the Plan. The Actuarial Note makes no comment or opinion with regard to the merits of the measure for which the Note is prepared; however, any identified technical or mechanical defects have been noted.

We have reviewed the input and results of our analysis for reasonableness, and relied upon the data and information provided by the Plan and their Claims Processing Contractor.

Kenneth C. Vieira, F.S.A., M.A.A.A., E.A.
Consulting Actuary

3/21/97
Date

Professional Peer Review by:

Fred W. Munzenmaier, F.S.A., M.A.A.A., E.A.
Managing Director

3/21/97
Date

Alexander & Alexander
Consulting Group

LONG-TERM CARE BENEFITS

PLAN CHANGE

Senate Bill 299 proposes that the North Carolina Teachers' & State Employees' Comprehensive Major Medical Plan (Plan) provide long-term care benefits for qualified employees, retired employees, and their dependents. The proposed bill does not provide for a subsidy from the State or its participating employer entities. The proposed long-term care plan will therefore be financially supported through the voluntary contributions from eligible participants.

The proposed bill establishes the framework for participant eligibility and the terms and conditions of coverage. The proposed act becomes law effective January 1, 1998

PROJECTED COST IMPACT

	% Increase			Based on "Midpoint" Increase (in 000's)		
Plan Design Change	Low	Mid	High	First Year Cost $	Second Year Cost $	Third Year Cost $
Requiring the Plan to assume the design and management of a voluntary long-term care program	None - All cost will be recovered through administrative fee charges to carrier.					

Based on the assumption that a fully insured product is adopted initially. Design and maintenance of a self-insured program will incur significantly increased costs.

PRICING APPROACH

- As the market for long-term care benefits is relatively immature and most carrier experience is with fully-insured plans, a prudent strategy for initial implementation is to fully insure the plan. This approach minimizes the State's risk and assures that the voluntary participants fund the entire cost for the program. As the plan gains experience, the State could request a transfer of assets from the carrier and assume management of a self-insured approach. (This note assumes that the Plan incurs negligible cost as the carrier includes all costs in its fully insured rates.)

- The cost to implement a fully insured long-term care plan is limited to plan design, vendor research, and carrier negotiations. These first year expenses are estimated to not exceed $50,000. Implementation costs for enrollment forms, plan booklets, and employee communication materials will be paid by the insurance carrier and included in the rate paid by the voluntary participants.

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April 9, 1997

MEMORANDUM

To: Senate Committee on Pensions & Retirement and Insurance

From: M. Lynn Marshbanks, Committee Counsel

Re: Senate Bill 609: Insurance Audit Recommendations

Senate Bill 609 would provide that money credited to the Department of Insurance Consumer Protection Fund could be used to retain experts or professionals needed to analyze or respond to statements or testimony made by other experts or professionals in a rate-making matter or to analyze evidence or exhibits filed or offered by an opposing party in a rate-making matter. The bill would also provide that money recovered from delinquency proceedings is to be credited to the Fund in an amount that would pay expenses associated with the delinquency proceeding, and that money received as recoveries in civil litigation is to be credited to the Fund in an amount that would pay the expenses associated with the civil litigation.

Effective date: October 1, 1997.

S609-SMRS-001

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

North Carolina General Assembly
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April 9, 1997

MEMORANDUM

To: Senate Committee on Pensions & Retirement and Insurance

From: M. Lynn Marshbanks, Committee Counsel

Re: Senate Bill 612: Insurer Financial Operations

Senate Bill 612 does the following:

1. Allows the Commissioner to restrict an insurer's license by prohibiting or limiting the kind or amount of business the insurer can do, and requires that the Commissioner give notice and opportunity for a hearing before revoking, suspending, restricting, or refusing to renew a license. Also allows the Commissioner to do one of these things if any representative of the insurer (now, just "the insurer") refuses to submit to any examination authorized by law or to perform any legal obligation in relation to an examination.

2. Requires that if a foreign insurer's license is suspended or revoked, the Commissioner must give written notification to all the insurer's agents in the State. The insurer may not write any new business in this State until the license and authority to do business in this State is restored.

3. Allows the Commissioner to restrict as well as suspend, revoke, or refuse to renew, the license of an insurer that fails to make any required NAIC filing or to pay all related filing fees.

4. Requires that, before a license is issued to a new domestic insurance company, each key person (proposed officer, director, or any other individual in a position to influence operating decisions), must give fingerprints and a recent photograph to the Commissioner. The fingerprints will be forwarded to the SBI, and if warranted to the FBI, for a criminal record check. The Commissioner may refuse to approve the company if the Commissioner finds one of several specified conditions, including: untrue material statement regarding the background or experience of a key person; violation of insurance laws by a key person; fraud in obtaining a license; or felony conviction of a key person. The applicant may ask for a hearing if denied a license.

5. Prohibits a domestic insurance company from paying dividends or other distributions to its stockholders when the Commissioner determines that might cause a hazardous financial condition. Prohibits a company from declaring dividends except from the unassigned

surplus of the company as reflected in the company's most recent financial statement filed with the Commissioner.

6. Amends G.S. 58-7-170(c), concerning diversification of investments made by an insurer in mortgage loans. The cost of investments with any one person or a single collateral package would be 3% of the insurer's admitted assets. There would be a 60% aggregate limitation. An insurer with mortgage investments exceeding the limitations must submit to the Commissioner by January 31, 1998, a plan to comply by January 1, 2003.

7. Allows an insurer to acquire, develop, manage, and dispose of certain income-producing real estate through partnership interests, under certain specified conditions.

8. Provides that a domestic mutual insurer may convert to a domestic stock insurer under a plan approved in advance by the Commissioner, and specifies under what circumstances the Commissioner may approve the plan.

9. Provides that a domestic insurer and a person in its holding company system may not enter into direct or indirect acquisitions or investments in a person that controls, or is an affiliate of, the insurer, in an amount that exceeds 2.5% of the insurer's surplus to policyholders, without notifying the Commissioner and unless the Commissioner does not disapprove the transaction.

10. Amends the requirements for unearned premium reserve and requires each title insurer to file an actuarial certification conforming to NAIC standards.

11. Requires every hospital, medical, and dental service corporation to make annual reports to the Commissioner, and provides that they are subject to examination of their records by the Commissioner. Requires annual reports by HMOs.

Effective date: October 1, 1997.

S612-SMRS-001

Pension &Retirement/ Insurance Committee

April 9,1997
15 minutes after session
1124 LOB

Sen. Jenkins, Chairman

AGENDA

SB 190 Increase Pension Benefits- 2
Sen. Warren

SB 747 1997 Retirement Benefits Act

Pensions & Retirement/ Insurance Committee Meeting

MINUTES

The Pensions & Retirement/ Insurance Committee met April 9,1997 at 4:15 in room 1124 of the Legislative Building. There were ten members in attendance including Sen. Jenkins, who presided.

SB 190 **Increase Pension Benefits -2.** Sen. Warren explained the bill. Sen. Wellons moved for a favorable report. The motion carried. Sen. Jenkins referred the bill to Appropriations.

SB 747 **1997 Retirement Benefits Act.** Sen. Jenkins called upon Sen. Soles to preside. Sen. Jenkins explained the bill . He asked Dennis Ducker, Deputy State Treasurer to give further explanation. Sen. Jenkins moved for a favorable report. The motion carried. Sen. Jenkins referred the bill to Appropriations.

The meeting was adjourned.

Sen. Jenkins, Chairman

Katy Haynes, Clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

PENSIONS & RETIREMENT/ INSURANCE COMMITTEE REPORT
Senator Tommy Jenkins, Chairman

Thursday, April 10, 1997

SENATOR TOMMY JENKINS,
submits the following with recommendations as to passage:

FAVORABLE

S.B. **190** Increase Pension Benefits.
Sequential Referral: None
Recommended Referral: Appropriations

S.B. **747** 1997 Retirement Benefits Act.
Sequential Referral: None
Recommended Referral: Appropriations

TOTAL REPORTED: 2

Committee Clerk Comment: None

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

S 1

SENATE BILL 190

Short Title: Increase Pension Benefits. (Public)

Sponsors: Senators Warren; Albertson, Conder, East, Garwood, Jordan, Kerr, Page, Phillips, Plyler, Reeves, and Soles.

Referred to: Pensions and Retirement and Insurance.

February 19, 1997

A BILL TO BE ENTITLED

AN ACT TO INCREASE THE MONTHLY BENEFITS FROM THE NORTH CAROLINA FIREMEN'S AND RESCUE SQUAD WORKERS' PENSION FUND.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-86-55 reads as rewritten:

"**§ 58-86-55. Monthly pensions upon retirement.**

Any member who has served 20 years as an 'eligible fireman' or 'eligible rescue squad worker' in the State of North Carolina, as provided in G.S. 58-86-25 and G.S. 58-86-30, and who has attained the age of 55 years is entitled to be paid a monthly pension from this fund. The monthly pension shall be in the amount of ~~one hundred thirty-five dollars ($135.00)~~ one hundred fifty dollars ($150.00) per month. Any retired fireman receiving a pension ~~of one hundred ten dollars ($110.00) per month~~ shall, effective July 1, ~~1995,~~ 1997, receive a pension of ~~one hundred thirty-five dollars ($135.00)~~ one hundred fifty dollars ($150.00) per month.

Members shall pay ten dollars ($10.00) per month as required by G.S. 58-86-35 and G.S. 58-86-40 for a period of no longer than 20 years. No 'eligible rescue squad member' shall receive a pension prior to July 1, 1983. No member shall be entitled to a pension hereunder until the member's official duties as a fireman or rescue squad worker for which the member is paid compensation shall have been terminated and the member shall have retired as such according to standards or rules fixed by the board of trustees.

A member who is totally and permanently disabled while in the discharge of the member's official duties as a result of bodily injuries sustained or as a result of extreme exercise or extreme activity experienced in the course and scope of those official duties and who leaves the fire or rescue squad service because of this disability shall be entitled to be paid from the fund a monthly benefit in an amount of ~~one hundred thirty-five dollars ($135.00)~~ one hundred fifty dollars ($150.00) per month beginning the first month after the member's fifty-fifth birthday. All applications for disability are subject to the approval of the board who may appoint physicians to examine and evaluate the disabled member prior to approval of the application, and annually thereafter. Any disabled member shall not be required to make the monthly payment of ten dollars ($10.00) as required by G.S. 58-86-35 and G.S. 58-86-40.

A member who is totally and permanently disabled for any cause, other than line of duty, who leaves the fire or rescue squad service because of this disability and who has at least 10 years of service with the pension fund, may be permitted to continue making a monthly contribution of ten dollars ($10.00) to the fund until the member has made contributions for a total of 240 months. The member shall upon attaining the age of 55 years be entitled to receive a pension as provided by this section. All applications for disability are subject to the approval of the board who may appoint physicians to examine and evaluate the disabled member prior to approval of the application and annually thereafter.

A member who, because his residence is annexed by a city under Part 2 or Part 3 of Article 4 of Chapter 160A of the General Statutes, or whose department is closed because of an annexation by a city under Part 2 or Part 3 of Article 4 of Chapter 160A of the General Statutes, and because of such annexation is unable to perform as a fireman of any status, and if the member has at least 10 years of service with the pension fund, may be permitted to continue making a monthly contribution of ten dollars ($10.00) to the fund until the member has made contributions for a total of 240 months. The member upon attaining the age of 55 years and completion of such contributions shall be entitled to receive a pension as provided by this section. Any application to make monthly contributions under this section shall be subject to a finding of eligibility by the Board of Trustees upon application of the member.

The pensions provided shall be in addition to all other pensions or benefits under any other statutes of the State of North Carolina or the United States, notwithstanding any exclusionary provisions of other pensions or retirement systems provided by law."

Section 2. This act becomes effective July 1, 1997.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

S 1

SENATE BILL 747

Short Title: 1997 Retirement Benefits Act. (Public)

Sponsors: Senators Jenkins; Albertson, Ballance, Conder, Dalton, Dannelly, Hoyle, Jordan, Kerr, Kinnaird, Lee, Lucas, Martin of Pitt, Miller, Odom, Perdue, Plyler, Rand, Reeves, Soles, Warren, and Wellons.

Referred to: Pensions & Retirement and Insurance.

April 7, 1997

A BILL TO BE ENTITLED

AN ACT TO ENHANCE THE RETIREMENT BENEFITS PAYABLE FROM THE TEACHERS' AND STATE EMPLOYEES' RETIREMENT SYSTEM, THE CONSOLIDATED JUDICIAL RETIREMENT SYSTEM, AND THE LOCAL GOVERNMENTAL EMPLOYEES' RETIREMENT SYSTEM.

The General Assembly of North Carolina enacts:

Section 1. G.S. 135-5(b16) reads as rewritten:

"(b16) Service Retirement Allowance of Members Retiring on or After July 1, ~~1995.~~ 1995, but Before July 1, 1997. -- Upon retirement from service in accordance with subsection (a) or (a1) above, on or after July 1, 1995, but before July 1, 1997, a member shall receive the following service retirement allowance:

(1) A member who is a law enforcement officer or an eligible former law enforcement officer shall receive a service retirement allowance computed as follows:

a. If the member's service retirement date occurs on or after his 55th birthday, and completion of five years of creditable service as a law enforcement officer, or after the completion of 30 years of creditable service, the allowance shall be equal to one and seventy-five hundredths percent (1.75%) of his average final compensation, multiplied by the number of years of his creditable service.

b. If the member's service retirement date occurs on or after his 50th birthday and before his 55th birthday with 15 or more years of creditable service as a law enforcement officer and prior to the completion of 30 years of creditable service, his retirement allowance shall be equal to the greater of:

1. The service retirement allowance payable under G.S. 135-5(b16)(1)a. reduced by one-third of one percent (1/3 of 1%) thereof for each month by which his retirement date precedes the first day of the month coincident with or next following the month the member would have attained his 55th birthday; or
2. The service retirement allowance as computed under G.S. 135-5(b16)(1)a. reduced by five percent (5%) times the difference between 30 years and his creditable service at retirement.

(2) A member who is not a law enforcement officer or an eligible former law enforcement officer shall receive a service retirement allowance computed as follows:

a. If the member's service retirement date occurs on or after his 65th birthday upon the completion of five years of creditable service or after the completion of 30 years of creditable service or on or after his 60th birthday upon the completion of 25 years of creditable service, the allowance shall be equal to one and seventy-five hundredths percent (1.75%) of his average final compensation, multiplied by the number of years of creditable service.

b. If the member's service retirement date occurs after his 60th and before his 65th birthday and prior to his completion of 25 years or more of creditable service, his retirement allowance shall be computed as in G.S. 135-5(b16)(2)a. but shall be reduced by one-quarter of one percent (1/4 of 1%) thereof for each month by which his retirement date precedes the first day of the month coincident with or next following his 65th birthday.

c. If the member's early service retirement date occurs on or after his 50th birthday and before his 60th birthday and after completion of 20 years of creditable service but prior to the completion of 30 years of creditable service, his early service retirement allowance shall be equal to the greater of:

1. The service retirement allowance as computed under G.S. 135-5(b16)(2)a. but reduced by the sum of five-twelfths of one percent (5/12 of 1%) thereof for each month by which his retirement date precedes the first day of the month coincident with or next following

the month the member would have attained his 60th birthday, plus one-quarter of one percent (1/4 of 1%) thereof for each month by which his 60th birthday precedes the first day of the month coincident with or next following his 65th birthday; or

2. The service retirement allowance as computed under G.S. 135-5(b16)(2)a. reduced by five percent (5%) times the difference between 30 years and his creditable service at retirement; or

3. If the member's creditable service commenced prior to July 1, 1994, the service retirement allowance equal to the actuarial equivalent of the allowance payable at the age of 60 years as computed in G.S. 135-5(b16)(2)b.

d. Notwithstanding the foregoing provisions, any member whose creditable service commenced prior to July 1, 1963, shall not receive less than the benefit provided by G.S. 135-5(b)."

Section 2. G.S. 135-5 is amended by adding a new subsection to read:

"(b17) Service Retirement Allowance of Members Retiring on or After July 1, 1997. -- Upon retirement from service in accordance with subsection (a) or (a1) above, on or after July 1, 1997, a member shall receive the following service retirement allowance:

(1) A member who is a law enforcement officer or an eligible former law enforcement officer shall receive a service retirement allowance computed as follows:

a. If the member's service retirement date occurs on or after his 55th birthday, and completion of five years of creditable service as a law enforcement officer, or after the completion of 30 years of creditable service, the allowance shall be equal to one and eighty-one hundredths percent (1.81%) of his average final compensation, multiplied by the number of years of his creditable service.

b. If the member's service retirement date occurs on or after his 50th birthday and before his 55th birthday with 15 or more years of creditable service as a law enforcement officer and prior to the completion of 30 years of creditable service, his retirement allowance shall be equal to the greater of:

1. The service retirement allowance payable under G.S. 135-5(b17)(1)a. reduced by one-third of one percent (1/3 of 1%) thereof for each month by which his retirement date precedes the first day of the month coincident with or next following the month the member would have attained his 55th birthday; or

2. The service retirement allowance as computed under G.S. 135-5(b17)(1)a. reduced by five percent (5%) times the difference between 30 years and his creditable service at retirement.

(2) A member who is not a law enforcement officer or an eligible former law enforcement officer shall receive a service retirement allowance computed as follows:

a. If the member's service retirement date occurs on or after his 65th birthday upon the completion of five years of membership service or after the completion of 30 years of creditable service or on or after his 60th birthday upon the completion of 25 years of creditable service, the allowance shall be equal to one and eighty-one hundredths percent (1.81%) of his average final compensation, multiplied by the number of years of creditable service.

b. If the member's service retirement date occurs after his 60th and before his 65th birthday and prior to his completion of 25 years or more of creditable service, his retirement allowance shall be computed as in G.S. 135-5(b17)(2)a. but shall be reduced by one-quarter of one percent (1/4 of 1%) thereof for each month by which his retirement date precedes the first day of the month coincident with or next following his 65th birthday.

c. If the member's early service retirement date occurs on or after his 50th birthday and before his 60th birthday and after completion of 20 years of creditable service but prior to the completion of 30 years of creditable service, his early service retirement allowance shall be equal to the greater of:

1. The service retirement allowance as computed under G.S. 135-5(b17)(2)a. but reduced by the sum of five-twelfths of one percent (5/12 of 1%) thereof for each month by which his retirement date precedes the first day of the month coincident with or next following the month the member would have attained his 60th birthday, plus one-quarter of one percent (1/4 of 1%) thereof for each month by which his 60th birthday precedes the first day of the month coincident with or next following his 65th birthday; or

2. The service retirement allowance as computed under G.S. 135-5(b17)(2)a. reduced by five percent (5%) times the difference between 30 years and his creditable service at retirement; or

3. If the member's creditable service commenced prior to July 1, 1994, the service retirement allowance

equal to the actuarial equivalent of the allowance payable at the age of 60 years as computed in G.S. 135-5(b17)(2)b.

d. Notwithstanding the foregoing provisions, any member whose creditable service commenced prior to July 1, 1963, shall not receive less than the benefit provided by G.S. 135-5(b)."

Section 3. G.S. 135-5(m) reads as rewritten:

"(m) Survivor's Alternate Benefit. -- Upon the death of a member in service, the principal beneficiary designated to receive a return of accumulated contributions shall have the right to elect to receive in lieu thereof the reduced retirement allowance provided by Option 2 of subsection (g) above computed by assuming that the member had retired on the first day of the month following the date of his death, provided that the following conditions apply:

(1) a. The member had attained such age and/or creditable service to be eligible to commence retirement with an early or service retirement allowance, or

b. The member had obtained 20 years of creditable service in which case the retirement allowance shall be computed in accordance with ~~G.S. 135-5(b16)(1)b.~~ G.S. 135-5(b17)(1)b. or ~~G.S. 135-5(b16)(2)c.,~~ G.S. 135-5(b17)(2)c., notwithstanding the requirement of obtaining age 50.

(2) The member had designated as the principal beneficiary to receive a return of his accumulated contributions one and only one person who was living at the time of his death.

(3) The member had not instructed the Board of Trustees in writing that he did not wish the provisions of this subsection to apply.

For the purpose of this benefit, a member is considered to be in service at the date of his death if his death occurs within 180 days from the last day of his actual service. The last day of actual service shall be determined as provided in subsection (l) of this section. Upon the death of a member in service, the surviving spouse may make all purchases for creditable service as provided for under this Chapter for which the member had made application in writing prior to the date of death, provided that the date of death occurred prior to or within 60 days after notification of the cost to make the purchase. The term "in service" as used in this subsection includes a member in receipt of a benefit under the Disability Income Plan as provided in Article 6 of this Chapter."

Section 4. G.S. 135-5 is amended by adding two new subsections to read:

"(ccc) From and after July 1, 1997, the retirement allowance to or on account of beneficiaries whose retirement commenced on or before July 1, 1996, shall be increased by three percent (3%) of the allowance payable on June 1, 1997, in accordance with G.S. 135-5(o). Furthermore, from and after July 1, 1997, the retirement allowance to or on account of beneficiaries whose retirement commenced after July 1, 1996, but before June 30, 1997, shall be increased by a prorated amount

of three percent (3%) of the allowance payable as determined by the Board of Trustees based upon the number of months that a retirement allowance was paid between July 1, 1996, and June 30, 1997.

(ddd) Increase in Allowance as to Persons on Retirement Rolls as of June 1, 1997. -- From and after July 1, 1997, the retirement allowance to or on account of beneficiaries on the retirement rolls as of June 1, 1997, shall be increased by three and four-tenths percent (3.4 %) of the allowance payable on June 1, 1997. This allowance shall be calculated on the allowance payable and in effect on June 30, 1997, so as not to be compounded on any other increase granted by act of the 1997 General Assembly."

Section 5. G.S. 135-65 is amended by adding a new subsection to read:

"(r) From and after July 1, 1997, the retirement allowance to or on account of beneficiaries whose retirement commenced on or before July 1, 1996, shall be increased by three percent (3%) of the allowance payable on June 1, 1997. Furthermore, from and after July 1, 1997, the retirement allowance to or on account of beneficiaries whose retirement commenced after July 1, 1996, but before June 30, 1997, shall be increased by a prorated amount of three percent (3%) of the allowance payable as determined by the Board of Trustees based upon the number of months that a retirement allowance was paid between July 1, 1996, and June 30, 1997."

Section 6. Required employer salary-related contributions for employees whose salaries are paid from department, office, institution, or agency receipts shall be paid from the same source as the source of the employees' salary. If an employee's salary is paid in part from the General Fund or Highway Fund and in part from department, office, institution, or agency receipts, required employer salary-related contributions may be paid from the General Fund or Highway Fund only to the extent of the proportionate part paid from the General Fund or Highway Fund in support of the salary of the employee, and the remainder of the employer's requirements shall be paid from the source that supplies the remainder of the employee's salary. The requirements of this section as to source of payment are also applicable to payments on behalf of the employee for hospital-medical benefits, longevity pay, unemployment compensation, accumulated leave, workers' compensation, severance pay, separation allowances, and applicable disability income and disability salary continuation benefits.

Section 7. Effective July 1, 1997, the State's employer contribution rates budgeted for retirement and related benefits as a percentage of covered salaries for the 1997-98 fiscal year are (i) ten and eighty-three hundredths percent (10.83%) - Teachers and State Employees; (ii) fifteen and eighty-three hundredths percent (15.83%) - State Law Enforcement Officers; (iii) nine and eighteen hundredths percent (9.18%) - University Employees' Optional Retirement Program; (iv) twenty-two and sixty-five hundredths percent (22.65%) - Consolidated Judicial Retirement System; and (v) twenty-four and fifty-eight hundredths percent (24.58%) - Legislative Retirement System. Each of the foregoing contribution rates includes two percent (2%) for hospital and medical benefits. The rate for State Law Enforcement Officers includes five percent (5%) for the Supplemental Retirement Income Plan. The rates

for Teachers and State Employees, State Law Enforcement Officers, and for the University Employees' Optional Retirement Program include fifty-two hundredths percent (0.52%) for the Disability Income Plan.

Section 8. G.S. 128-27(b15) reads as rewritten:

"(b15) Service Retirement Allowance of Members Retiring on or after July 1, ~~1995.~~ 1995, but before July 1, 1997. -- Upon retirement from service in accordance with subsection (a) or (a1) above, on or after July 1, 1995, but before July 1, 1997, a member shall receive the following service retirement allowance:

(1) A member who is a law enforcement officer or an eligible former law enforcement officer shall receive a service retirement allowance computed as follows:

a. If the member's service retirement date occurs on or after his 55th birthday, and completion of five years of creditable service as a law enforcement officer, or after the completion of 30 years of creditable service, the allowance shall be equal to one and seventy-two hundredths percent (1.72%) of his average final compensation, multiplied by the number of years of his creditable service.

b. If the member's service retirement date occurs on or after his 50th birthday and before his 55th birthday with 15 or more years of creditable service as a law enforcement officer and prior to the completion of 30 years of creditable service, his retirement allowance shall be equal to the greater of:

1. The service retirement allowance payable under G.S. 128-27(b15)(1)a. reduced by one-third of one percent (1/3 of 1%) thereof for each month by which his retirement date precedes the first day of the month coincident with or next following the month the member would have attained his 55th birthday; or

2. The service retirement allowance as computed under G.S. 128-27(b15)(1)a. reduced by five percent (5%) times the difference between 30 years and his creditable service at retirement.

(2) A member who is not a law enforcement officer or an eligible former law enforcement officer shall receive a service retirement allowance computed as follows:

a. If the member's service retirement date occurs on or after his 65th birthday upon the completion of five years of creditable service or after the completion of 30 years of creditable service or on or after his 60th birthday upon the completion of 25 years of creditable service, the allowance shall be equal to one and seventy-two hundredths percent (1.72%) of his average final compensation, multiplied by the number of years of creditable service.

b. If the member's service retirement date occurs after his 60th and before his 65th birthday and prior to his completion of 25 years or more of creditable service, his retirement allowance shall be computed as in G.S. 128-27(b15)(2)a. but shall be reduced by one-quarter of one percent (1/4 of 1%) thereof for each month by which his retirement date precedes the first day of the month coincident with or next following his 65th birthday.

c. If the member's early service retirement date occurs on or after his 50th birthday and before his 60th birthday and after completion of 20 years of creditable service but prior to the completion of 30 years of creditable service, his early service retirement allowance shall be equal to the greater of:

1. The service retirement allowance as computed under G.S. 128-27(b15)(2)a. but reduced by the sum of five-twelfths of one percent (5/12 of 1%) thereof for each month by which his retirement date precedes the first day of the month coincident with or next following the month the member would have attained his 60th birthday, plus one-quarter of one percent (1/4 of 1%) thereof for each month by which his 60th birthday precedes the first day of the month coincident with or next following his 65th birthday; or
2. The service retirement allowance as computed under G.S. 128-27(b15)(2)a. reduced by five percent (5%) times the difference between 30 years and his creditable service at retirement; or
3. If the member's creditable service commenced prior to July 1, 1995, the service retirement allowance equal to the actuarial equivalent of the allowance payable at the age of 60 years as computed in G.S. 128-27(b15)(2)b.

d. Notwithstanding the foregoing provisions, any member whose creditable service commenced prior to July 1, 1965, shall not receive less than the benefit provided by G.S. 128-27(b)."

Section 9. G.S. 128-27 is amended by adding a new subsection to read:

"(b16) Service Retirement Allowance of Members Retiring on or After July 1, 1997. -- Upon retirement from service in accordance with subsection (a) or (a1) above, on or after July 1, 1997, a member shall receive the following service retirement allowance:

(1) A member who is a law enforcement officer or an eligible former law enforcement officer shall receive a service retirement allowance computed as follows:

a. If the member's service retirement date occurs on or after his 55th birthday, and completion of five years of creditable service as a law enforcement officer, or after the completion of 30 years of creditable service, the allowance shall be equal to one and seventy-six hundredths percent (1.76%) of his average final compensation, multiplied by the number of years of his creditable service.

b. If the member's service retirement date occurs on or after his 50th birthday and before his 55th birthday with 15 or more years of creditable service as a law enforcement officer and prior to the completion of 30 years of creditable service, his retirement allowance shall be equal to the greater of:

1. The service retirement allowance payable under G.S. 128-27(b16)(1)a. reduced by one-third of one percent (1/3 of 1%) thereof for each month by which his retirement date precedes the first day of the month coincident with or next following the month the member would have attained his 55th birthday; or

2. The service retirement allowance as computed under G.S. 128-27(b16)(1)a. reduced by five percent (5%) times the difference between 30 years and his creditable service at retirement.

(2) A member who is not a law enforcement officer or an eligible former law enforcement officer shall receive a service retirement allowance computed as follows:

a. If the member's service retirement date occurs on or after his 65th birthday upon the completion of five years of creditable service or after the completion of 30 years of creditable service or on or after his 60th birthday upon the completion of 25 years of creditable service, the allowance shall be equal to one and seventy-six hundredths percent (1.76%) of his average final compensation, multiplied by the number of years of creditable service.

b. If the member's service retirement date occurs after his 60th and before his 65th birthday and prior to his completion of 25 years or more of creditable service, his retirement allowance shall be computed as in G.S. 128-27(b16)(2)a. but shall be reduced by one-quarter of one percent (1/4 of 1%) thereof for each month by which his retirement date precedes the first day of the month coincident with or next following his 65th birthday.

c. If the member's early service retirement date occurs on or after his 50th birthday and before his 60th birthday and after completion of 20 years of creditable service but prior to the

completion of 30 years of creditable service, his early service retirement allowance shall be equal to the greater of:

1. The service retirement allowance as computed under G.S. 128-27(b16)(2)a. but reduced by the sum of five-twelfths of one percent (5/12 of 1%) thereof for each month by which his retirement date precedes the first day of the month coincident with or next following the month the member would have attained his 60th birthday, plus one-quarter of one percent (1/4 of 1%) thereof for each month by which his 60th birthday precedes the first day of the month coincident with or next following his 65th birthday; or
2. The service retirement allowance as computed under G.S. 128-27(b16)(2)a. reduced by five percent (5%) times the difference between 30 years and his creditable service at retirement; or
3. If the member's creditable service commenced prior to July 1, 1995, the service retirement allowance equal to the actuarial equivalent of the allowance payable at the age of 60 years as computed in G.S. 128-27(b16)(2)b.

d. Notwithstanding the foregoing provisions, any member whose creditable service commenced prior to July 1, 1965, shall not receive less than the benefit provided by G.S. 128-27(b)."

Section 10. G.S. 128-27 is amended by adding two new subsections to read:

"(ss) From and after July 1, 1997, the retirement allowance to or on account of beneficiaries whose retirement commenced on or before July 1, 1996, shall be increased by three percent (3%) of the allowance payable on June 1, 1997, in accordance with G.S. 128-27(k). Furthermore, from and after July 1, 1997, the retirement allowance to or on account of beneficiaries whose retirement commenced after July 1, 1996, but before June 30, 1997, shall be increased by a prorated amount of three percent (3%) of the allowance payable as determined by the Board of Trustees based upon the number of months that a retirement allowance was paid between July 1, 1996, and June 30, 1997.

(tt) Increase in Allowance as to Persons on Retirement Rolls as of June 1, 1997. -- From and after July 1, 1997, the retirement allowance to or on account of beneficiaries on the retirement rolls as of June 1, 1997, shall be increased by two and three-tenths percent (2.3 %) of the allowance payable on June 1, 1997. This allowance shall be calculated on the allowance payable and in effect on June 30, 1997, so as not to be compounded on any other increase payable under subsection (k) of this section or otherwise granted by act of the 1997 General Assembly."

Section 11. G.S 128-27(m) reads as rewritten:

"(m) Survivor's Alternate Benefit. -- Upon the death of a member in service, the principal beneficiary designated to receive a return of accumulated contributions shall have the right to elect to receive in lieu thereof the reduced retirement allowance provided by Option two of subsection (g) above computed by assuming that the member had retired on the first day of the month following the date of his death, provided that all three of the following conditions apply:

(1) a. The member had attained such age and/or creditable service to be eligible to commence retirement with an early or service retirement allowance, or

b. The member had obtained 20 years of creditable service in which case the retirement allowance shall be computed in accordance with ~~G.S. 128-27(b15)(1)b.~~ G.S. 128-27(b16)(1)b. or ~~G.S. 128-27(b15)(2)c.,~~ G.S. 128-27(b16)(2)c., notwithstanding the requirement of obtaining age 50.

(2) The member had designated as the principal beneficiary to receive a return of his accumulated contributions one and only one person who is living at the time of his death.

(3) The member had not instructed the Board of Trustees in writing that he did not wish the provisions of this subsection apply.

For the purpose of this benefit, a member is considered to be in service at the date of his death if his death occurs within 180 days from the last day of his actual service. The last day of actual service shall be determined as provided in subsection (l) of this section. Upon the death of a member in service, the surviving spouse may make all purchases for creditable service as provided for under this Chapter for which the member had made application in writing prior to the date of death, provided that the date of death occurred prior to or within 60 days after notification of the cost to make the purchase."

Section 12. This act becomes effective July 1, 1997.

State of North Carolina
Department of the Treasurer

HARLAN E. BOYLES
STATE TREASURER

April 10, 1997

325 NORTH SALISBURY STREET
RALEIGH, NORTH CAROLINA 27603-1385

The Honorable Beverly M. Perdue
Co-Chair of the Senate Committee on Appropriations
Suite 629 of the Legislative Office Building
Raleigh, North Carolina

The Honorable Aaron W. Plyler
Co-Chair of the Senate Committee on Appropriations
Suite 627 of the Legislative Office Building
Raleigh, North Carolina

The Honorable Thomas LaF. Odom
Chair of the Senate Committee on Base Budget
Suite 300-B of the Legislative Office Building
Raleigh, North Carolina

Re: Recommendations on Retirement System Benefit Enhancements

Dear Senators Perdue, Plyler and Odom:

This is written in my capacities as State Treasurer and as ex officio Chairman of the Boards of Trustees of the Teachers' and State Employees' Retirement System and the Local Governmental Employees' Retirement System. My purpose in writing is to make you fully aware of our legislative recommendations for the current Session and to urge your support of these benefit enhancements.

Our total package of recommended benefit enhancements is embodied in Senate Bill 747, which is now before the Senate Appropriations Committee. Our recommendations included in this legislation are as follows:

- a 3% cost-of-living adjustment for retirees and other beneficiaries in the Teachers' and State Employees' Retirement System, the Local Governmental Employees' Retirement System, and the Consolidated Judicial Retirement System, which assumes that State employees will be granted a 3% across-the-board increase in salary;

- an increase from 1.75% to 1.81% in the formula accrual rate for current members' future retirement in the Teachers' and State Employees' Retirement System, with a corresponding adjustment in the monthly allowances of retirees and other beneficiaries equal to 3.4% and,

- an increase from 1.72% to 1.76% in the formula accrual rate for current members' future retirement in the Local Governmental Employees' Retirement System, with a corresponding adjustment in the monthly allowances of retirees and other beneficiaries equal to 2.3%.

All costs associated with this legislation are borne by use of the Retirement Systems' unencumbered actuarial gains, primarily from investments, and would require no additional appropriations beyond continuation of current contributions and funding. Continuation of the current contribution rates for the Retirement Systems would be sufficient to fund these benefit enhancements.

This legislation has the universal support and endorsement of all the organizations representing teachers, State employees, law enforcement officers, State and local governmental retirees, and local governments. This legislation contains all of the benefit enhancements and recommendations of the Retirement Systems' Boards of Trustees.

We will leave to your judgment whether to consider our recommendations for inclusion with your expansion budget, as has been the past practice, or to further consider Senate Bill 747 separately.

Again, we urge your support and ask for your assistance with this legislation.

Very truly yours,

Harlan E. Boyles
State Treasurer

HEB/dsp

cc: Senator Marc Basnight
Senator Thomas K. Jenkins ✓

North Carolina General Assembly
Legislative Services Office

George R. Hall, Legislative Services Officer
(919) 733-7044

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16 W. Jones Street
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Terrence D. Sullivan, Director
Research Division
Suite 545, LOB
300 N. Salisbury St.
Raleigh, NC 27603-5925
(919) 733-2578

April 8, 1997

MEMORANDUM

TO: Senator Tommy Jenkins

FROM: Stanley Moore SM
Fiscal Research Division

SUBJECT: Actuarial Note (Senate Bill 747)

Re: **Teachers' and State Employees' Retirement System** - Increases the accrual rate for active members from 1.75% to 1.81% for each year of service, grants an adjusting increase of 3.4% to retirees as a result of the accrual rate change and provides a post-retirement increase of three percent (3%) in the benefits of retirees. The bill also set the State's employer contribution rates as a percent of covered salaries for 1997-98. **Consolidated Judicial Retirement System** - Provides a post-retirement increase of three percent (3%) in the benefits of retirees. **Local Governmental Employees' Retirement System** - Increases the accrual rate for active members from 1.72% to 1.76% for each year of service, grants an adjusting increase of 2.3% to retirees as a result of the accrual rate change and provides a post-retirement increase of three percent (3%) in the benefits of retirees.

In accordance with North Carolina General Statute 120-114 and applicable Rules of the North Carolina Senate and House of Representatives, attached is a certified copy of an original actuarial note on the above subject as prepared by the General Assembly's Consulting Actuary. A certified copy of an original actuarial note on the same subject from the Plan Administrator's Consulting Actuary is also attached for your review.

cc: Senate Principal Clerk

Attachment(s):
(1) Legislative Actuarial Note
(2) Actuarial Note, Buck Consultants, April 7, 1997
(3) Actuarial Note. Dilts, Umstead & Dunn, April 4, 1997

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

NORTH CAROLINA GENERAL ASSEMBLY

LEGISLATIVE ACTUARIAL NOTE

BILL NUMBER: Senate Bill 747

SHORT TITLE: 1997 Retirement Benefits Act

SPONSOR(S): Senator Jenkins

SYSTEM OR PROGRAM AFFECTED: Teacher's & State Employees' Retirement System, Consolidated Judicial Retirement System and Local Governmental Employees' Retirement System

FUNDS AFFECTED: General Fund, Highway Fund, Receipt Fund and Local Funds

BILL SUMMARY: Teachers' and State Employees' Retirement System - Increases the accrual rate for active members from 1.75% to 1.81% for each year of service, grants an adjusting increase of 3.4% to retirees as a result of the accrual rate change and provides a post-retirement increase of three percent (3%) in the benefits of retirees. The bill also set the State's employer contribution rates as a percent of covered salaries for 1997-98. **Consolidated Judicial Retirement System** - Provides a post-retirement increase of three percent (3%) in the benefits of retirees. **Local Governmental Employees' Retirement System** - Increases the accrual rate for active members from 1.72% to 1.76% for each year of service, grants an adjusting increase of 2.3% to retirees as a result of the accrual rate change and provides a post-retirement increase of three percent (3%) in the benefits of retirees.

EFFECTIVE DATE: July 1, 1997

ESTIMATED IMPACT ON STATE:

Teachers' and State Employee's Retirement System

Retirement System Actuary: Buck Consultants estimates the cost to be 2.92% of payroll.

	1997-98	1998-99	1999-2000	2000-01	2001-02
General Fund	$160.5m	$167.4m	$174.5m	$182.1m	$189.9m
Highway Fund	$ 13.0m	$ 13.6m	$ 14.2m	$ 14.8m	$ 15.4m
Receipt Funds	$ 37.2m	$ 38.8m	$ 40.5m	$ 42.2m	$ 44.0m

General Assembly Actuary: Dilts, Umstead & Dunn estimates the cost to be 2.89% of payroll.

	1997-98	1998-99	1999-2000	2000-01	2001-02
General Fund	$158.8m	$165.7m	$172.8m	$180.2m	$188.0m
Highway Fund	$ 12.9m	$ 13.4m	$ 14.0m	$ 14.6m	$ 15.3m
Receipt Funds	$ 36.8m	$ 38.4m	$ 40.1m	$ 41.8m	$ 43.6m

Consolidated Judicial Retirement System

Retirement System Actuary: Buck Consultants estimates the cost to be 0.99% of payroll.

	1997-98	1998-99	1999-2000	2000-01	2001-02
General Fund	$386,100	$405,173	$425,189	$446,193	$468,235

General Assembly Actuary: Dilts, Umstead & Dunn estimates the cost to be 1.04% of payroll.

	1997-98	1998-99	1999-2000	2000-01	2001-02
General Fund	$386,100	$405,173	$425,189	$446,193	$468,235

Local Governmental Employee's Retirement System

Retirement System Actuary: Buck Consultants estimates the cost to be 0.96% of payroll.

	1997-98	1998-99	1999-2000	2000-01	2001-02
Local Funds	$28.8m	$30.8m	$32.8m	$35.1m	$37.m

General Assembly Actuary: Dilts, Umstead & Dunn estimates the cost to be 0.97% of payroll.

	1997-98	1998-99	1999-2000	2000-01	2001-02
Local Funds	$29.1m	$31.1m	$33.2m	$35.4m	$37.8m

ASSUMPTIONS AND METHODOLOGY:

Teacher's & State Employees' Retirement System

The cost estimates of the System's Actuary are based on the employee data, actuarial assumptions and actuarial methods used to prepare the December 31, 1995 actuarial valuation of the fund. The data included 256,904 active members with an annual payroll of $6.596 billion and 84,915 retired members in receipt of annual pensions totaling $986.2 million. Significant actuarial assumptions used include (a) an investment return rate of 7.5%, (b) salary increase rate of 6.25%, (c) the George B. Buck Mortality Tables for deaths in service and after retirement and (d) rates of separation from active service based on System experience. The actuarial cost method used was the entry age normal method with open-end unfunded accrued liability and an frozen unfunded liquidation period of nine years. Detailed information concerning these assumptions and methods is shown in the actuary's report which is available upon request from Stanley Moore.

Consolidated Judicial Retirement System

The cost estimates of the System's Actuary are based on the employee data, actuarial assumptions and actuarial methods used to prepare the December 31, 1995 actuarial valuation of the fund. The data included 438 active members with an annual payroll of $35.7 million and 329 retired members in receipt of annual pensions totaling $9.9 million. Significant actuarial assumptions used include (a) an investment return rate of 7.5%, (b) salary increase rate of 6.25%, (c) the 1979 George B. Buck Mortality Table for deaths after retirement, and (d) rates of separation from active service based on System experience. The actuarial cost method used to determine the liabilities is the projected benefit method; however, the method used to determine the contribution rate is the projected unit credit method with an unfunded liquidation period of ten years. Detailed information concerning these assumptions and methods is shown in the actuary's report which is available upon request from Stanley Moore.

Local Governmental Employees' Retirement System

The cost estimates of the System's Actuary are based on the employee data, actuarial assumptions and actuarial methods used to prepare the December 31, 1995 actuarial valuation of the fund. The data included 101341 active members with an annual payroll of $2.429 billion and 22,732 retired members in receipt of annual pensions totaling $201.7 million. Significant actuarial assumptions used include (a) an investment return rate of 7.5%, (b) salary increase rate of 6.25%, (c) the 1979 George B. Buck Mortality Tables for deaths in service and after retirement and (d) rates of separation from active service based on System experience. The actuarial cost method used was the projected benefit method with aggregate level normal cost and frozen accrued liability. Detailed information concerning these assumptions and methods is shown in the actuary's report which is available upon request from Stanley Moore.

SOURCES OF DATA: : System Actuary - Buck Consultant, Inc.
General Assembly Actuary - Dilts, Umstead & Dunn

FISCAL RESEARCH DIVISION: The above information is provided in accordance with North Carolina General Statute 120-114 and applicable Rules of the North Carolina Senate and House of Representatives. The above cost estimates are bases on the salary base as of July 1, 1997 projected at the average annual increase in compensation base for each system over the last five years.

(919) 733-4910
PREPARED BY: Stanley Moore
APPROVED BY: Tom Covington
DATE: April 8, 1997

BUCK
CONSULTANTS
200 Galleria Parkway, N.W. Suite 1200
Atlanta, Georgia 30339-5945

April 7, 1997

Mr. Dennis Ducker
Deputy Treasurer and Director
Retirement Systems Divisions
Department of State Treasurer
325 North Salisbury Street
Raleigh, North Carolina 27603-1388

Dear Mr. Ducker:

Re: **Senate Bill 747**

We have received your letter of April 4 regarding Senate Bill 747 which affects the Teachers' and State Employees' Retirement System, the Local Governmental Employees' Retirement System and the Consolidated Judicial Retirement System. This legislation also affects the Legislative Retirement System and the Optional Retirement Program, which we will not address because we are not the consulting actuaries for those systems.

This legislation appears to provide benefit enhancements to members and beneficiaries of the several retirement systems. The changes and enhancements in the legislation for each affected retirement system are as follows.

Teachers' and State Employees' Retirement System

This legislation appears to change the calculation of service and early retirement allowances by increasing the defined benefit formula accrual rate from 1.75% for each year of a member's creditable service to 1.81% effective as of July 1, 1997.

In addition, this legislation appears to amend the provisions of the Survivor's Alternate Benefit to conform with the increase in the defined benefit formula accrual rate from 1.75% to 1.81% for the calculation of monthly allowances to surviving beneficiaries.

This legislation also appears to grant post-retirement increases in the allowances of retirees and other beneficiaries equal to (i) 3.4% for all those in receipt of retirement allowances on June 1, 1997 and (ii) 3.0% for those who commenced retirement on or before July 1, 1996, and a prorated portion of the 3.0% post-retirement increase for those who commenced retirement after July 1, 1996 and before June 30, 1997, with all increases payable on and after July 1, 1997.

Buck Consultants, Inc.
770|955-2488 Fax 770|933-8336

Local Governmental Employees' Retirement System

This legislation appears to change the calculation of service and early retirement allowances by increasing the defined benefit formula accrual rate from 1.72% for each year of a member's creditable service to 1.76% effective as of July 1, 1997.

In addition, this legislation appears to amend the provisions of the Survivor's Alternate Benefit to conform with the increase in the defined benefit formula accrual rate from 1.72% to 1.76% for the calculation of monthly allowances to surviving beneficiaries.

This legislation also appears to grant post-retirement increases in the allowances of retirees and other beneficiaries equal to (i) 2.3% for all those in receipt of retirement allowances on June 1, 1997 and (ii) 3.0% for those who commenced retirement on or before July 1, 1996, and a prorated portion of the 3.0% post-retirement increase for those who commenced retirement after July 1, 1996 and before June 30, 1997, with all increases payable on and after July 1, 1997.

Consolidated Judicial Retirement System

This legislation appears to grant post-retirement increases in the allowances of retirees and other beneficiaries equal to 3.0% for all those who commenced retirement on or before July 1, 1996, and a prorated portion of the 3.0% post-retirement increase for those who commenced retirement after July 1, 1996 and before June 30, 1997, with all increases payable on and after July 1, 1997.

State's Employer Contribution Rates

This legislation appears to establish the State's employer contribution rates payable for retirement systems and related benefit programs, as a percentage of covered payroll for the fiscal year beginning July 1, 1997 and ending June 30, 1998, as follows:

	Retirement System	Retirees' Health	Death Benefit	Disability Income	401(k) Plan	Total
Teachers and State Employees	8.15%	2.00%	0.16%	0.52%	-0-	10.83%
State Law Enforcement	8.15	2.00	0.16	0.52	5.00%	15.83
Consolidated Judicial	20.65	2.00	-0-	-0-	-0-	22.65

Fiscal Results of the Benefit Enhancements

The attached schedule reflects the fiscal results of the benefit enhancements contained in this legislation on the various retirement systems. The results are based on the latest actuarial valuations of the retirement systems, with the equivalent appropriation amounts based on the estimated covered payrolls agreed to among the Legislative Fiscal Research Division, the Office of State Budget and the Department of State Treasurer.

If we can be of further assistance with regard to this legislation, please do not hesitate to contact us.

Sincerely,

Donald M. Overholser
Principal and Consulting Actuary

DMO:jq
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THIS IS TO CERTIFY THAT THIS IS A TRUE AND EXACT COPY OF AN ORIGINAL ACTUARIAL NOTE

SENATE BILL 747

System	GAINS As a % of Payroll			GAINS Equivalent Appropriations		SENATE BILL 747 Cost As	SENATE BILL 747 Equivalent Appropriations		Additional Appropriations	
	Actuarial	GASB 25/27	Total	General Fund	Highway Fund	% Payroll	General Fund	Highway Fund	General Fund	Highway Fund
Teachers' and State Employees' Retirement System	0.94%	2.13%	3.07%	$168,697,000	$13,692,000	2.92%	$160,454,000	$13,023,000	($8,243,000)	($669,000)
Consolidated Judicial Retirement System	0.87	2.57	3.44	1,341,000	N/A	0.99	386,000	N/A	(955,000)	N/A
Local Governmental Employees' Retirement System	0.30	0.81	1.11	33,300,000*	N/A	0.96	28,800,000*	N/A	(4,500,000)*	N/A

* Equivalent local funding

April 7, 1997

DILTS, UMSTEAD & DUNN

ACTUARIAL CONSULTING

MARK V. HARTMAN, FSA, MAAA, MCA, EA

Phone: (910) 731-4038
Fax: (910) 731-2583

668 Link Road
Lexington, NC 27295

April 4, 1997

Mr. Stanley Moore
Fiscal Research Division
North Carolina General Assembly
300 N. Salisbury Street
Raleigh, NC 27603-5925

Re: Senate Bill 747: An Act to Enhance Retirement Benefits in the TSERS, CJRS, and LGERS Systems

Dear Mr. Moore:

This bill would amend the North Carolina General Statues to enhance retirement benefits payable from the Teachers and State Employees Retirement System (TSERS), the Consolidated Judicial Retirement System (CJRS), and the Local Governmental Employees Retirement System (LGERS). The benefit increases provided by this bill are as follows:

1. In the TSERS, the bill would

   - increase the annual accrual rate from 1.75% to 1.81% for members retiring on or after July 1, 1997

   - increase the retirement allowance by 3.4% for all beneficiaries on the retirement rolls as of June 1, 1997

   - increase the retirement allowance an additional 3% for all beneficiaries who retired on or before July 1, 1996, with a prorated increase for retirements between July 1, 1996 and June 30, 1997.

2. In the CJRS, the bill would provide a 3% increase in the retirement allowances payable to beneficiaries whose retirement began on or before July 1, 1996, with a prorated increase for retirements between July 1, 1996 and June 30, 1997.

3. In the LGERS, the bill would

   - increase the annual accrual rate from 1.72% to 1.76% for members retiring on or after July 1, 1997

   - increase the retirement allowance by 2.3% for all beneficiaries on the retirement rolls as of June 1, 1997

   - increase the retirement allowance an additional 3% for all beneficiaries who retired on or before July 1, 1996, with a prorated increase for retirements between July 1, 1996 and June 30, 1997.

All provisions of this act are effective July 1, 1997. The estimated cost of this act for the fiscal year beginning July 1, 1997, expressed as a percent of payroll, is shown below. The cost is shown separately for the 3.0% COLA and the formula accrual rate adjustments (including adjustments to current beneficiaries).

System	3.0% COLA	Increase in Accrual Rate	Amort. Period for Unfunded Liability
TSERS	0.68%	2.21%	9 years
CJRS	1.04	n/a	9 years
LGERS	0.24	0.73	n/a

This estimation is based on the data contained in the most recent actuarial valuations prepared as of December 31, 1995.

If you have any questions, please let me know.

Sincerely,

Mark Hartman

Mark V. Hartman, FSA, MAAA, MCA, EA
Consulting Actuary

MVH/jj

ACTUARIAL NOTE
True & Exact Copy of Original
Certified By: Stanley Moore Date: 4-8-97
Legislative Fiscal Research

PENSIONS & RETIREMENT/ INSURANCE COMMITTEE
April 16,1997
10:00
1124 LB

AGENDA

SB 400
Mental Health Parity
Sen. Winner, sponsor

SB 614
Insurance Licensing Amendments
Sen. Miller, sponsor

SB 613
Insurance Company Audits and Exams
Sen. Miller, sponsor

Sen. Tommy Jenkins, chairman

Pensions & Retirement / Insurance Committee
Minutes
April 16,1997

The meeting of the Pensions& Retirement/ Insurance Committee met April 16, 1997 at 10:00 in room 1124 of the Legislative Building.

Sen. Jenkins appointed a sub-committee in regards to SB455. In addition to Sen, Jenkins, Senators Reeves, Kinnaid, Wellons, L. Shaw, Kincaid, East, and McDaniels were appointed to serve on that committee.

Sen Winner, sponsor of SB 400, Mental Health Parity explained the bill. Kate Chester, the mother of a mentally ill child , spoke in favor of the bill. Brad Aycock, Blue-Blue Shield, spoke against the bill. After a period of questions and answers, the meeting was adjourned.

Sen. Tommy Jenkins, chairman

Katy Haynes, clerk

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

S 3

SENATE BILL 400*
Pensions & Retirement and Insurance Committee Substitute Adopted 4/28/97
Third Edition Engrossed 4/30/97

Short Title: Mental Health Parity. (Public)

Sponsors:

Referred to:

March 17, 1997

A BILL TO BE ENTITLED

AN ACT TO REQUIRE PARITY IN HEALTH INSURANCE FOR MENTAL ILLNESS.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-50-155 is amended by adding the following new subsection to read:

"(a2) Notwithstanding G.S. 58-50-125(c), the standard health plan developed and approved under G.S. 58-50-125 shall provide coverage for the treatment of mental illness that is at least equal to the coverage required by G.S. 58-51-55. The plan may use a case management program in accordance with G.S. 58-51-55.

Section 2. G.S. 58-51-55 reads as rewritten:

"**§ 58-51-55. No discrimination against the mentally ill and chemically dependent.**

(a) As used in this section, the term:

(1) 'Mental illness' has the same meaning as defined in G.S. 122C-3(21); and

(2) 'Chemical dependency' has the same meaning as defined in G.S. 58-51-50

with a diagnosis found in the Diagnostic and Statistical Manual of Mental Disorders ~~DSM-3-R~~ DSM-IV or the International Classification of Diseases ICD/9/CM, or a later edition of those manuals.

(b) No insurance company licensed in this State under ~~the provisions of Articles 1 through 64 of~~ this Chapter shall, solely because an individual to be insured has or had a mental illness or chemical dependency:

(1) Refuse to issue or deliver to that individual any policy that affords benefits or coverages for any medical treatment or service for physical illness or injury;

(2) Have a higher premium rate or charge for physical illness or injury coverages or benefits for that individual; or

(3) Reduce physical illness or injury coverages or benefits for that individual.

(c) Nothing in this section prevents any insurance company from excluding from coverage any physical illness or injury ~~or mental illness~~ or chemical dependency which has existed previous to coverage of the individual by the insurance company or from refusing to issue or deliver to that individual any policy because of the underwriting of any physical condition whether or not related to ~~mental illness or~~ chemical dependency.

~~(d) This section applies only to group health insurance contracts covering 20 or more employees.~~

(d) Every insurer that writes a policy or contract of group or blanket health insurance or group or blanket accident and health insurance shall provide to its insureds benefits for the necessary care and treatment of mental illness that are not less favorable than benefits for physical illness generally. Benefits for treatment of mental illness shall be subject to the same limits as are benefits for physical illness generally. For purposes of this subdivision, 'limits' includes durational limits, deductibles, coinsurance factors, copayments, maximum out-of-pocket limits, annual and lifetime dollar limits, and any other dollar limits or fees for covered services.

(e) An insurer may use a case management program for mental illness benefits to evaluate and determine medically necessary and medically appropriate care and treatment for each patient, provided that the program complies with rules adopted by the Commissioner of Insurance. These rules shall ensure that case management programs are not designed to avoid the requirements of this section concerning parity between the benefits for mental illness and those for physical illness generally.

(f) Subsections (d) and (e) of this section apply only to group health insurance contracts covering 5 or more employees. The remainder of this section applies only to group health insurance contracts covering 20 or more employees.

(g) Subsections (d) and (e) of this section shall not apply to a policy or contract if the insurer demonstrates to the Commissioner that compliance has increased the cost of the policy by two percent (2%) or more on an annual basis."

Section 3. G.S. 58-65-90 reads as rewritten:

"**§ 58-65-90. No discrimination against the mentally ill and chemically dependent.**

(a) As used in this section, the term:

(1) 'Mental illness' has the same meaning as defined in G.S. 122C-3(21); and

(2) 'Chemical dependency' has the same meaning as defined in G.S. 58-65-75

with a diagnosis found in the Diagnostic and Statistical Manual of Mental Disorders ~~DSM-3-R~~ DSM-IV or the International Classification of Diseases ICD/9/CM, or a later edition of those manuals.

(b) No ~~hospital, medical, dental or health service~~ corporation governed by this Chapter shall, solely because an individual to be insured has or had a mental illness or chemical dependency:

(1) Refuse to issue or deliver to that individual any individual or group hospital, dental, medical or health service contract in this State that affords benefits or coverage for medical treatment or service for physical illness or injury;

(2) Have a higher premium rate or charge for physical illness or injury coverages or benefits for that individual; or

(3) Reduce physical illness or injury coverages or benefits for that individual.

(c) Nothing in this section prevents any hospital or medical plan from excluding from coverage any physical illness or injury ~~or mental illness~~ or chemical dependency which has existed previous to coverage of the individual by the hospital or medical plan or from refusing to issue or deliver to that individual any policy because of the underwriting of any physical condition whether or not related to ~~mental illness or~~ chemical dependency.

~~(d) This section applies only to group contracts covering 20 or more employees.~~

(d) Every group insurance certificate or group subscriber contract under a hospital or medical plan subject to this Article shall provide to its insureds benefits for the necessary care and treatment of mental illness that are not less favorable than benefits for physical illness generally. Benefits for treatment of mental illness shall be subject to the same limits as are benefits for physical illness generally. For purposes of this subsection, 'limits' includes durational limits, deductibles, coinsurance factors, copayments, maximum out-of-pocket limits, annual and lifetime dollar limits, and any other dollar limits or fees for covered services.

(e) The service corporation may use a case management program for mental illness benefits to evaluate and determine medically necessary and medically appropriate care and treatment for each patient, provided that the program complies with rules adopted by the Commissioner of Insurance. These rules shall ensure that case management programs are not designed to avoid the requirements of this section concerning parity between the benefits for mental illness and those for physical illness generally.

(f) Subsections (d) and (e) of this section apply only to group contracts covering 5 or more employees. The remainder of this section applies only to group contracts covering 20 or more employees.

(g) Subsections (d) and (e) of this section shall not apply to a subscriber contract or certificate if the service corporation demonstrates to the Commissioner that

compliance has increased the cost of the contract or certificate by two percent (2%) or more on an annual basis."

Section 4. G.S. 58-67-75 reads as rewritten:

"**§ 58-67-75. No discrimination against the mentally ill and chemically dependent.**

(a) As used in this section, the term:

(1) 'Mental illness' has the same meaning as defined in G.S. 122C-3(21); and

(2) 'Chemical dependency' has the same meaning as defined in G.S. 58-67-70

with a diagnosis found in the Diagnostic and Statistical Manual of Mental Disorders ~~DSM-3-R~~ DSM-IV or the International Classification of Diseases ICD/9/CM, or a later edition of those manuals.

(b) No health maintenance organization governed by this Chapter shall, solely because an individual has or had a mental illness or chemical dependency:

(1) Refuse to enroll that individual in any health care plan covering physical illness or injury;

(2) Have a higher premium rate or charge for physical illness or injury coverages or benefits for that individual; or

(3) Reduce physical illness or injury coverages or benefits for that individual.

(c) Nothing in this section prevents any health maintenance organization from excluding from coverage any physical illness or injury ~~or mental illness~~ or chemical dependency which has existed previous to coverage of the individual by the health maintenance organization or from refusing to issue or deliver to that individual any policy because of the underwriting of any physical condition whether or not related to ~~mental illness or~~ chemical dependency.

~~(d) This section applies only to group contracts covering 20 or more employees.~~

(d) Every health maintenance organization that issues a health care plan on a group basis for medical and hospitalization care shall provide to its insureds benefits for the necessary care and treatment of mental illness that are not less favorable than benefits for physical illness generally. Benefits for treatment of mental illness shall be subject to the same limits as are benefits for physical illness generally. For purposes of this subsection, 'limits' includes durational limits, deductibles, coinsurance factors, copayments, maximum out-of-pocket limits, annual and lifetime dollar limits, and any other dollar limits or fees for covered services.

(e) A health maintenance organization may use a case management program for mental illness benefits to evaluate and determine medically necessary and medically appropriate care and treatment for each patient, provided that the program complies with rules adopted by the Commissioner of Insurance. These rules shall ensure that case management programs are not designed to avoid the requirements of this section concerning parity between the benefits for mental illness and those for physical illness generally.

(f) This section applies only to group contracts covering five or more employees.

(g) Subsections (d) and (e) of this section shall not apply to a health care plan if the HMO demonstrates to the Commissioner that compliance has increased the cost of the plan by two percent (2%) or more on an annual basis."

Section 5. This act is effective when it becomes law and applies to contracts issued, delivered, or renewed on or after January 1, 1998. This act expires October 1, 2001.

Senate Insurance 4-16-97

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Lucia Deal	NC Medical Society
Mac Boxley	N.C. Podiatric Medical Society
[illegible]	DMHDDSAS
[illegible]	DCDA
Ron Aycock	County Commissioners Assoc.
Alan Miles	Bailey & Dixon LLP
D. Propst	NC DOT
Emily Hawthorne	NCHA
Amy Jo Bain	Smith Anderson
Dave Horne	"

Senate Insurance — 4-16-97

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
David Anders	PCPNC
Ballard Ernest	NC Alliance for the Mentally Ill
Otis Carter	Carter & Assoc.
Buff Bailey	Bailey & Dixon DOA
Ken Eudy	Capital Strategies
MT Burnette	GACPD - DOA
A.C. Dawson	NC. Ret Sch Personnel
Steve Keene	NC MEDICAL SOCIETY
Eugene Hafer	CAPIA
Martha Alexander	Representative

Senate Insurance

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Art Hale	NCDOI
Daschiell Phipps	"
Mimi Gross	NCDOI
Jo Stein	SAS
Gordon Vaster	PCNCT
Mike Carreto	NCAHA
Steve Jenkins	Property and Casualty Insurance N.C.

Senate Insurance — 4-16-97

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Rick Padgett	Young, Moore & Henderson, P.A.
Jennifer Barrett	Aetna
David G. DeVane	NC State Health Plan
Sara Boyd	Leg. Fiscal Research
Gary Pearce	N.C. Retired School Personnel
George Reed	NC Council of Churches
PAUL MAHONEY	NC HMO ASSOCIATION
PERRI MORGAN	NFIB
Richard O'Brien	PFFNC
Helen Lyons	Meck. Co. DSS

Senate Insurance — 4-16-97

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Tommy Wolfe	Carolina Health Care Systems
Leigh H. Hammond	N.C. Retired Gov't Employees Assn
Robert Price	BSBS N.C. Life Ins. Cos.
Bobby a Duffy	State Budget
Leslie Eubanks	NCCBE
Ken Williams	UHC; NC
Brad Wilcox	BCBSNC
Julian Phillips	NCFB
Ken Wright	BCBSNC
John Buchanan	Integon Corp.

SENATE INSURANCE 4-16-97

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[signature]	NASW-NC
Robin Huffman	Charter Behavioral Health of NC
Megan Carney	BSW Student - Meredith College
WIL EDGERTON	MHA/NC
John Baggett	DHR
Jerome H. Askew, Jr.	Governor's Off of Substance Abuse Policy
Bonnie Moore	DHR/Div MH
Mary Gay	NC AMT
ADAM SEARING	NC Health Access
Susan Valauri	Nationwide Ins.

Senate Insurance — 4/16/97

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Katherine Hunt	NC Psychiatric Assoc
KATE CHESTER	1721-F E. Cornwallis Rd Durham 27713
Jim Brawley	Holly Hill/Chanton Behavioral Health System
Beth Melcher	NC Alliance for the Mentally Ill
Hal L Cooper	NC Psychological Assn.
Jim Tate	MHA
Sally Cameron	NCPA
John Bason + crew	UNC-TV
Mark Stein	NC Psychological Assoc.
Ben Aiken	NCAA

PENSIONS & RETIREMENT/ INSURANCE COMMITTEE
April 16,1997
1124 LB

AGENDA

SB 297
Amend Charter Sch. Laws
Sen. .Gulley

SB 713
City of Raleigh Fireman's Supplemental Retirement Fund
Sen. Reeves, Sponsor

SB 677
Repeal Albemarle Firemen's Pensions
Conder, Sponsor

Sen. Tommy Jenkins, chairman

Pensions & Retirement/ Insurance Committee
MINUTES
April 16,199
1027 LB

The Pensions & Retirement/ Insurance committee met April 16, 1997 at 3:45PM in room 1027 of the Legislative Building.. There were 11 members in attendance including Sen. Jenkins, who presided.

Sen Conder, sponsor of SB 677, Repeal Albemarle Firemen's Pension, explained the bill. Sen. Carpenter moved for a favorable report. The motion carried unanimously.

Sen Reeves explained SB 713, City of Raleigh Fireman's Supplemental Fund. Sen Reeves moved for a favorable report. The motion carried unanimously.

Sen. Miller explained SB 614 , Insurance Licensing Amendments. Sen. Kincaid moved for a favorable report. The motion was carried unanimously.

The meeting was adjourned.

Sen Tommy Jenkins, chairman

Katy Haynes, clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

PENSIONS & RETIREMENT/ INSURANCE COMMITTEE REPORT
Senator Tommy Jenkins, Chairman

Thursday, April 17,1997

SENATOR TOMMY JENKINS,
submits the following with recommendations as to passage:

FAVORABLE

S.B. **677** Repeal Albemarle Firemen's Pension
Sequential Referral: None
Recommended Referral: None

S.B. **713** City of Raleigh Firemen's Supplemental Retirement Fund
Sequential Referral: None
Recommended Referral: None

TOTAL REPORTED: 2

Committee Clerk Comment: None

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

PENSIONS & RETIREMENT/ INSURANCE COMMITTEE REPORT
Senator Tommy Jenkins, Chairman

Monday, April 21, 1997

SENATOR TOMMY JENKINS,
submits the following with recommendations as to passage:

FAVORABLE

S.B. 614 Insurance Licensing Amendments.
Sequential Referral: None
Recommended Referral: None

TOTAL REPORTED: 1

Committee Clerk Comment: None

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

S 1

SENATE BILL 677

Short Title: Repeal Albemarle Firemen's Pension. (Local)

Sponsors: Senators Conder and Plyler.

Referred to: Pensions & Retirement and Insurance.

April 3, 1997

A BILL TO BE ENTITLED

AN ACT TO REPEAL THE ACT ESTABLISHING A SUPPLEMENTARY PENSION FUND FOR FIREMEN IN THE CITY OF ALBEMARLE.

The General Assembly of North Carolina enacts:

Section 1. Chapter 102 of the 1957 Session Laws, as amended by Chapter 589 of the 1963 Session Laws and Chapter 606 of the 1967 Session Laws, is repealed.

Section 2. All funds held by the Trustees of the Albemarle Supplementary Pension Fund are transferred to the Board of Trustees of the Albemarle Firemen's Relief Fund to be held and administered as provided in Article 84 of Chapter 58 of the General Statutes.

Section 3. This act becomes effective July 1, 1997.

GENERAL ASSEMBLY OF NORTH CAROLINA
1997 SESSION

S.L. 1997-460
SENATE BILL 713

AN ACT TO REPEAL THE AUTHORIZATION OF SUPPLEMENTAL RETIREMENT BENEFITS FOR FIREMEN IN THE CITY OF RALEIGH.

The General Assembly of North Carolina enacts:

Section 1. Chapter 421 of the 1969 Session Laws, as amended by Chapter 504 of the 1975 Session Laws, Chapter 328 of the 1979 Session Laws, and Chapter 917 of the 1989 Session Laws, is repealed.

Section 2. All funds held by the Trustees of the City of Raleigh Firemen's Supplemental Retirement Fund are transferred to the City of Raleigh Firemen's Relief Fund to be held and administered as provided in Article 84 of Chapter 58 of the General Statutes of North Carolina.

Section 3. This act becomes effective July 1, 1997.

In the General Assembly read three times and ratified this the 18th day of August, 1997.

s/ Dennis A. Wicker
President of the Senate

s/ Harold J. Brubaker
Speaker of the House of Representatives

s/ James B. Hunt, Jr.
Governor

Approved 6:01 p.m. this 29th day of August, 1997

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

S 1

SENATE BILL 713

Short Title: City of Raleigh Firemen's Supplemental Retirement Fund. (Public)

Sponsors: Senator Reeves.

Referred to: Pensions & Retirement and Insurance.

April 7, 1997

A BILL TO BE ENTITLED

AN ACT TO REPEAL THE AUTHORIZATION OF SUPPLEMENTAL RETIREMENT BENEFITS FOR FIREMEN IN THE CITY OF RALEIGH.

The General Assembly of North Carolina enacts:

Section 1. Chapter 421 of the 1969 Session Laws, as amended by Chapter 504 of the 1975 Session Laws, Chapter 328 of the 1979 Session Laws, and Chapter 917 of the 1989 Session Laws, is repealed.

Section 2. All funds held by the Trustees of the City of Raleigh Firemen's Supplemental Retirement Fund are transferred to the City of Raleigh Firemen's Relief Fund to be held and administered as provided in Article 84 of Chapter 58 of the General Statutes of North Carolina.

Section 3. This act becomes effective July 1, 1997.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

S

SENATE BILL 614

Short Title: Insurance Licensing Amendments. (Public)

Sponsors: Senator Miller.

Referred to: Pensions & Retirement and Insurance.

April 1, 1997

A BILL TO BE ENTITLED

AN ACT TO REVISE THE LICENSING LAWS ADMINISTERED BY THE DEPARTMENT OF INSURANCE, INCLUDING THE LAWS RELATING TO THE PAYMENT OF CIVIL MONEY PENALTIES, HEARING PROCEDURES, NOTICES OF ADDRESS CHANGES AND CRIMINAL CONVICTIONS, APPLICATIONS FOR LEARNER'S PERMITS, EXTENSIONS OF TIME FOR CONTINUING EDUCATION REQUIREMENTS, THE BASES UPON WHICH LICENSES MAY BE DENIED, REVOKED, OR SUSPENDED, THE NUMBER OF CONTINUING EDUCATION HOURS REQUIRED FOR BAIL BONDSMEN AND RUNNERS, AND THE BOND REQUIREMENT FOR VIATICAL SETTLEMENT PROVIDERS.

The General Assembly of North Carolina enacts:

PART I. CIVIL PENALTY LAW CHANGES.

Section 1. G.S. 58-2-70 reads as rewritten:

"**§ 58-2-70. Civil penalties or restitution for violations; ~~summary suspension of license or certificate.~~ administrative procedure.**

(a) This section applies to any person who is subject to licensure or certification under ~~the provisions of Articles 1 through 64, 65 and 66, 67, 69, 70, or 71 of~~ this Chapter.

(b) Whenever the Commissioner has reason to believe that any person has violated any of the provisions of ~~the statutes cited in subsection (a) of this section,~~ this Chapter, and the violation subjects the license or certification of that person to suspension or revocation, ~~or whenever the Commissioner has reason to believe that any person has violated Article 63 of this Chapter, the Commissioner may issue and~~

~~serve upon that person a written statement of charges and a written notice of hearing, to be held at a time and place fixed in the notice. The date for the hearing shall not be less than 10 days after the date of service. It shall be sufficient to give such notice either by delivering it to the person charged or by sending the notice to the last known address of that person by certified mail, return receipt requested. At the time and place fixed for the hearing the person charged shall have an opportunity to answer the charges against him and present evidence on his behalf. Upon good cause shown, the Commissioner may permit any adversely affected person to intervene, appear, and be heard at the hearing by counsel or in person. The Commissioner may consolidate a hearing under this section with a hearing allowed under G.S. 58-63-25 where there is common subject matter involved and subject to procedural requirements set out in both sections being followed.~~ the Commissioner may, after notice and opportunity for a hearing, proceed under the appropriate subsections of this section.

(c) ~~In any case where a hearing pursuant to subsection (b) of this section results in the findings by the Commissioner of~~ If, under subsection (b) of this section, the Commissioner finds a violation ~~of any of the provisions of the statutes cited in subsection (a) of this section, and the violation subjects the license or certification of that person to suspension or revocation, or findings by the Commissioner of a violation of Article 63~~ of this Chapter, the Commissioner may, in addition to or ~~in lieu~~ instead of suspending or revoking the license or certification, order the payment of a monetary penalty as provided in subsection (d) of this section or apply to the Superior Court of Wake County for an order directing payment of restitution as provided in subsection (e) of this section, or both. Each day during which a violation occurs ~~shall constitute~~ constitutes a separate ~~offense.~~ violation.

(d) Upon a finding by the Commissioner of a violation as specified in subsection (c) of this section, the Commissioner shall direct the payment of a penalty of not less than one hundred dollars ($100.00) nor more than one thousand dollars ($1,000). In determining the amount of the penalty, the Commissioner shall consider the degree and extent of harm caused by the violation, the amount of money that inured to the benefit of the violator as a result of the violation, whether the violation was committed willfully, and the prior record of the violator in complying or failing to comply with laws, rules, or orders applicable to the violator. The penalty shall be payable to the Commissioner, who shall then forward the clear proceeds of which ~~to the State Treasurer for deposit in the General Fund of the State.~~ in accordance with Section 7 of Article IX of the North Carolina Constitution. Payment of the civil penalty under this section shall be in addition to payment of any other penalty for a violation of the criminal laws of this State.

(e) Upon application of the Commissioner and a finding by the court of a violation as specified in subsection (c) of this section, the court may order the person who committed the violation to make restitution in an amount that would make whole any person harmed by the violation.

(f) Restitution to any State agency for extraordinary administrative expenses incurred in the investigation and hearing of the violation may also be ordered by the court in such amount that would reimburse the agency for the expenses.

(g) Nothing in this section ~~shall prevent~~ prevents the Commissioner from negotiating a mutually acceptable agreement with any person as to the status of the person's license or certificate or as to any civil penalty or restitution.

(h) ~~Notwithstanding subsection (b) of this section, if the Commissioner finds that the public health, safety, or welfare requires emergency action and incorporates this finding in his order, summary suspension of a license or certificate may be ordered effective on the date specified in the order or on service of the certified copy of the order at the last known address of the licensee, whichever is later, and effective during the proceedings to suspend, revoke, or refuse renewal provided for in subsection (b) of this section. The proceedings shall be promptly commenced and determined.~~ Unless otherwise specifically provided for, all administrative proceedings under this Chapter are governed by Chapter 150B of the General Statutes."

Section 2. G.S. 143-143.13(c) reads as rewritten:

"(c) In addition to the authority to deny, suspend, or revoke a license under this Article, the Board ~~also has the authority to~~ may impose a civil penalty upon any person violating the provisions of this Article. Upon a finding by the Board of a violation of this Article, the Board shall direct the payment of a penalty of not less than one hundred dollars ($100.00) nor more than five hundred dollars ($500.00). In determining the amount of the penalty, the Board shall consider the degree and extent of harm caused by the violation, the amount of money that inured to the benefit of the violator as a result of the violation, whether the violation was committed willfully, and the prior record of the violator in complying or failing to comply with laws, rules, or orders applicable to the violator. Each day during which a violation occurs ~~shall constitute~~ constitutes a separate ~~offense.~~ violation. The penalty shall be payable to the Board, which shall then forward the clear proceeds of which ~~to the State Treasurer for deposit in the General Fund of the State.~~ in accordance with Section 7 of Article IX of the North Carolina Constitution. Payment of the civil penalty under this section ~~shall be~~ is in addition to payment of any other penalty for a violation of the criminal laws of this State. Nothing in this subsection ~~shall prevent~~ prevents the Board from negotiating a mutually acceptable agreement with any person as to the status of the person's license or certificate or as to any civil penalty."

PART II. NOTICES FROM INDIVIDUAL LICENSEES.

Section 3. Article 2 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-2-69. Notification of criminal convictions and changes of address; service of notice.**

(a) As used in this section:

(1) 'License' includes any license, certificate, registration, or permit issued under this Chapter.

(2) 'Licensee' means any person who holds a license.

(b) Every applicant for a license shall inform the Commissioner of the applicant's residential address. Every licensee shall give written notification to the Commissioner of any change of the licensee's residential address within 10 business days after the licensee moves into the licensee's new residence. This requirement applies if the change of residential address is by governmental action and there has been no actual change of residence location; in which case the licensee must notify the Commissioner within 10 business days after the effective date of the change. A violation of this subsection is not a ground for revocation, suspension, or nonrenewal of the license or for the imposition of any other penalty by the Commissioner.

(c) If a licensee is convicted in any court of competent jurisdiction for any crime or offense other than a motor vehicle infraction, the licensee shall notify the Commissioner within 10 days after the date of the conviction. As used in this subsection, 'conviction' includes an adjudication of guilt, a plea of guilty, or a plea of nolo contendere.

(d) Notwithstanding any other provision of law, whenever the Commissioner is authorized or required to give any notice under this Chapter to a licensee, the notice may be given personally or by sending the notice by first-class mail to the licensee at the address that the licensee has provided to the Commissioner under subsection (b) of this section.

(e) The giving of notice by mail under subsection (d) of this section is complete upon the expiration of four days after the deposit of the notice. Proof of the giving of notice by mail may be made by the certificate of any employee of the Department."

PART III. INSURANCE AGENTS, BROKERS, AND ADJUSTERS.

Section 4. G.S. 58-33-70 reads as rewritten:

"**§ 58-33-70. Special provisions for adjusters and motor vehicle damage appraisers.**

(a) It shall be unlawful and cause for revocation of license for a licensed adjuster to engage in the practice of law.

(b) On behalf and on request of an insurer by which ~~he is appointed or for which he is licensed, any~~ an agent or limited representative is appointed, the agent or limited representative may from time to time act as an adjuster and investigate and report upon claims without being ~~required to be~~ licensed as an ~~adjuster, provided: In no event may any~~ adjuster. No agent or limited representative shall adjust any losses ~~in any amount~~ where ~~his~~ the agent's or representative's remuneration for the sale of insurance is in any way dependent upon the adjustment of ~~such~~ those losses.

(c) Upon the filing of the application for ~~the license as adjuster and~~ an adjuster's license, the advance payment of the examination ~~fee and upon~~ fee, and the filing with the Commissioner of a certificate signed by the ~~employer of the applicant certifying that the applicant is an individual of good character and is employed by the signer of the certificate and will operate as a student or learner under the instruction and general supervision of a licensed adjuster, and that the employer will be responsible for the adjustment acts of the learner during the learning period,~~ applicant's employer, the Commissioner may issue ~~to the applicant~~ a learner's permit authorizing the applicant to act as an adjuster for a learning period of 90 days without a requirement of any other ~~or additional license; provided that not~~ license. Not more

than one ~~learner~~ learner's permit shall ever be issued to one individual. The employer's certificate required by this subsection shall certify that:

(1) The applicant is an individual of good character.

(2) The applicant is employed by the signer of the certificate.

(3) The applicant will operate as a student or learner under the instruction and general supervision of a licensed adjuster.

(4) The employer will be responsible for the adjustment acts of the applicant during the learning period.

~~(d) No license shall be required of an adjuster licensed as such in another state for the adjustment in this State of a single loss, or of losses arising out of a catastrophe common to all such losses; provided that such adjuster notifies the Commissioner in writing prior to the adjusting of such loss or losses.~~

(e) The Commissioner may permit an experienced adjuster, who regularly adjusts in another state and who is licensed in ~~such~~ the other ~~state (if such state requires a license),~~ state, to act as an adjuster in this State without a North Carolina license, for emergency insurance adjustment work, for a period of not exceeding 30 days, done for an employer who is an adjuster licensed by this State or who is a regular employer of one or more adjusters licensed by this State; provided that the employer shall furnish to the Commissioner a notice in writing immediately upon the beginning of any such emergency insurance adjustment work. As used in this subsection, 'emergency insurance adjustment work' includes adjusting of a single loss or losses arising out of a catastrophe common to all of those losses in any area declared to be a state of disaster by the Governor under G.S. 166A-6 or by the President of the United States under applicable federal law.

(f) The Commissioner may permit an experienced motor vehicle damage appraiser who is regularly appraising in another state and who is licensed in ~~such~~ the other state ~~(if such state requires a license)~~ to act as a motor vehicle damage appraiser in this State without a North Carolina license for emergency motor vehicle damage appraisal work for a period not exceeding 30 days done for an employer who notifies the Commissioner, in writing, at the beginning of the period of emergency appraisal work and who is:

(1) An insurance adjuster licensed by this State;

(2) A motor vehicle damage appraiser licensed by this State;

(3) A regular employer of one or more insurance adjusters licensed by this State; or

(4) A regular employer of one or more motor vehicle damage appraisers licensed by this State."

Section 5. G.S. 58-33-45 reads as rewritten:

"**§ 58-33-45. Suspension, revocation, or nonrenewal of licenses.**

(a) The Commissioner may suspend, revoke, or refuse to renew any license issued under this Article if, in accordance with the provisions of Article 3A of Chapter 150B, ~~he~~ the Commissioner finds as to the licensee any one or more of the following conditions:

(1) Any untrue material statement in the license application;

(2) Any cause for which issuance of the license could have been refused had it then existed and been known to the Commissioner at the time of issuance;

(3) Violation of, or noncompliance with, any insurance laws, or of any lawful rule, or order of the Commissioner or of a Commissioner of another state;

(4) Obtaining or attempting to obtain any such license through misrepresentation or fraud;

(5) Improperly withholding, misappropriating, or converting to his own use any moneys belonging to policyholders, insurers, beneficiaries or others received in the course of his insurance business;

(6) Misrepresentation of the terms of any actual or proposed insurance contract;

(7) Willfully overinsuring property;

(8) Conviction of a misdemeanor involving moral turpitude, or conviction of a felony;

(9) The person has been found guilty of any unfair trade practice or fraud;

(10) In the conduct of his affairs under the license, the licensee has used fraudulent, coercive or dishonest practices, or has shown himself to be incompetent, untrustworthy, or financially irresponsible;

(11) His license has been suspended or revoked in any other state, province, district, or territory;

(12) The person has forged another's name to an application for insurance; or

(13) The person has cheated on an examination for an insurance license.

~~(b) Notwithstanding the notice and hearing requirements of subsection (a) of this section, if the Commissioner finds that the public health, safety, or welfare requires emergency action and incorporates this finding in his order, summary suspension of a license may be ordered effective on the date specified in the order or on service of the certified copy of the order at the last known address of the licensee, whichever is later, and effective during the proceedings to suspend, revoke, or refuse renewal provided for in subsection (a) of this section. The proceedings shall be promptly commenced and determined.~~

(c) Repealed by Session Laws 1993, c. 504, s. 28.

(d) For the purposes of investigation under this section, the Commissioner shall have all the power conferred upon him by G.S. 58-3-125.

(e) The license of a partnership or corporation may be suspended, revoked, not continued, or refused if the Commissioner finds, after hearing, that an individual licensee's violation was known or should have been known by one or more of the partners, officers, or managers acting on behalf of the partnership or corporation and

such violation was not reported to the Commissioner nor corrective action taken in relation thereto.

(f) Upon the filing for protection under the United States Bankruptcy Code by any person licensed under this Article, or by any insurance agency in which such licensed person holds a position of employment, management or ownership, such person shall notify the Commissioner of the filing for protection within three business days after the filing. Upon the appointment of a receiver by a court of this State for any person licensed under this Article, or for any insurance agency in which such licensed person holds a position of employment, management or ownership, such person shall notify the Commissioner of the appointment within three business days thereafter. The willful failure to notify the Commissioner within three business days after the filing for protection or the appointment of a receiver shall, after hearing, cause the license of any person failing to make such notification to be suspended for a period of not less than 60 days nor more than three years, in the discretion of the Commissioner.

(g) If the Commissioner refuses to grant a license, or suspends, or revokes a license, any appointment of such applicant or licensee shall likewise be revoked. No individual whose license is revoked shall be issued another license without first complying with all requirements of this Article.

~~(h) The provisions of G.S. 58-2-70 apply to any person subject to licensure under this Article.~~

(i) No person shall be issued a license or appointment to enter the employment of any agency or person, which agency or person is at that time found by the Commissioner to be in violation of any of the insurance laws of this State, or which has been in any manner disqualified under the laws of this State to engage in the insurance business."

Section 6. G.S. 58-33-130(c) reads as rewritten:

"(c) ~~On and after January 1, 1992, any individual agent or broker desiring to renew an appointment or license shall offer evidence satisfactory to the Commissioner that he has complied with the continuing professional education requirements approved by the Commissioner.~~ The license of any person who fails to comply with the continuing education requirements under this section shall lapse. The Commissioner may, for good cause shown, grant extensions of time to licensees to comply with these requirements."

Section 7. G.S. 58-33-130(h) reads as rewritten:

"(h) Any licensee ~~who~~ who, after obtaining an extension under subsection (c) of this section, offers evidence satisfactory to the Commissioner ~~on forms prescribed by the Commissioner that he~~ that the licensee has satisfactorily completed the required continuing professional education courses ~~shall be deemed to have complied~~ is in compliance with this section."

PART IV. BAIL BONDSMEN AND RUNNERS.

Section 8. G.S. 58-71-50 reads as rewritten:

"**§ 58-71-50. Qualification for bail bondsmen and runners.**

(a) An applicant for a license as a bail bondsman or ~~runner, must~~ runner shall furnish the Commissioner with a complete set of the applicant's fingerprints and a recent passport size full-face photograph of the applicant. The applicant's fingerprints shall be certified by an authorized law-enforcement officer. The fingerprints of every applicant shall be forwarded to the State Bureau of Investigation for a search of the applicant's criminal history record file, if any. If warranted, the State Bureau of Investigation shall forward a set of the fingerprints to the Federal Bureau of Investigation for a national criminal history record check. An applicant shall pay the cost of the State and any national criminal history record check of the applicant.

(b) Every applicant for a license under this Article as a bail bondsman or runner must meet all of the following qualifications:

(1) Be 18 years of age or over.

(2) Be a resident of this State.

~~(3) Be a person of good moral character and not have been convicted of a felony or any crime involving moral turpitude.~~

(4) Have knowledge, training, or experience of sufficient duration and extent to provide the competence necessary to fulfill the responsibilities of a licensee.

(5) Have no outstanding bail bond obligations.

(6) Have no current or prior violations of any provision of this Article or of Article 26 of Chapter 15A of the General Statutes or of any similar provision of law of any other state.

(7) Not have been in any manner disqualified under the laws of this State or any other state to engage in the bail bond business."

Section 9. G.S. 58-71-80 reads as rewritten:

"**§ 58-71-80. Grounds for denial, suspension, revocation or refusal to renew licenses.**

(a) The Commissioner may deny, suspend, ~~or revoke~~ revoke, or refuse to renew any license ~~issued~~ under this Article for any of the following causes:

(1) For any cause sufficient to deny, suspend, or revoke the license under any other provision of this Article.

(2) Violation of any laws of this State relating to bail in the course of dealings under the license issued by the Commissioner.

(3) Material misstatement, misrepresentation or fraud in obtaining the license.

(4) Misappropriation, conversion or unlawful withholding of moneys belonging to insurers or others and received in the conduct of business under the license.

(5) Fraudulent or dishonest practices in the conduct of business under the license.

(6) Conviction of a ~~felony regardless of the time the conviction occurred and regardless of whether the conviction resulted from conduct in or related to the bail bond business.~~ crime involving moral turpitude.

(7) Failure to comply with or violation of the provisions of this Article or of any order, rule or regulation of the Commissioner.

(8) When in the judgment of the Commissioner, the licensee has in the conduct of the licensee's affairs under the license, demonstrated incompetency, financial irresponsibility, or untrustworthiness; or that the licensee is no longer in good faith carrying on the bail bond business; or that the licensee is guilty of rebating, or offering to rebate, or offering to divide the premiums received for the bond.

(9) For failing to pay any judgment or decree rendered on any forfeited undertaking in any court of competent jurisdiction.

(10) For charging or receiving, as premium or compensation for the making of any deposit or bail bond, any sum in excess of that permitted by this Article.

(11) For requiring, as a condition of executing a bail bond, that the principal agree to engage the services of a specified attorney.

(12) For cheating on an examination for a license under this Article.

(13) For entering into any business association or agreement with any person who is at that time found by the Commissioner to be in violation of any of the bail bond laws of this State, or who has been in any manner disqualified under the bail bond laws of this State or any other state, whereby the person has any direct or indirect financial interest in the bail bond business of the licensee or applicant.

(14) For knowingly aiding or abetting others to evade or violate the provisions of this Article.

(15) Any cause for which issuance of the license could have been refused had it then existed and been known to the Commissioner at the time of issuance.

~~(b) The Commissioner, in lieu of revoking or suspending a license in accordance with the provisions of this Article, may, in any one proceeding, by order, require the licensee to pay to the school fund in the licensee's county of residence a civil penalty of two hundred fifty dollars ($250.00) for each offense. Upon the licensee's failure to pay the penalty within 20 days after the order is mailed, postage prepaid, registered and addressed to the licensee's last known place of business, unless the order is stayed by an order of the court of competent jurisdiction or unless the Commissioner has already suspended or revoked the license of the licensee, the Commissioner may revoke the license or may suspend the license for any period.~~

(c) The Commissioner shall deny, revoke, or refuse to renew any license under this Article if the applicant or licensee is or has ever been convicted of a felony."

Section 10. G.S. 58-71-71(a) reads as rewritten:

"(a) In order to be eligible to take the examination required to be licensed as a runner or bail bondsman under G.S. 58-71-70, each person shall complete at least ~~20~~ 16 hours of education in subjects pertinent to the duties and responsibilities of a

runner or bail bondsman, including all laws and regulations related to being a runner or bail bondsman."

Section 11. G.S. 58-71-71(b) reads as rewritten:

"(b) Each year every licensee shall complete at least ~~10~~ eight hours of continuing education in subjects related to the duties and responsibilities of a runner or bail bondsman before renewal of the license. This continuing education shall not include a written or oral examination. A person who receives his first license on or after January 1 of any year does not have to comply with this subsection until the period between his first and second license renewals."

Section 12. G.S. 58-71-165 reads as rewritten:

"**§ 58-71-165. Monthly report required.**

Each professional bail bondsman and surety bondsman shall file with the Commissioner ~~of Insurance~~ a written report in form prescribed by the Commissioner regarding all bail bonds on which the bondsman is liable as of the first day of each month showing (i) each individual bonded, (ii) the date the bond was given, (iii) the principal sum of the bond, (iv) the State or local official to whom given, and (v) the fee charged for the bonding service in each instance. The report shall be filed on or before the fifteenth day of each month. ~~Within the same time, a copy of this written report must also be filed with the clerk of superior court in any county in which the bondsman is obligated on bail bonds.~~ Any person who knowingly and willfully falsifies a report required by this section is guilty of a Class I felony."

Section 13. G.S. 58-71-71(e) reads as rewritten:

"(e) ~~Any person who falsely represents to the Commissioner that the requirements of this section have been met is subject, after notice and opportunity for hearing, to G.S. 58-2-70.~~ The license of any person who fails to comply with the continuing education requirements under this section shall lapse. The Commissioner may, for good cause shown, grant extensions of time to licensees to comply with these requirements. Any licensee who, after obtaining an extension under this subsection, offers evidence satisfactory to the Commissioner that the licensee has satisfactorily completed the required continuing professional education courses is in compliance with this section."

Section 14. G.S. 58-71-85(a) reads as rewritten:

"(a) The suspension or revocation of, or refusal to renew, any license under G.S. 58-71-80 shall be in accordance with the provisions of ~~Article 3A of~~ Chapter 150B of the General Statutes."

PART V. VIATICAL SETTLEMENT PROVIDERS.

Section 15. G.S. 58-58-42(j) reads as rewritten:

"(j) Authority to Adopt Standards. -- The Commissioner may:

(1) Adopt rules to implement this section.

(2) Establish standards for evaluating reasonableness of payments under contracts. This authority includes regulation of discount rates used to determine the amount paid in exchange for assignment, transfer, sale, devise, or bequest of a benefit under a policy.

(3) Establish appropriate registration and other regulatory requirements for brokers.

~~(4) Require a bond.~~"

PART VI. HOME INSPECTORS.

Section 16. G.S. 143-151.45 reads as rewritten:

"**§ 143-151.45. Definitions.**

The following definitions apply in this Article:

(1) Associate home inspector. -- An individual who is affiliated with or employed by a licensed home inspector to conduct a home inspection of a residential building on behalf of the licensed home inspector.

(2) Board. -- The North Carolina Home Inspector Licensure Board.

(3) Compensation. -- A fee or anything else of value.

(4) Home inspection. -- A written evaluation of ~~one~~ two or more of the following components of a residential building: heating system, cooling system, plumbing system, electrical system, structural components, foundation, roof, masonry structure, exterior and interior components, or any other related residential housing component.

(5) Home inspector. -- An individual who engages in the business of performing home inspections for compensation.

(6) Residential building. -- A structure intended to be, or that is in fact, used as a residence by one or more individuals."

Section 17. G.S. 143-151.52 reads as rewritten:

"**§ 143-151.52. Requirements to be licensed as an associate home inspector.**

To be licensed as an associate home inspector, a person must do all of the following:

(1) Submit a completed application to the Board upon a form provided by the Board.

(2) Pass a licensing examination prescribed by the Board.

(3) Pay the applicable fees.

(4) Have a high school diploma or its equivalent.

(5) Be employed by or affiliated with or intend to be employed by or affiliated with a licensed home inspector and submit a sworn statement by ~~the~~ that licensed home inspector ~~with whom the applicant is or intends to be affiliated~~ certifying that the licensed home inspector will actively supervise and train the applicant."

Section 18. G.S. 143-151.53 reads as rewritten:

"**§ 143-151.53. Notification ~~of~~ to applicant following evaluation of application.**

~~The Board must review each application for a license submitted to it and must notify each applicant that the application is either accepted or rejected. The Board must send the notification of acceptance or rejection within 30 days of receiving the application. If the Board rejects an application, the notice sent to the applicant must state the reasons for the rejection.~~ If the Board finds that the applicant has not met

fully the requirements for licensing, the Board shall refuse to issue the license and shall notify in writing the applicant of the denial, stating the grounds of the denial. The application may also be denied for any reason for which a license may be suspended or revoked or not renewed under G.S. 143-151.56. Within 30 days after service of the notification, the applicant may make a written demand upon the Board for a review to determine the reasonableness of the Board's action. The review shall be completed without undue delay, and the applicant shall be notified promptly in writing as to the outcome of the review. Within 30 days after service of the notification as to the outcome, the applicant may make a written demand upon the Board for a hearing under Article 3A of Chapter 150B of the General Statutes if the applicant disagrees with the outcome."

Section 19. G.S. 143-151.56 reads as rewritten:

"**§ 143-151.56. Suspension, revocation, and refusal to renew license.**

(a) The Board may deny or refuse to issue or renew a license, may suspend or revoke a license, or may impose probationary conditions on a license if the license holder or applicant for licensure has engaged in any of the following conduct:

(1) Employed fraud, deceit, or misrepresentation in obtaining or attempting to obtain or renew a license.

(2) Committed an act of malpractice, gross negligence, or incompetence in the practice of home inspections.

(3) Without having a current license, either performed home inspections for compensation or claimed to be licensed.

(4) Engaged in conduct that could result in harm or injury to the public.

(5) Been convicted of or pled guilty or nolo contendere to any ~~crime~~ misdemeanor involving moral ~~turpitude.~~ turpitude or to any felony.

(6) Been adjudicated ~~insane or incompetent and has not presented proof of recovery from the condition.~~ incompetent.

(7) Engaged in any act or practice that violates any of the provisions of this Article or any rule issued by the Board, or aided, abetted, or assisted any person in a ~~violation.~~ violation of any of the provisions of this Article.

(b) A denial of licensure, refusal to renew, suspension, revocation, or imposition of probationary conditions upon a license holder may be ordered by the Board after a hearing held in accordance with Article 3A of Chapter 150B of the General Statutes and rules adopted by the Board. An application may be made to the Board for reinstatement of a revoked license if the revocation has been in effect for at least one year."

PART VII. EFFECTIVE DATE.

Section 20. Section 3 of this act becomes effective January 1, 1998. Sections 6, 7, 9, 13, 18, and 19 of this act become effective October 1, 1997, and Section 19 applies to applications for licensure or renewal submitted on or after that date. Section 4 of this act becomes effective September 1, 1997. The remainder of this act is effective when it becomes law.

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April 16, 1997

MEMORANDUM

TO: Senator Thomas Jenkins, Chairman,
Senate Pensions, Retirement and Insurance Committee

FROM: Karen Cochrane Brown, Committee Co-Counsel KCB

RE: **Senate Bill 677 - Repeal Albemarle Firemen's Pension.**
Senate Bill 713 - Raleigh Firemen's Supplemental Retirement Fund.

Senate Bills 677 and 713 each repeal local firemen's supplemental pension funds. Senate Bill 677 repeals the Albemarle Supplementary Pension Fund which was created by Chapter 102 of the 1957 Session Laws and Senate Bill 713 repeals the Raleigh Firemen's Supplemental Retirement Fund which was authorized by Chapter 421 of the 1969 Session Laws.

Section 2 of both bills directs that the money presently held by the trustees of the supplemental pension funds be transferred to the local Firemen's Relief Fund to be held and administered as provided in Article 84 of Chapter 58. G.S. 58-84-35 sets forth the purposes for which these funds, which are derived from a tax on insurance premiums, may be used. A copy of G.S. 58-84-35 is attached.

These acts would both become effective July 1, 1997.

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

before the board. (1907, c. 831, s. 6; C.S., s. 6068; 1925, c. 41; 1945, c. 74, s. 1; 1947, c. 720; 1949, c. 1054; 1973, c. 1365; 1985, c. 666, s. 64; 1987, c. 174, ss. 1, 5.)

Local Modification. — City of Hickory: 1985, c. 139; city of Lenoir: 1977, c. 118; 1981, c. 291; 1991 (Reg. Sess., 1992), c. 800; city of Lumberton: 1989, c. 357, s. 1; 1991 (Reg. Sess., 1992), c. 792; city of Mayodan: 1985, c. 255; city of New Bern: 1983, c. 551; city of Rocky Mount: 1969, c. 434; 1983, c. 498; 1991, c. 497; city of Shelby: 1985, c. 209; 1991 (Reg. Sess., 1992), c. 791; city of Whiteville: 1987 (Reg. Sess., 1988), c. 1018, s. 1; city of Williamston: 1985, c. 188; city of Wilmington: 1983, c. 505; town of Selma: 1987, c. 614, s. 6; town of Tarboro: 1985, c. 157; 1987, c. 609; town of Valdese: 1983, c. 501; town of Wilkesboro: 1985, c. 131.

Local Supplemental Firemen's Retirement Fund. — City of Rocky Mount: 1969, c. 434; 1983, c. 498; 1991, c. 497.

§ 58-84-35. Disbursement of funds by trustees.

The board of trustees shall have entire control of the funds derived from the provisions of this Article, and shall disburse the funds only for the following purposes:

(1) To safeguard any fireman in active service from financial loss, occasioned by sickness contracted or injury received while in the performance of his duties as a fireman.

(2) To provide a reasonable support for those actually dependent upon the services of any fireman who may lose his life in the fire service of his town, city, or State, either by accident or from disease contracted or injury received by reason of such service. The amount is to be determined according to the earning capacity of the deceased.

(2.1) To provide assistance, upon approval by the Secretary of the State Firemen's Association, to a destitute member fireman who has served honorably for at least five years.

(3) Repealed by Session Laws 1985, c. 666, s. 61.

(4) To provide for the payment of any fireman's assessment in the Firemen's Fraternal Insurance Fund of the State of North Carolina if the board of trustees finds as a fact that said fireman is unable to pay the said assessment by reason of disability.

(5) To provide for benefits of supplemental retirement, workers compensation, and other insurance and pension protection for firemen otherwise qualifying for benefits from the Firemen's Relief Fund as set forth in Article 85 of this Chapter.

(6) To provide for educational benefits to firemen and their dependents who otherwise qualify for benefits from the Firemen's Relief Fund as set forth in Article 85 of this Chapter.

Notwithstanding any other provisions of law, no expenditures shall be made pursuant to subsections (5) and (6) of this section unless the State Firemen's Association has certified that such expenditures will not render the Fund actuarially unsound for the purposes of providing the benefits set forth in subsections (1), (2), and (4) of this section. If, for any reason, funds made available for subsections (5) and (6) of this section shall be insufficient to pay in full any benefits, the benefits pursuant to subsections (5) and (6) shall be reduced pro rata for as long as the amount of insufficient funds exists. No claim shall accrue with respect to any amount by

)68; 1925, c. 41; 1945, 1365; 1985, c. 666, s.

of Williamston: 1985, c. ilmington: 1983, c. 505; 1987, c. 614, s. 6; town of c. 157; 1987, c. 609; town 1983, c. 501; town of 985, c. 131.
plemental Firemen's Re- ind. — City of Rocky c. 434; 1983, c. 498; 1991,

by trustees.

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ervice from financial ed or injury received ies as a fireman. hose actually depen- who may lose his life or State, either by r injury received by is to be determined the deceased. l by the Secretary of a destitute member r at least five years. 66, s. 61.
man's assessment in nd of the State of ds as a fact that sessment by rea-

retirement, workers d pension protection nefits from the Fire- e 85 of this Chapter. firemen and their benefits from the Article 85 of this

w, no expenditures l (6) of this section tified that such ex- ly unsound for the subsections (1), (2), made available for sufficient to pay in sections (5) and (6) ount of insufficient to any amount by

which a benefit under subsections (5) and (6) shall have been reduced. (1907, c. 831, s. 6; 1919, c. 180; C.S., s. 6069; Ex. Sess. 1921, c. 55; 1923, c. 22; 1925, c. 41; 1945, c. 74, s. 2; 1985, c. 666, s. 61; 1987, c. 174, ss. 2, 3.)

Local Modification. — Mecklenburg: 1949, c. 728; New Hanover: 1929, c. 328; city of Asheboro, 1985, c. 186; city of Asheville: 1959, c. 759; city of Charlotte: 1947, c. 837; 1949, c. 728; city of Conover: 1977, c. 334, s. 2; 1991, c. 260; city of Durham: 1951, c. 577; city of Fayetteville: 1979, c. 557, s. 1; 1991, c. 149, s. 2; city of Gastonia: 1945, c. 183; city of Greensboro: 1953, c. 931; city of Henderson: 1959, c. 943; city of Hendersonville: 1993, c. 244, s. 2; city of Hickory: 1971, c. 65; 1981, c. 407; 1985, c. 139; city of High Point: 1961, c. 523; city of Lenoir: 1977, c. 118; 1981, c. 291; 1991 (Reg. Sess., 1992), c. 800; city of Mayodan: 1985, c. 255; city of New Bern: 1983, c. 551; city of Radford: 1983, c. 496; city of Rocky Mount: 1969, c. 434; 1983, c. 498; 1991, c. 497; 1991, c. 761, s. 43; city of Shelby: 1985, c. 209; 1991 (Reg. Sess., 1992), c. 791; city of Whiteville: 1987 (Reg. Sess., 1988), c. 1018, s. 1; city of Williamston: 1985, c. 188; city of Wilmington: 1983, c. 505; town of Cary: 1985, c. 159; 1991, c. 147; 1989 (Reg. Sess., 1990), c. 924; town of Kernersville: 1979, 2nd Sess., c. 1106; town of Morganton: 1963, c. 689; town of Selma: 1987, c. 614, s. 2; town of Tarboro: 1985, c. 157; 1987, c. 609; town of Valdese: 1983, c. 501; town of Wilkesboro: 1985, c. 131; Windsor Firemen's Local Relief Fund: 1989 (Reg. Sess., 1990), c. 930.

Local Supplemental Firemen's Retirement Fund. — City of Rocky Mount: 1969, c. 434; 1983, c. 498; 1991, c. 497.

CASE NOTES

Cited in Carroll v. North Carolina State Firemen's Ass'n, 230 N.C. 436, 53 S.E.2d 524 (1949).

§ 58-84-40. Trustees to keep account and file certified reports.

(a) Each local board of trustees shall keep a correct account of all moneys received and disbursed by them. On a form prescribed by the North Carolina State Firemen's Association, each local board shall certify by October 31 of each year the following to the Association: the balance of the local fund, proof of sufficient bonding, a full accounting of the previous year's expenditures, and a full accounting of membership qualifications. Such certification shall be made concurrently with the local unit's statement of Fire Readiness.

(b) In turn, the State Firemen's Association shall certify to the Department of Insurance by January 1 of each year on a form prescribed by the Department, the local units which have complied with the requirements of subsection (a) of this section.

(c) In the event that any board of trustees in any of the towns and cities benefited by this Article shall neglect or fail to perform their duties, or shall willfully misappropriate the funds entrusted in their care by obligating or disbursing such funds for any purpose other than those set forth in G.S. 58-84-35, then the Insurance Commissioner shall withhold any and all further payments to such board of trustees, or their successors, until the matter has been fully investigated by an official of the State Firemen's Association, and adjusted to the satisfaction of the Insurance Commissioner.

(d) In the event that any local relief fund provided for in this Article becomes impaired, then the Firemen's Relief Fund may in

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April 8, 1997

MEMORANDUM

TO: Senator Richard Conder
Senator Aaron Plyler

FROM: Stanley Moore SM
Fiscal Research Division

SUBJECT: Actuarial/Fiscal Note (Senate Bill 677)
Albemarle Firemen's Supplemental Pension Fund

In accordance with North Carolina General Statute 120-114 and applicable Rules of the North Carolina Senate and House of Representatives, attached is a certified copy of an original actuarial/fiscal note on the above subject as prepared by the General Assembly's Consulting Actuary and this Division.

cc: Chairman, Senate Committee on Pensions & Retirement
Senate Principal Clerk

Attachment(s):
(1) Actuarial/Fiscal Note, Senate Bill 677, April 4, 1997

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

North Carolina General Assembly
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April 4, 1997

Senators Richard Conder and Aaron Plyler
North Carolina Senate
Raleigh, North Carolina 27603-5925

Re: Actuarial/Fiscal Note (Senate Bill 677)
Albemarle Firemen's Supplemental Pension Fund

Dear Senators Conder and Plyler:

In accordance with North Carolina General Statute 120-114 and applicable Rules of the North Carolina Senate and House of Representatives, we hereby submit an Actuarial/Fiscal Note on the following: Repeal of the Albemarle Firemen's Supplemental Fund.

A reliable estimate of the financial and actuarial effects of the foregoing proposal is as follows: The Albemarle Firemen's Supplemental Fund is presently financed by the transfer of all funds including investment income in excess of $500 from the City of Albemarle Firemen's Local Relief Fund on an annual money-purchase basis. This Fund presently provides a monthly benefit of $ .75 for each year of service up to 26 years and 8 months to retired firemen of the City of Albemarle. With this repeal, all funds will be transferred from the Albemarle Firemen's Supplemental Fund back to the City of Albemarle Firemen's Local Relief Fund to be used as allowed by G. S. 58-84-35.

Actuarial Endorsement:

Charles W. Dunn
Consulting Actuary
Dilts, Umstead & Dunn
Durham, North Carolina

Sincerely,

Stanley Moore
Fiscal Analyst
Fiscal Research Division

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

ACTUARIAL NOTE
True & Exact Copy of Original
Certified By: Stanley Moore Date: 4-8-97
Legislative Fiscal Research

North Carolina General Assembly
Legislative Services Office

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April 8, 1997

MEMORANDUM

TO: Senator Eric Reeves

FROM: Stanley Moore
Fiscal Research Division

SUBJECT: Actuarial/Fiscal Note (Senate Bill 713)
Raleigh Firemen's Supplemental Retirement Fund

In accordance with North Carolina General Statute 120-114 and applicable Rules of the North Carolina Senate and House of Representatives, attached is a certified copy of an original actuarial/fiscal note on the above subject as prepared by the General Assembly's Consulting Actuary and this Division.

cc: Chairman, Senate Committee on Pensions & Retirement
Senate Principal Clerk

Attachment(s):
(1) Actuarial/Fiscal Note, Senate Bill 713, April 4, 1997

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

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April 4, 1997

Senator Eric Reeves
North Carolina Senate
Legislative Building
Raleigh, North Carolina 27601

Re: Actuarial/Fiscal Note (Senate Bill 713)
Raleigh Firemen's Supplemental Retirement Fund

Dear Senator Reeves:

In accordance with North Carolina General Statute 120-114 and applicable Rules of the North Carolina Senate and House of Representatives, we hereby submit an Actuarial/Fiscal Note on the following: Repeal of the Raleigh Firemen's Supplemental Retirement Fund.

A reliable estimate of the financial and actuarial effects of the foregoing proposal is as follows: The Raleigh Firemen's Supplemental Retirement Fund is presently financed by the transfer of all investment income from the City of Raleigh Firemen's Local Relief Fund on an annual money-purchase basis. This Fund presently provides an annual benefit of $1,000 to retired firemen with 20 or more years of service as a fireman with the City of Raleigh. With this repeal, all funds will be transferred from the Raleigh Firemen's Supplemental Retirement Fund back to the City of Raleigh Firemen's Local Relief Fund to be used as allowed by G. S. 58-84-35.

Actuarial Endorsement:

Charles W. Dunn
Consulting Actuary
Dilts, Umstead & Dunn
Durham, North Carolina

Sincerely,

Stanley Moore
Fiscal Analyst
Fiscal Research Division

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

ACTUARIAL NOTE
True & Exact Copy of Original
Certified By: Stanley Moore **Date:** 4-8-97
Legislative Fiscal Research

NORTH CAROLINA DEPARTMENT OF INSURANCE

MEMORANDUM

April 16,1997

TO: Members of the Senate Pensions and Retirement and Insurance Committee

FROM: William K. Hale
Deputy Commissioner

SUBJECT: Senate Bill 614 -- Insurance Licensing Amendments

This bill would change the law on hearings and civil penalties for insurance licensees by replacing antiquated notice and hearing provisions with a requirement that the Commissioner proceed after notice and opportunity for a hearing and by clearly making all administrative proceedings under Chapter 58 subject to the Administrative Procedure Act, unless otherwise specifically provided.

It would add a law requiring that an individual licensee notify the Commissioner within 10 days after the date of conviction of any crime or offense other than motor vehicle infraction. It would require every license applicant to inform the Commissioner of the applicant's address and require every individual licensee to give written notification to the Commissioner of any change in the licensee's residential address within 10 business days after the change. It would further provide that when the Commissioner is required to give a notice to a licensee, the Commissioner may mail the notice to the address that the licensee has provided.

It would rewrite the law allowing an experienced adjuster licensed in another state to act as an adjuster in North Carolina without a license if the adjuster is doing "emergency insurance adjustment work", which includes adjusting losses arising out of a catastrophe common to all those losses that is declared a disaster by the Governor or the President.

It would repeal a redundant law on summary suspensions of agent, broker, and adjuster licenses.

It would provide that the license of any agent or adjuster who fails to comply with continuing education requirements lapses and would provide for extensions of time to comply with the requirements, for good cause shown.

It would remove a requirement that an applicant for bondsman's or runner's license be of good moral character and not have been convicted of a felony or any crime involving moral turpitude. In its place would be a provision to allow the Commissioner to deny, suspend, revoke, or refuse to renew a bondsman's or runner's license if the applicant or licensee is convicted of a crime involving moral turpitude; and to require the Commissioner to deny, revoke, or refuse to renew the application or license if an applicant or licensee has ever been convicted of a felony. It would repeal a redundant civil penalty law for bondsmen and runners.

It would reduce the prelicensing education hours from 20 to 16 and reduce the annual continuing education hours from 10 to 8 for bondsmen and runners. It would also provide that a bondsman's or runner's license lapses for failure to comply with continuing education requirements and that the Commissioner may grant extensions of time to comply for good cause shown.

It would repeal the bond requirement for viatical settlement providers. A viatical settlement is a contract in which the owner of a life insurance policy who has a catastrophic illness transfers it to another person (the viatical settlement provider) in exchange for payment of less than the expected death benefit of the policy.

It would make numerous technical amendments to the law that created the Home Inspector Licensure Board. It would also change the requirement that the Board act on a license application within 30 days after receipt. If an applicant does not measure up to the licensing requirements, the Board must refuse to issue a license and notify the applicant in writing of grounds for the denial.

The applicant then has 30 days to demand that the Board review its action and 30 days after that review to demand a hearing under the Administrative Procedure Act.

The provision on insurance licensees notifying the Commissioner of convictions and changes of addresses is effective January 1, 1998. The provision on emergency work by out-of-state adjusters is effective Sept. 1, 1997. The provisions on continuing education requirements, grounds for denial or suspension of licenses, and home inspector licensing are effective October 1, 1997. The remainder of act is effective when the bill becomes law.

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April 16, 1997

MEMORANDUM

To: Senate Committee on Pensions & Retirement and Insurance

From: M. Lynn Marshbanks, Committee Counsel

Re: Senate Bill 614: Insurance Licensing Amendments

Senate Bill 614 would revise the insurance licensing laws by doing the following:

1. Amends G.S. 58-2-70, concerning penalties for violations of licensing and certification requirements in Chapter 58, by deleting the current requirements for notice and a hearing, and stating that, unless otherwise provided for, all administrative proceedings are governed by Chapter 150B, the Administrative Procedure Act.

2. Amends G.S. 58-2-70 and G.S. 143-143.13, concerning licensing of manufactured home manufacturers and dealers, to state that money collected for violations under those sections is to be forwarded to the county school funds of the counties where the money was collected (Art. IX, Sec. 7 of the N.C. Constitution).

3. Adds G.S. 58-2-69, providing that: (1) every license applicant under Chapter 58 must inform the Commissioner of the applicant's residental address; (2) every licensee must notify the Commisisoner of an address change; (3) any licensee convicted for any crime other than a motor vehicle infraction ("conviction" includes a guilty sentence, a guilty plea, or a plea of no contest) must notify the Commissioner within 10 days; and (4) when the Commissioner is required to give notice to a licensee, it may be done personally or by first class mail. Effective January 1, 1998.

4. Amends G.S. 58-33-70, which allows insurance adjusters licensed in other states to do "emergency insurance adjustment work" for up to 30 days in North Carolina, to define "emergency insurance adjustment work" as the adjusting of losses arising out of a catastrophe declared a disaster by the Governor or by the President. Effective September 1, 1997.

5. Deletes G.S. 58-33-45(b), which allows the Commissioner to suspend a license in an emergency situation without notice and a hearing.

6. Amends G.S. 58-33-130(c) to provide that the license of an insurance agent who does not comply with the continuing education requirements will lapse, and that the Commissioner may grant extensions of time for compliance. Effective October 1, 1997.

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

7. Amends G.S. 58-71-5 to remove the requirement that an applicant for a license as a bail bondsman or runner must be of good moral character and not have been convicted of a felony or any crime involving moral turpitude. In turn, however, it amends G.S. 58-71-80 to provide that the Commissioner may deny, suspend or revoke, or refuse to renew a bail bondsman's or runner's license if the person is convicted of a crime involving moral turpitude, and to provide that the Commissioner must deny, suspend, revoke, or refuse to renew a license if the person has ever been convicted of a felony. Also, effective October 1, 1997, removes the Commissioner's authority to require a licensee to pay $250 per offense to the county school fund in lieu of revoking or suspending the license.

8. Amends G.S. 58-71-71 to reduce the number of hours of education to be a bail bondsman or runner from 20 to 16. Also reduces from 10 to 8 hours the amount of required yearly continuing education. Effective October 1, 1997, provides that the license of a person failing to comply with these requirements will lapse, but the Commissioner may grant extensions of time for compliance.

9. Deletes the requirement in G.S. 58-71-165 that a bail bondsman or surety bondsman file with the clerk of superior court in a county where the person is obligated on bail bonds a copy of the monthly report required by the Insurance Department.

10. Removes the Commissioner's authority under G.S. 58-58-42 to require a bond as part of a viatical settlement (a contract in which the insurance policy holder with a life-threatening illness transfers it to another person for less payment than the expected death benefit of the policy).

11. Amends G.S. 143-151.45 to provide that an "associate home inspector" includes a person affiliated with a licensed home inspector to conduct an inspection, and amends G.S. 143-151.52 to allow a person who is employed by, or intends to be employed by, a licensed home inspector to meet one of the requirements to be an associate home inspector (currently, the person must be "affiliated with" or "intend[s] to be affiliated with".)

12. Removes requirement in G.S. 143-151.53 that the Home Inspector Licensure Board must notify an applicant for a license within 30 days whether it has accepted the application. Substitutes a requirement that the Board must notify an applicant when it denies a license, and within 30 days of notification, the applicant may ask for a review. Within 30 days of notification of the outcome of the review, the applicant may ask for a hearing under Chapter 150B. Effective October 1, 1997.

13. Amends G.S. 143-151.56 to allow the Home Inspector Licensure Board to deny, refuse to renew, suspend, revoke, or put probationary conditions on, a license, if the applicant has been convicted of a misdemeanor involving moral turpitude or any felony (currently, "any crime involving moral turpitude"). Effective October 1, 1997, applying to applications for licensure or renewal submitted on or after that date.

Effective date for remainder of act: When it becomes law.

3:30

Pen + Ret — 4-16-97

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Martin Eeler	Seef-Help
Gene Causby	E-E&C
Mike Cannata	NCDSA
David Anders	PTRC
Richard O'Brien	PFFNC
Weaver Rogers	SPBR
KEITH HUNDLEY	WSW&H
Tom Morrow	SPBR
VLM-Bride	NCDA

Pen. & Pet. — 4-16-97

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Susan Valauri	Nationwide
Paul Smith	Raleigh Fire Dept.
James Farantatos	Ral. Fire Dept.
Brian Washington	NCAE
[illegible] Hall	NCAOI
DD Propes	"
Ann Schwindaman	NC Council of Comm. Programs
Bob Belcher	NCSBA
Ann Belcher	SBE
Adam Searing	NC Health Access Coalition

Pension &Retirement/ Insurance Committee

April 23,1997
10:00
1124 LOB

Sen. Jenkins, Chairman

AGENDA

SB 434 National Guard Health Benefits
Sen. Forrester

SB 714 Coverage for Reconstr. Surgery
Sen. Forrester

SB 785 Direct Payment Sunsets Off
Sen. Martin

SB 843 Insurance Technical Changes
Sen. Jenkins

MINUTES

Pensions & Retirement/ Insurance Committee

The Pensions & Retirement/ Insurance committee met April 23, 1997 at 10:00 in room 1124 of the Legislative Building. There were thirteen members in attendance, including Sen. Jenkins, who presided. The following bills were acted upon:

SB 975 **Workers' Compensation Self-Insurance** was explained by Sen. Kincaid. Sen. Kincaid moved for a favorable report. The motion carried.

SB 434 **National Guard Health Benefits** was explained by Sen. Forrester. An amendment was sent forth by Sen. Wellons which was approved. It was rolled into a committee substitute. Sen. Odom moved for an unfavorable as to bill, but favorable to committee substitute. The motion carried. The bill was referred to Appropriations by Sen. Jenkins.

SB 714 **Coverage for Reconstr. Surgery** was explained by Sen. Forrester. Sen. Wellons sent forth an amendment that addressed additional coverage in SB 796 Areola Reconstruction Coverage. The amendment was approved and rolled into a committee substitute. Sen. Wellons moved for an unfavorable as to original bill, but favorable as to committee substitute. The motion carried. The bill was referred to Appropriations by Sen. Jenkins, chairman.

SB 785 **Direct Payment Sunset Off** was explained by Sen. Kinnaid. Sen. McDaniel moved for a favorable report. The motion carried.

The meeting was adjourned.

Sen. Jenkins, Chairman

Katy Haynes

Katy Haynes, Clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

PENSIONS & RETIREMENT/ INSURANCE COMMITTEE REPORT
Senator Tommy Jenkins, Chairman

Wednesday, April 23, 1997

SENATOR TOMMY JENKINS,
submits the following with recommendations as to passage:

FAVORABLE

S.B. **785** Direct Payment Sunset Off
Sequential Referral: None
Recommended Referral: None

S.B. **975** Workers' Compensation Self-Insurance
Sequential Referral: None
Recommended Referral: None

TOTAL REPORTED: 2

Committee Clerk Comment: None

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

PENSIONS & RETIREMENT/INSURANCE COMMITTEE REPORT
Senator Tommy Jenkins, Chairman

Tuesday, April 29, 1997

SENATOR JENKINS,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO C.S. BILL

S.B. **714** Coverage for Reconstr. Surgery

Draft Number:	PCS1797
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 1

Committee Clerk Comment:

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

PENSIONS & RETIREMENT/ INSURANCE COMMITTEE REPORT
Senator Tommy Jenkins, Chairman

Thursday, June 12, 1997

SENATOR TOMMY JENKINS,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 1,
BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

H.B.(CS #1)434 Federal Health Insurance Changes/AB

Draft Number:	PCS1397
Sequential Referral:	NONE
Recommended Referral:	NONE
Long Title Amended:	No

TOTAL REPORTED: 1

Committee Clerk Comment: None

GENERAL ASSEMBLY OF NORTH CAROLINA
1997 SESSION

S.L. 1997-362
SENATE BILL 975

A BILL TO BE ENTITLED

AN ACT TO REWRITE THE LAWS CONCERNING EMPLOYER AND EMPLOYER GROUP WORKERS' COMPENSATION SELF-INSURANCE AND CODIFY RELATED ADMINISTRATIVE RULES AND TO PROVIDE FOR GUIDELINES FOR PERSONS AND ENTITIES THAT ADMINISTER OR SERVICE WORKERS' COMPENSATION BUSINESS FOR SELF-INSURED EMPLOYERS AND EMPLOYER GROUPS.

The General Assembly of North Carolina enacts:

Section 1. The heading of Article 47 of Chapter 58 of the General Statutes reads as rewritten:

"~~North Carolina Health Care Excess Liability Fund.~~
Workers' Compensation Self-Insurance."

Section 2. G.S. 58-47-1, 58-47-5, 58-47-10, 58-47-15, 58-47-20, 58-47-25, 58-47-30, 58-47-35, 58-47-40, 58-47-45, and 58-47-50 are repealed.

Section 3. Article 47 of Chapter 58 of the General Statutes is amended by adding the following:

"Part 1. Employer Groups.

"**§ 58-47-60. Definitions.**

As used in this Part:

(1) 'Act' means the Workers' Compensation Act in Article 1 of Chapter 97 of the General Statutes, as amended.
(2) 'Affiliate' has the same meaning as in G.S. 58-19-5(1).
(3) 'Annual statement filing' means the most recent annual filing made with the Commissioner under G.S. 58-2-165.
(4) 'Board' means the board of trustees or other governing body of a group.
(5) 'Books and records' means all files, documents, and databases in a paper form, electronic medium, or both.
(6) 'Control' means "control" as defined in G.S. 58-19-5(2).
(7) 'GAAP financial statement' means a financial statement as defined by generally accepted accounting principles.
(8) 'Group' means two or more employers who agree to pool their workers' compensation liabilities under the Act and are licensed under this Part.
(9) 'Hazardous financial condition' means that, based on its present or reasonably anticipated financial condition, a person is insolvent or, although not financially impaired or insolvent, is unlikely to be able to meet obligations for known claims and reasonably

anticipated claims or to pay other obligations in the normal course of business.

(10) 'Member' means an employer that participates in a group.

(11) 'Qualified actuary' means a member in good standing of the Casualty Actuarial Society or a member in good standing of the American Academy of Actuaries, who has been approved as qualified for signing casualty loss reserve opinions by the Casualty Practice Council of the American Academy of Actuaries, and is in compliance with G.S. 58-2-171.

(12) 'Rate' means the cost of insurance per exposure unit, whether expressed as a single number or as a prospective loss cost with an adjustment to account for the treatment of expenses, profit, and variations in loss experience, before any application of individual risk variations based on loss or expense considerations, and does not include minimum premiums.

(13) 'Service company' means an entity that has contracted with an employer or group for the purpose of providing any services related to claims adjustment, loss control, or both.

(14) 'Third-party administrator' or 'TPA' means a person engaged by a board to execute the policies established by the board and to provide day-to-day management of the group. 'Third-party administrator' or 'TPA' does not mean:

a. An employer acting on behalf of its employees or the employees of one or more of its affiliates.

b. An insurer that is licensed under this Chapter or that is acting as an insurer with respect to a policy lawfully issued and delivered by it and under the laws of a state in which the insurer is licensed to write insurance.

c. An agent or broker who is licensed by the Commissioner under Article 33 of this Chapter whose activities are limited exclusively to the sale of insurance.

d. An adjuster licensed by the Commissioner under Article 33 of this Chapter whose activities are limited to adjustment of claims.

e. An individual who is an officer, a member, or an employee of a board.

(15) 'Underwriting' means the process of selecting risks and classifying them according to their degrees of insurability so that the appropriate rates may be assigned. The process also includes rejection of those risks that do not qualify.

"**§ 58-47-65. Licensing; qualification for approval.**

(a) No group shall self-insure its workers' compensation liabilities under the Act unless it is licensed by the Commissioner under this Part.

(b) An applicant for a license shall file with the Commissioner the information required by subsection (f) of this section on a form prescribed by the Commissioner at least 90 days before the proposed licensing date. The applicant shall furnish to the Commissioner satisfactory proof of the proposed group's financial ability, through its members, to comply with the Act. No application is complete until the Commissioner has received all required information.

(c) The group shall comprise two or more employers who are members of and are sponsored by a single bona fide trade or professional association. The association shall (i) comprise members engaged in the same or substantially similar business or profession within the State, (ii) have been incorporated in North Carolina, (iii) have

been in existence for at least five years before the date of application to the Commissioner to form a group, and (iv) submit a written determination from the Internal Revenue Service that it is exempt from taxation under 26 U.S.C. § 501(c). This subsection does not apply to a group that was organized and approved under North Carolina law before July 1, 1995.

(d) Only an applicant whose members' employee base is actuarially sufficient in numbers and provides an actuarially appropriate spreading of risk may apply for a license. The Commissioner shall consider (i) the financial strength and liquidity of the applicant relative to its ability to comply with the Act, (ii) the applicant's criteria and procedures regarding the review and monitoring of members' financial strength, (iii) reliability of the financial information, (iv) workers' compensation loss history, (v) underwriting guidelines, (vi) claims administration, (vii) excess insurance or reinsurance, and (viii) access to excess insurance or reinsurance.

(e) Before issuing a license to any applicant, the Commissioner shall require, in addition to the other requirements provided by law, that the applicant file an affidavit signed by the association's board members that it has not violated any of the applicable provisions of this Part or the Act during the last 12 months, and that it accepts the provisions of this Part and the Act in return for the license.

(f) The license application shall comprise the following information:

(1) Biographical affidavits providing the education, prior occupation, business experience, and other supplementary information submitted for each promoter, incorporator, director, trustee, proposed management personnel, and other persons similarly situated.

(2) A forecast for a five-year period based on the initial capitalization of the proposed group and its plan of operation. The forecast shall be prepared by a certified public accountant, a qualified actuary, or both, be in sufficient detail for a complete analysis to be performed, and be accompanied by a list of the assumptions utilized in making the forecast.

(3) An individual application, under G.S. 58-47-125, of each member applying for coverage in the proposed group on the inception date of the proposed group, with a current GAAP financial statement of the member. The financial statements are confidential, but the Commissioner may use them in any judicial or administrative proceeding.

(4) A breakdown of all forecasted administrative expenses for the proposed group's fiscal year in a dollar amount and as a percentage of the estimated annual premium.

(5) The proposed group's procedures for evaluating the current and continuing financial strength of members.

(6) Evidence of the coverage required by G.S. 58-47-95.

(7) Demonstration provided by the board, satisfactory to the Commissioner, that the proposed group's member employee base is actuarially sufficient in numbers and provides an actuarially appropriate spreading of risk.

(8) An assessment plan under G.S. 58-47-135(a).

(9) A listing of the estimated premium to be developed for each member individually and in total for the proposed group. Payroll data for each of the three preceding years shall be furnished by risk classification.

(10) An executed agreement by each member showing the member's obligation to pay to the proposed group not less than twenty-five

percent (25%) of the member's estimated annual premium not later than the first day of coverage afforded by the proposed group.

(11) Composition of the initial board.

(12) An indemnity agreement on a form prescribed by the Commissioner.

(13) Proof, satisfactory to the Commissioner, that either the applicant has within its own organization ample facilities and competent personnel to service its program for underwriting, claims, and industrial safety engineering, or that the applicant will contract for any of these services. If the applicant is to perform any servicing, biographical affidavits of those persons who will be responsible for or performing servicing shall be included with the information in subdivision (1) of this subsection. If a group contracts with a service company or TPA to administer and adjust claims, the group shall provide proof of compliance with the other provisions of this Part.

(14) A letter stipulating the applicant's acceptance of membership in the North Carolina Self-Insurance Guaranty Association under Article 4 of Chapter 97 of the General Statutes.

(15) Any other specific information the Commissioner considers relevant to the organization of the proposed group.

(g) Every applicant shall execute and file with the Commissioner an agreement, as part of the application, in which the applicant agrees to deposit with the Commissioner cash or securities acceptable to the Commissioner.

"§ 58-47-70. License denial; termination; revocation; restrictions.

(a) If the Commissioner denies a license, the Commissioner shall inform the applicant of the reasons for the denial. The Commissioner may issue a license to an applicant that remedies the reasons for a denial within 60 days after the Commissioner's notice. The Commissioner may grant additional time to an applicant to remedy any deficiencies in its application. A request for an extension of time shall be made in writing by the applicant within 30 days after the Commissioner's notice. If the applicant fails to remedy the reasons for the denial, the application shall be withdrawn or denied.

(b) A group shall not terminate its license or cease the writing of renewal business without obtaining prior written approval from the Commissioner. The Commissioner shall not grant the request of any group to terminate its license unless the group has closed or reinsured all of its incurred workers' compensation obligations and has settled all of its other legal obligations, including known and unknown claims and associated expenses.

(c) No group shall transfer its workers' compensation obligations under an assumption reinsurance agreement without complying with Part 2 of Article 10 of this Chapter.

(d) Every group is subject to Article 19 of this Chapter. No group shall merge with another group unless both groups are engaged in the same or a similar type of business.

"§ 58-47-75. Reporting and records.

(a) As used in this section:

(1) 'Audited financial report' has the same meaning as in the NAIC Model Rule Requiring Annual Audited Financial Reports, as specified in G.S. 58-2-205.

(2) 'Duplicate record' means a counterpart produced by the same impression as the original record, or from the same matrix, or by mechanical or electronic rerecording or by chemical reproduction,

or by equivalent techniques, such as imaging or image processing, that accurately reproduce the original record.

(3) 'Original record' means the writing or recording itself or any counterpart intended to have the same effect by a person executing or issuing it, in the normal and ordinary course of business, or data stored in a computer or similar device, the printout or other output readable by sight, shown to reflect the data accurately. An 'original' of a photograph includes the negative or any print from the negative.

(b) Each group shall file with the Commissioner the following:

(1) A statement in accordance with G.S. 58-2-165.

(2) An audited financial report.

(3) Annual payroll information within 90 days after the close of its fiscal year. The report shall summarize the payroll by annual amount paid and by classifications using the rules, classifications, and rates set forth in the most recently approved Workers' Compensation and Employers' Liability Insurance Manual governing audits of payrolls and adjustments of premiums. Each group shall maintain true and accurate payroll records. The payroll records shall be maintained to allow for verification of the completeness and accuracy of the annual payroll report.

(c) Each group shall make its financial statement and audited financial report available to its members upon request.

(d) All records shall be maintained by the group for the years during which an examination under G.S. 58-2-131 has not yet been completed.

(e) All records that are required to be maintained by this section shall be either original or duplicate records.

(f) If only duplicate records are maintained, the following requirements apply:

(1) The data shall be accessible to the Commissioner in legible form, and legible, reproduced copies shall be available.

(2) Before the destruction of any original records, the group in possession of the original records shall:

a. Verify that the records stored consist of all information contained in the original records, and that the original records can be reconstructed therefrom in a form acceptable to the Commissioner; and

b. Implement disaster preparedness or disaster recovery procedures that include provisions for the maintenance of duplicate records at an off-site location.

(3) Adequate controls shall be established with respect to the transfer and maintenance of data.

(g) Each group shall maintain its records under G.S. 58-7-50, G.S. 58-7-55, and the Act.

(h) All books of original entry and corporate records shall be retained by the group or its successor for a period of 15 years after the group ceases to exist.

"§ 58-47-80. Assets and invested assets.

Funds shall be held and invested by the board under G.S. 58-7-160, 58-7-162, 58-7-163, 58-7-165, 58-7-167, 58-7-168, 58-7-170, 58-7-172, 58-7-173, 58-7-177, 58-7-178, 58-7-179, 58-7-180, 58-7-183, 58-7-185, 58-7-187, 58-7-188, 58-7-192, 58-7-193, 58-7-195, 58-7-197, and 58-7-200.

"§ 58-47-85. Surplus requirements.

Every group shall maintain minimum surplus under one of the options in subdivision (1), (2), or (3) of this section:

(1) Maintain minimum surplus in accordance with Article 12 of this Chapter. A group organized and authorized before the effective date of this section shall comply with this section under the following schedule:

a. Forty percent (40%) of the surplus, in accordance with Article 12, by January 1, 1999.

b. Fifty-five percent (55%) of the surplus, in accordance with Article 12, by January 1, 2000.

c. Seventy percent (70%) of the surplus, in accordance with Article 12, by January 1, 2001.

d. Eighty-five percent (85%) of the surplus, in accordance with Article 12, by January 1, 2002.

e. One hundred percent (100%) of the surplus, in accordance with Article 12, by January 1, 2003.

The Commissioner shall not approve any dividend request that results in a surplus that is less than one hundred percent (100%) of the minimum surplus required by Article 12 of this Chapter.

(2) Maintain minimum surplus at an amount equal to ten percent (10%) of the group's total undiscounted outstanding claim liability, according to the group's annual statement filing, or such other amount as the Commissioner prescribes based on, but not limited to, the financial condition of the group and the risk retained by the group. In addition, the group shall:

a. Maintain specific excess insurance or reinsurance that provides the coverage limits in G.S. 58-47-95(a). The group shall retain no specific risk greater than five percent (5%) of the group's total annual earned premium according to the group's annual statement filing.

b. Maintain aggregate excess insurance or reinsurance with a coverage limit being the greater of two million dollars ($2,000,000) or twenty percent (20%) of the group's annual earned premium, according to the group's annual statement filing. The aggregate excess attachment point shall be one hundred ten percent (110%) of the annual earned premium, according to the group's annual statement filing. The required attachment point shall be reduced by each point, or fraction of a point, that a group's expense ratio exceeds thirty percent (30%). Conversely, the required attachment point may be increased by each point, or fraction of a point, that a group's expense ratio is less than thirty percent (30%), but in no event shall the attachment point be greater than one hundred fifteen percent (115%) of the annual earned premium.

c. Adopt a policy whereby every member:

1. Pays a deposit to the group of twenty-five percent (25%) of the member's estimated annual earned premium, or another amount that the Commissioner prescribes based on, but not limited to, the financial condition of the group and the risk retained by the group; or

2. Once every year files with the group the member's most recent year-end balance sheet, compiled by an independent certified public accountant. The balance

sheet shall demonstrate that the member's financial position does not show a deficit equity and is appropriate for membership in the group. At the request of the Commissioner, the group shall make these filings available for review. These filings shall be kept confidential; provided that the Commissioner may use that information in any judicial or administrative proceeding.

(3) Maintain minimum surplus at an amount equal to three hundred thousand dollars ($300,000). The group shall immediately assess its members if, at any time, the group's surplus is less than the minimum surplus amount. In addition, the group shall maintain:

a. Specific excess insurance or reinsurance that provides coverage limits pursuant to G.S. 58-47-95(a). The group shall retain no specific risk greater than five percent (5%) of the group's total annual earned premium according to the group's annual statement filing.

b. Aggregate excess insurance or reinsurance with a coverage limit being the greater of two million dollars ($2,000,000) or twenty percent (20%) of the group's annual earned premium, according to the group's annual statement filing. The aggregate excess attachment point shall be one hundred ten percent (110%) of the annual earned premium, according to the group's annual statement filing. The required attachment point shall be reduced by each point, or fraction of a point, that a group's expense ratio exceeds thirty percent (30%). Conversely, the required attachment point may be increased by each point, or fraction of a point, that a group's expense ratio is less than thirty percent (30%), but in no event shall the attachment point be greater than one hundred fifteen percent (115%) of the annual earned premium.

The Commissioner may require different levels, or waive the requirement, of specific and aggregate excess loss coverage consistent with the market availability of excess loss coverage, the group's claims experience, and the group's financial condition.

"**§ 58-47-90. Deposits.**

(a) Each group shall deposit with the Commissioner an amount equal to ten percent (10%) of the group's total annual earned premium, according to the group's annual statement filing, but not less than six hundred thousand dollars ($600,000), or another amount that the Commissioner prescribes based on, but not limited to, the financial condition of the group and the risk retained by the group.

(b) G.S. 58-5-1, 58-5-20, 58-5-25, 58-5-30, 58-5-35, 58-5-40, 58-5-63, 58-5-75, 58-5-80, 58-5-90(a) and (c), 58-5-95, 58-5-110, 58-5-115, and 58-5-120 apply to groups.

(c) A group organized and authorized before January 1, 1998, has until January 1, 2001, to comply with subsection (b) of this section. However, a dividend request shall not be approved by the Commissioner until the group has replaced its surety bonds with the deposit required by subsection (b) of this section.

(d) No judgment creditor, other than a claimant entitled to benefits under the Act, may levy upon any deposits made under this section.

(e) Surety bonds shall be in a form prescribed by the Commissioner and issued by an insurer authorized by the Commissioner to write surety business in North Carolina.

(f) Any surety bond may be exchanged or replaced with another surety bond that meets the requirements of this section if 90 days' advance written notice is provided to the Commissioner. An endorsement to a surety bond shall be filed with the Commissioner within 30 days after its effective date.

(g) If a group ceases to self-insure, dissolves, or transfers its workers' compensation obligations under an assumption reinsurance agreement, the Commissioner shall not release any deposits until the group has fully discharged all of its obligations under the Act.

"**§ 58-47-95. Excess insurance and reinsurance.**

(a) Each group, on or before its effective date of operation and on a continuing basis thereafter, shall maintain specific and aggregate excess loss coverage through an insurance policy or reinsurance contract. Groups shall maintain limits and retentions commensurate with their exposures. A group's retention shall be the lowest retention suitable for groups with similar exposures and annual premium. The Commissioner may require different levels, or waive the requirement, of specific and aggregate excess loss coverage consistent with the market availability of excess loss coverage, the group's claims experience, and the group's financial condition.

(b) Any excess insurance policy or reinsurance contract under this section shall be issued by a licensed insurance company, an approved surplus lines insurance company, or an accredited reinsurer, and shall:

(1) Provide for at least 30 days' written notice of cancellation by certified mail, return receipt requested, to the group and to the Commissioner.

(2) Be renewable automatically at its expiration, except upon 30 days' written notice of nonrenewal by certified mail, return receipt requested, to the group and to the Commissioner.

(c) Every group shall provide to the Commissioner evidence of its excess insurance or reinsurance coverage, and any amendments, within 30 days after their effective dates. Every group shall, at the request of the Commissioner, furnish copies of any excess insurance policies or reinsurance contracts and any amendments.

"**§ 58-47-100. Examinations.**

G.S. 58-2-131, 58-2-132, and 58-2-133 apply to groups.

"**§ 58-47-105. Dividends and other distributions.**

(a) Group dividends and other distributions shall be made in accordance with G.S. 58-7-130, 58-8-25(b), and 58-19-30. A group shall be in compliance with this Part before payment of dividends or other distributions to its members. No group shall pay dividends or other distributions to its members until two years after the group's licensing date.

(b) Payment of dividends to the members of any group shall not be contingent upon the maintenance or continuance of membership in the group.

"**§ 58-47-110. Premium rates.**

(a) As used in this section:

(1) 'Bureau' means the North Carolina Rate Bureau in Article 36 of this Chapter.

(2) 'Expenses' means that portion of a premium rate attributable to acquisition, field supervision, collection expenses, and general expenses, as determined by the group.

(3) 'Multiplier' means a group's determination of the expenses, other than loss expense and loss adjustment expense, associated with writing workers' compensation and employers' liability insurance, which shall be expressed as a single nonintegral number to be applied equally and uniformly to the prospective loss costs

approved by the Commissioner in making rates for each classification of risks utilized by that group.

(4) 'Prospective loss costs' means that portion of a rate that does not include provisions for expenses (other than loss adjustment expenses) or profit and that is based on historical aggregate losses and loss adjustment expenses adjusted through development to their ultimate value and forecasted through trending to a future point in time.

(5) 'Supplementary rating information' means any manual or plan of rates, classification, rating schedule, minimum premium, policy fee, rating rule, rate-related underwriting rule, experience rating plan, statistical plan, and any other similar information needed to determine the applicable rate in effect or to be in effect.

(b) Rates and the effective date shall be submitted by the group to the Commissioner for prior approval in the form of a rate filing. The rate filing:

(1) Shall be on a form prescribed by the Commissioner and shall be supported by competent analysis, prepared by an actuary who is a member in good standing of the Casualty Actuarial Society or the American Academy of Actuaries, demonstrating that the resulting rates meet the standards of not being excessive, inadequate, or unfairly discriminatory;

(2) Shall have the final rates and the effective date determined independently and individually by the group;

(3) Shall have manual rates that are the combination of the prospective loss costs and the multiplier;

(4) Shall file any other information that the group considers relevant and shall provide any other information requested by the Commissioner;

(5) Shall be considered complete when the required information and all additional information requested by the Commissioner is received by the Commissioner. When a filing is not accompanied by the information required under this section, the Commissioner shall inform the group within 30 days after the initial filing that the filing is incomplete and shall note the deficiencies. If information required by a rate filing or requested by the Commissioner is not maintained or cannot be provided, the group shall certify that to the Commissioner;

(6) May include deviations to the prospective loss cost based on the group's anticipated experience. Sufficient documentation supporting the deviations and the impact of the deviation shall be included in the rate filing. Expense loads, whether variable, fixed, or a combination of variable and fixed, may vary by individual classification or grouping. Each filing that varies the expense load by class shall specify the expense factor applicable to each class and shall include information supporting the justification for the variation;

(7) Shall include any proposed use of a premium-sized discount program, a schedule rating program, a small deductible credit program or an expense constant or minimum premium, and the use shall be supported in the rate filing; and

(8) Shall be deemed approved, unless disapproved by the Commissioner in writing, within 60 days after the rate filing is made in its entirety. A group is not required to refile rates

previously approved until two years after the effective date of this Part.

(c) At the time of the rate filing, a group may request to have its approved multiplier remain in effect and continue to use either the prospective loss cost filing in effect at the time of the rate filing or the prospective loss cost filing in effect at the time of the filing, along with all other subsequent prospective loss cost filings, as approved.

(d) To the extent that a group's manual rates are determined solely by applying its multiplier, as presented and approved in the rate filing, to the prospective loss costs contained in the Bureau's reference filing and printed in the Bureau's rating manual, the group need not develop or file its final rate pages with the Commissioner. If a group chooses to print and distribute final rate pages for its own use, based solely upon the application of its filed prospective loss costs, the group need not file those pages with the Commissioner. If the Bureau does not print the prospective loss costs in its manual, the group shall submit its rates to the Commissioner.

(e) If a new filing of rules, relativities, and supplementary rating information is filed by the Bureau and approved:

(1) The group shall not file anything with the Commissioner if the group decides to use the revisions as filed, with the effective date as filed together with the prospective loss multiplier on file with the Commissioner.

(2) The group shall notify the Commissioner of its effective date before the Bureau filing's effective date if the group decides to use the revisions as filed but with a different effective date.

(3) The group shall notify the Commissioner before the Bureau filing's effective date if the group decides not to use the revision or revisions.

(4) The group shall file the modification with the Commissioner, for approval, specifying the basis for the modification and the group's proposed effective date if different from the Bureau filing's effective date, if the group decides to use the revision with deviations.

(f) Every group shall adhere to the uniform classification plan and experience rating plan filed by the Bureau.

(g) Groups shall maintain data in accordance with the uniform statistical plan approved by the Commissioner.

(h) Each group shall submit annually a rate certification, signed by an actuary who is a member in good standing of the Casualty Actuarial Society or the American Academy of Actuaries, which states that the group's prospective rates are not excessive, inadequate, or unfairly discriminatory. The certification is to accompany the group's rate filing. If a rate filing is not required, the actuarial rate certification is to be submitted by the end of the calendar year.

"**§ 58-47-115. Premium payment requirements.**

Groups shall collect members' premiums for each policy period in a manner so that at no time the sum of a member's premium payments is less than the total estimated earned premium for that member.

"**§ 58-47-120. Board; composition, powers, duties, and prohibitions.**

(a) Each group shall be governed by a board or other governing body comprising no fewer than three persons, elected for stated terms of office, and subject to the Commissioner's approval. All board members shall be residents of this State or members of the group. At least two-thirds of the board shall comprise employees, officers, or directors of members; provided that the Commissioner may waive this requirement for good cause. The group's TPA, service company, or any owner,

officer, employee, or agent of, or any other person affiliated with, the TPA or service company shall not serve as a board member. The board shall ensure that all claims are paid promptly and take all necessary precautions to safeguard the assets of the group.

(b) The board shall be responsible for the following:

(1) Maintaining minutes of its meetings and making the minutes available to the Commissioner.

(2) Providing for the execution of its policies, including providing for day-to-day management of the group and delineating in the minutes of its meetings the areas of authority it delegates.

(3) Designating a chair to facilitate communication between the group and the Commissioner.

(4) Adopting a policy of reimbursement from the assets of the group for out-of-pocket expenses incurred as board members, if so desired.

(c) The board shall not:

(1) Be compensated by the group, TPA, or service company except for out-of-pocket expenses incurred as board members.

(2) Extend credit to members for payment of a premium, except under payment requirements set forth in this Part.

(3) Borrow any money from the group or in the name of the group, except in the ordinary course of business, without first informing the Commissioner of the nature and purpose of the loan and obtaining the Commissioner's approval.

(d) The board shall adopt bylaws to govern the operation of the group. The bylaws shall comply with the provisions of this section and shall include:

(1) The method for selecting the board members, including terms of office.

(2) The method for amending the bylaws and the plans of operation and assessment.

(3) The method for establishing and maintaining the group.

(4) The procedures and requirements for dissolving the group.

(e) Each group shall file a copy of its bylaws with the Commissioner. Any changes to the bylaws shall be filed with the Commissioner no later than 30 days before their effective dates. The Commissioner may order the group to rescind or revoke any bylaw if it violates this section or any other applicable law or administrative rule.

(f) The board shall adopt and administer a plan of operation to assure the fair, reasonable, and equitable administration of the group. All members shall comply with the plan. The plan shall comply with this section and include:

(1) Procedures for administering the assets of the group.

(2) A plan of assessment.

(3) Loss control services to be provided to the members.

(4) Rules for payment and collection of premium.

(5) Basis for dividends.

(6) Reimbursement of board members.

(7) Intervals for meetings of the board, which shall be held at least semiannually.

(8) Procedures for the maintenance of records of all transactions of the group.

(9) Procedures for the selection of the board members.

(10) Additional provisions necessary or proper for the execution of the powers and duties of the group.

(11) Qualifications for group membership, including underwriting guidelines and procedures to identify members that are in hazardous financial conditions.

(g) The plan and any amendments become effective upon approval in writing by the Commissioner.

(h) Each year the board shall review:

(1) The performance evaluation of the TPA or service company, if applicable.
(2) Loss control services.
(3) Investment policies.
(4) Delinquent debts.
(5) Membership cancellation procedures.
(6) Admission of new members.
(7) Claims administration and reporting.
(8) Payroll audits and findings.
(9) Excess insurance or reinsurance coverage.

The board's findings from its review shall be documented in the board's minutes.

(i) G.S. 58-7-140 applies to board members.

"**§ 58-47-125. Admission and termination of group members.**

(a) Prospective group members shall submit applications for membership to the board. The board, a designated employee of the group, or TPA shall approve an application for membership under the bylaws of the group. Members shall have bona fide offices in this State and members' employees shall be primarily engaged in business activities within this State. Members shall receive certificates of coverage from the board on a form acceptable to the Commissioner.

(b) The group shall make available to the Commissioner properly executed applications and indemnity agreements for all members, on forms prescribed by the Commissioner. If the applications and indemnity agreements are not executed properly and maintained, the Commissioner may order the group to cease writing all new business until all of the agreements are executed properly and obtained.

(c) Members may elect to terminate their participation in a group and may be canceled by the group under G.S. 97-99 and the bylaws of the group.

"**§ 58-47-130. Disclosure.**

Every group through its board, TPA, service company, agents, or other representatives shall require, before accepting an application, each applicant for membership to acknowledge in writing that the applicant has received the following:

(1) A document disclosing that the members are jointly and severally liable for the obligations of the group.
(2) A copy of the group's plan of assessment.
(3) The amount of specific and aggregate stop loss or excess insurance or reinsurance carried by the group, the amount and kind of risk retained by the group, and the name and rating of the insurer providing stop loss, excess insurance, or reinsurance.

"**§ 58-47-135. Assessment plan and indemnity agreement.**

(a) Each group shall establish an assessment plan that provides for a reasonable and equitable mechanism for assessing its members. The plan and any amendments shall be approved by the Commissioner. The plan shall include descriptions of the circumstances that initiate an assessment, basis, and allocation to members of the amount being assessed, and collection of the assessment.

(b) The board shall notify the Commissioner of an assessment no fewer than 60 days before an assessment.

(c) The Commissioner shall impose an assessment on members if the board or third-party administrator fails to take action to correct a hazardous financial condition.

(d) Every group shall file an indemnity agreement on a form prescribed by the Commissioner, which jointly and severally binds the members of the group to comply with the provisions of the act and pay obligations imposed by the Act.

"§ 58-47-140. Other provisions of this Chapter.

G.S. 58-1-10, 58-2-45, 58-2-50, 58-2-70, 58-2-100, 58-2-105, 58-2-155, 58-2-161, 58-2-180, 58-2-185, 58-2-190, 58-2-200, 58-3-71, 58-3-81, 58-3-100, 58-3-120, 58-3-125, 58-6-25, 58-7-21, 58-7-26, 58-7-30, 58-7-33, and Articles 13, 19, 30, 33, 34, and 63 of this Chapter apply to groups.

"Part 2. Third-Party Administrators and Service Companies for Individual and Group Self-Insurers.

"§ 58-47-150. Definitions.

As used in this Part:

(1) 'Books and records' means all files, documents, and databases in a paper form, electronic medium, or both.

(2) 'Self-insurer' means a group of employers licensed by the Commissioner under Part 1 of this Article or a single employer licensed by the Commissioner under Article 5 of Chapter 97 of the General Statutes to retain its liability under the Workers' Compensation Act and to pay directly the compensation in the amount and manner and when due as provided for in the Act.

(3) 'Service company' means an entity that has contracted with a self-insurer for the purpose of providing any services related to claims adjustment, loss control, or both.

(4) 'Third-party administrator' or 'TPA' means a person engaged by a self-insurer to execute the policies established by the self-insurer and to provide day-to-day management of the self-insurer. 'Third-Party Administrator' and 'TPA' does not mean:

a. A self-insurer acting on behalf of its employees or the employees of one or more of its affiliates.

b. An insurer that is licensed under this Chapter or that is acting as an insurer with respect to a policy lawfully issued and delivered by it and under the laws of a state in which the insurer is licensed to write insurance.

c. An agent or broker who is licensed by the Commissioner under Article 33 of this Chapter whose activities are limited exclusively to the sale of insurance.

d. An adjuster licensed by the Commissioner under Article 33 of this Chapter whose activities are limited to adjustment of claims.

e. An individual who is an officer, a member, or an employee of a board.

(5) 'Underwriting' means the process of selecting risks and classifying them according to their degrees of insurability so that the appropriate rates may be assigned. The process also includes rejection of those risks that do not qualify.

"§ 58-47-155. TPAs and service companies; authority; qualifications.

(a) No person shall act as, offer to act as, or hold himself or herself out as a TPA or a service company with respect to risks located in this State for a self-insurer unless that person complies with this Article.

(b) A TPA or service company shall post with the self-insurer a fidelity bond or other appropriate coverage, issued by an authorized insurer, in a form acceptable to the Commissioner, in an amount commensurate with the risk, and with the governing board of the self-insurer as obligee or beneficiary.

(c) A TPA or service company shall maintain errors and omissions coverage or other appropriate liability insurance in a form acceptable to the Commissioner and in an amount commensurate with the risk. The governing body of the self-insurer shall be obligee or beneficiary of the coverage or insurance.

(d) If the Commissioner determines that a TPA or service company or any other person has not materially complied with this Article or with any rule adopted or order issued under this Article, after notice and opportunity to be heard, the Commissioner may order for each separate violation a civil penalty under G.S. 58-2-70(d).

(e) If the Commissioner finds that because of a material noncompliance that a self-insurer has suffered any loss or damage, the Commissioner may maintain a civil action brought by or on behalf of the self-insurer and its covered members or persons and creditors for recovery of compensatory damages for the benefit of the self-insurer and its covered members or persons and creditors, or for other appropriate relief.

(f) Nothing in this Article affects the Commissioner's right to impose any other penalties provided for in this Chapter or limits or restricts the rights of covered members or persons, claimants, and creditors.

(g) If an order of rehabilitation or liquidation of the self-insurer has been entered under Article 30 of this Chapter, and the receiver appointed under that order determines that the TPA or service company or any other person has not materially complied with this Article or any rule adopted or order issued under this Article, and the self-insurer suffered any loss or damage from the noncompliance, the receiver may maintain a civil action for recovery of damages or other appropriate sanctions for the benefit of the self-insurer.

"**§ 58-47-160. Written agreement; composition; restrictions.**

(a) No person may act as a TPA or service company without a written agreement between the TPA or service company and the self-insurer. The written agreement shall be retained by the self-insurer and the TPA or service company for the duration of the agreement and for five years thereafter. The agreement shall contain all provisions required by this Article, to the extent those requirements apply to the functions performed by the TPA or service company.

(b) Groups shall file with the Commissioner the written agreement, and any amendments to the agreement, within 30 days after execution. Single employers shall furnish the Commissioner, upon request, the written agreement and any amendments to the agreement. The information required by this section, including any trade secrets, shall be kept confidential; provided that the Commissioner may use that information in any judicial or administrative proceeding instituted against the TPA or service company.

(c) The written agreement shall set forth the duties and powers of the TPA or service company and the self-insurer. The Commissioner shall disapprove any such written agreement that:

(1) Subjects the self-insurer to excessive charges for expenses or commission.

(2) Vests in the TPA or service company any control over the management of the affairs of the self-insurer to the exclusion of the governing board of the self-insurer.

(3) Is entered into with any TPA or service company if the person acting as the TPA or service company, or any of the officers or directors of the TPA or service company, is of known bad

character or has been affiliated directly or indirectly through ownership, control, management, reinsurance transactions, or other insurance or business relationships with any person known to have been involved in the improper manipulation of assets, accounts, or reinsurance.

(4) Is determined by the Commissioner to contain provisions that are not fair and reasonable to the self-insurer.

(d) The self-insurer, TPA, or service company may, by written notice, terminate the agreement as provided in the agreement. The self-insurer may suspend the underwriting authority of the TPA during the pendency of any dispute regarding the cause for termination of the agreement. The self-insurer shall fulfill any lawful obligations with respect to policies affected by the agreement, regardless of any dispute between the self-insurer and the TPA or service company.

(e) The contract may not be assigned in whole or part by the TPA or service company without prior approval by the governing board of the self-insurer and the Commissioner.

"§ 58-47-165. Books and records.

(a) Every TPA or service company shall maintain and make available to the self-insurer complete books and records of all transactions performed on behalf of the self-insurer. The books and records shall be maintained by the self-insurer, TPA, or service company in accordance with G.S. 58-47-180.

(b) The Commissioner shall have access to books and records maintained by a TPA or service company for the purposes of examination, audit, or inspection. The Commissioner shall keep confidential any trade secrets contained in those books and records, including the identity and addresses of the covered members of a self-insurer, except that the Commissioner may use the information in any judicial or administrative proceeding instituted against the TPA or service company.

(c) The Commissioner may use the TPA or service company as an intermediary in the Commissioner's dealings with the self-insurer if the Commissioner determines that this will result in a more rapid and accurate flow of information from the self-insurer and will aid in the self-insurer's compliance with this Article and the Workers' Compensation Act.

(d) The self-insurer shall own the books and records generated by the TPA or service company pertaining to the self-insurer's business.

(e) The self-insurer shall have access to and rights to duplicate all books and records related to its business.

(f) If the self-insurer and the TPA or service company cancel their agreement, notwithstanding the provisions of subsection (a) of this section, the TPA or service company, shall transfer all books and records to the new TPA, service company, or the self-insurer in a form acceptable to the Commissioner. The new TPA or service company shall acknowledge, in writing, that it is responsible for retaining the books and records of the previous TPA, service company, or the self-insurer as required in subsection (a) of this section.

"§ 58-47-170. Payments to TPA or service company.

If a self-insurer uses the services of a TPA, the payment to the TPA of any premiums or charges for insurance by or on behalf of the insured party is considered payment to the self-insurer. The payment of return premiums or claim payments forwarded by the self-insurer to the TPA or service company is not considered payment to the insured party or claimant until the payments are received by the insured party or claimant. This section does not limit any right of the self-insurer against the TPA or service company resulting from the failure of the TPA or service company to make payments to the self-insurer, insured parties, or claimants.

"§ 58-47-175. Approval of advertising.

A TPA or service company may use only the advertising pertaining to or affecting the business underwritten by a self-insurer that has been approved in writing by the self-insurer before its use.

"**§ 58-47-180. Premium collection and payment of claims.**

(a) The TPA or service company, at a minimum, shall:

(1) Periodically render an accounting to the self-insurer detailing all transactions performed by the TPA or service company pertaining to the business underwritten, premium or other charges collected, and claims paid by the self-insurer, when applicable.

(2) Deposit all receipts directly into an account maintained in the name of the self-insurer.

(3) Pay claims on drafts or checks of and authorized by the self-insurer.

(4) Not withdraw from the self-insurer's account except for authority limited to pay claims and refund premiums.

(5) Remit return premium, directly from the self-insurer's account, to the person entitled to the return premium.

(b) Any check disbursement authority granted to the TPA or service company may be terminated upon the self-insurer's written notice to the TPA or service company or upon termination of the agreement. The self-insurer may suspend the check disbursement authority during the pendency of any dispute regarding the cause for termination.

"**§ 58-47-185. Notices; disclosure.**

(a) When the services of a TPA are used, the TPA shall provide a written notice approved by the self-insurer to covered members advising them of the identity of, and relationship among, the TPA, the member, and the self-insurer.

(b) When a TPA collects funds, the reason for collection of each item shall be identified to the member and each item shall be shown separately from any premium. Additional charges may not be made for services to the extent the services have been paid for by the self-insurer.

(c) The TPA shall disclose to the self-insurer all charges, fees, and commissions received from all services in connection with the provision of administrative services for the self-insurer, including any fees or commissions paid by self-insurers for obtaining reinsurance.

(d) The TPA or service company shall disclose to the self-insurer the nature of other business in which it is involved.

"**§ 58-47-190. Compensation.**

A TPA or service company shall not enter into any agreement or understanding with a self-insurer that makes the amount of the TPA's or service company's commissions, fees, or charges contingent upon savings affected in the adjustment, settlement, and payment of losses covered by the self-insurer's obligations. This section does not prohibit a TPA or service company from receiving performance-based compensation for providing medical services through a physician-based network or auditing services and does not prevent the compensation of a TPA or service company from being based on premiums or charges collected or the number of claims paid or processed.

"**§ 58-47-195. Examinations.**

TPAs and service companies may be examined under G.S. 58-2-131, 58-2-132, and 58-2-133.

"**§ 58-47-200. Unfair trade practices.**

TPAs and service companies are subject to Article 63 of this Chapter.

"**§ 58-47-205. Other requirements.**

(a) A TPA or service company, or any owner, officer, employee, or agent of a TPA or service company, or any other person affiliated with or related to the TPA or service company shall not serve as a trustee of a self-insurer.

(b) Each TPA or service company shall make available for inspection by the Commissioner copies of all contracts with persons using the services of the TPA."

Section 4. Chapter 97 of the General Statutes is amended by adding a new Article to read:

"ARTICLE 5.
"Individual Employers.

"**§ 97-165. Definitions.**

As used in this Article:

(1) 'Act' means the Workers' Compensation Act established in Article 1 of this Chapter.

(2) 'Certified audit' means an audit on which a certified public accountant expresses his or her professional opinion that the accompanying statements fairly present the financial position of the self-insurer, in conformity with generally accepted accounting principles as considered necessary by the auditor under the circumstances.

(3) 'Certified public accountant' or 'CPA' means a CPA who is in good standing with the American Institute of Certified Public Accountants and in all states in which the CPA is licensed to practice. A CPA shall be recognized as independent as long as the CPA conforms to the standards of the profession, as contained in the Code of Professional Ethics of the American Institute of Certified Public Accountants and Rules and Regulations and Code of Ethics and Rules of Professional Conduct of the North Carolina State Board of Certified Public Accountant Examiners, or similar code. The Commissioner may hold a hearing to determine whether a CPA is independent and, considering the evidence presented, may rule that the CPA is not independent for purposes of expressing an opinion on the GAAP financial statement and require the individual to replace the CPA with another whose relationship with the individual is independent within the meaning of this definition.

(4) 'Commissioner' means the Commissioner of Insurance.

(5) 'Corporate surety' means an insurance company authorized by the Commissioner to write surety business in this State.

(6) 'GAAP financial statement' means a financial statement as defined by generally accepted accounting principles.

(7) 'Hazardous financial condition' means that, based on its present or reasonably anticipated financial condition, a self-insurer is insolvent or, although not yet financially impaired or insolvent, is unlikely to be able to meet obligations with respect to known claims and reasonably anticipated claims or to pay other obligations in the normal course of business.

(8) 'Management' means those persons who are authorized to direct or control the operations of a self-insurer.

(9) 'Qualified actuary' means a member in good standing of the Casualty Actuarial Society or a member in good standing of the American Academy of Actuaries, who has been approved as qualified for signing casualty loss reserve opinions by the Casualty

Practice Council of the American Academy of Actuaries, and is in compliance with G.S. 58-2-171.

(10) 'Self-insurer' means a single employer who retains liability under the Act and is licensed under this Article.

"**§ 97-170. License applications; required information.**

(a) No employer shall self-insure its workers' compensation liabilities under the Act unless it is licensed by the Commissioner under this Article.

(b) An applicant for a license as a self-insurer shall file with the Commissioner the information required by subsection (d) of this section on a form prescribed by the Commissioner at least 90 days before the proposed licensing date. No application is complete until the Commissioner has received all required information.

(c) Only an applicant whose employee base is actuarially sufficient in numbers and provides an actuarially appropriate spreading of risk and whose total fixed assets amount to five hundred thousand dollars ($500,000) or more may apply for a license. In judging the applicant's financial strength and liquidity relative to its ability to comply with the Act, the Commissioner shall consider the applicant's:

(1) Organizational structure and management;
(2) Financial strength;
(3) Source and reliability of financial information;
(4) Risks to be retained;
(5) Workers' compensation loss history;
(6) Number of employees;
(7) Claims administration;
(8) Excess insurance; and
(9) Access to excess insurance or reinsurance.

(d) The license application shall comprise the following information:

(1) Company name, organizational structure, location of principal office, contact person, organization date, type of operations within this State, management background, and addresses of all plants or offices in this State.
(2) Certified audited GAAP financial statements prepared by a CPA for the two most recent years. The financial statement formulation shall facilitate application of ratio and trend analysis.
(3) Evidence of the insurance required by G.S. 97-190.
(4) Demonstration, satisfactory to the Commissioner, that the employee base is actuarially sufficient in numbers and provides an actuarially appropriate spreading of risk.
(5) For applicants with 20 or more full-time employees, a certificate or other evidence of safety inspection, satisfactory to the Commissioner, that certifies that all safety requirements of the Department of Labor have been met.
(6) Summary of workers' compensation benefits paid for the last three calendar years, as well as the total liability for all open claims within 30 days or some other period acceptable to the Commissioner not to exceed 90 days, before the filing of the application.
(7) Summary, by risk classification, of annual payroll and number of employees within the State.
(8) Book value of fixed assets located within the State.
(9) Proof of compliance with the claims administration provisions of Article 47 of Chapter 58 of the General Statutes.

(10) A letter of assent, stipulating the applicant's acceptance of membership status in the North Carolina Self-Insurance Guaranty Association under Article 4 of this Chapter.

(e) Every applicant shall execute and file with the Commissioner an agreement, as part of the application, in which the applicant agrees to deposit with the Commissioner cash, acceptable securities, or a surety bond issued by a corporate surety that will guarantee the applicant's compliance with this Article and the Act pursuant to G.S. 97-185.

"§ 97-175. License.

(a) After the review of the application and all supporting materials, the Commissioner shall either grant or deny a license. If a license is denied, the Commissioner shall notify the applicant of the denial and inform the applicant of the deficiencies that constitute the basis for denial.

(b) If the deficiencies are resolved within 60 days after the Commissioner's notice of denial, the applicant shall be granted a license. The applicant may be granted additional time to remedy the deficiencies in its application. A request for an extension of time shall be made in writing by the applicant within 30 days after notice of denial by the Commissioner. If the requirements of this Article have not been met, the application shall be withdrawn or denied.

"§ 97-180. Reporting and records.

(a) Every self-insurer shall submit, within 120 days after the end of its fiscal year, a certified audited GAAP financial statement, prepared by a CPA, for that fiscal year. The financial statement formulation shall facilitate the application of ratio and trend analysis.

(b) Every self-insurer shall submit within 120 days after the end of its fiscal year a certification from a qualified actuary setting forth the actuary's opinion relating to loss and loss adjustment expense reserves for workers' compensation obligations for each state in which the self-insurer does business. The certification shall show liabilities, excess insurance carrier and other qualifying credits, if any, and net retained workers' compensation liabilities. The qualified actuary shall present an annual report to the self-insurer on the items within the scope of and supporting the certification, within 90 days after the close of the self-insurer's fiscal year. Upon request, the report shall be submitted to the Commissioner.

(c) Every self-insurer shall submit within 120 days after the end of its fiscal year a report in the form of a sworn statement prescribed by the Commissioner, setting forth the total workers' compensation benefits paid in the previous fiscal year, as well as the total outstanding workers' compensation liabilities for each loss year, recorded at the close of its fiscal year for the net retained liability.

(d) Every self-insurer shall submit within 120 days after the end of its fiscal year annual payroll information. The report shall summarize payroll, by annual amount paid, and the number of employees, by classification, using the rules, classifications, and rates in the most recently approved Workers' Compensation and Employers' Liability Insurance Manual governing the audits of payrolls and the adjustments of premiums. Every self-insurer shall maintain true and accurate payroll records. These payroll records shall be maintained to allow for verification of the completeness and accuracy of the annual payroll report.

(e) Every self-insurer shall report promptly to the Commissioner changes in the names and addresses of the businesses it self-insures or intends to self-insure, as well as significant changes in the financial condition, including bankruptcy filings, and changes in its business structure, including its divisions, subsidiaries, affiliates, and internal organization. Any change shall be reported in writing to the Commissioner within 10 days after the effective date of the change.

"§ 97-185. Deposits or surety bond.

(a) Every self-insurer shall deposit with the Commissioner an amount equal to twenty-five percent (25%) of the self-insurer's total undiscounted outstanding claim liability per the most recent certification from a qualified actuary as required by G.S. 97-180(b), but not less than five hundred thousand dollars ($500,000), or such other amount as the Commissioner prescribes based on, but not limited to, the financial condition of the self-insurer and the risk retained by the self-insurer.

(b) A self-insurer organized and authorized before the effective date of this section shall have 24 months from the effective date of this section to comply with this section.

(c) Deposits received, changes to existing deposits, or deposits exchanged after the effective date of this section, shall comprise one or more of the following:

(1) Interest-bearing bonds of the United States of America.

(2) Interest-bearing bonds of the State of North Carolina, or of its cities or counties.

(3) Certificates of deposit issued by any solvent bank domesticated in the State of North Carolina that have a maturity of one year or greater.

(4) Surety bonds in a form acceptable to the Commissioner and issued by a corporate surety.

(5) Any other investments that are approved by the Commissioner.

(d) All bonds or securities that are posted as a security deposit shall be valued annually at market value. If market value is less than face value, the Commissioner may require the self-insurer to post additional securities. In making this determination, the Commissioner shall consider the self-insurer's financial condition, the amount by which market value is less than face value, and the likelihood that the securities will be needed to provide benefits.

(e) Securities deposited under this section shall be assigned to the Commissioner, the Commissioner's successors, assigns, or trustees, on a form prescribed by the Commissioner in a manner that renders the securities negotiable by the Commissioner. If a self-insurer is deemed by the Commissioner to be in a hazardous financial condition, the Commissioner may sell or collect, or both, such amounts that will yield sufficient funds to meet the self-insurer's obligations under the Act. Interest accruing on any negotiable security deposited under this Article shall be collected and transmitted to the self-insurer if the self-insurer is not in a hazardous financial condition.

(f) No judgment creditor, other than a claimant entitled to benefits under the Act, may levy upon any deposits made under this section.

(g) Securities held by the Commissioner under this section may be exchanged or replaced by the self-insurer with other securities of like nature and amount as long as the self-insurer is not in a hazardous financial condition. No release shall be effectuated until replacement securities or bonds of an equal value have been substituted. Any surety bond may be exchanged or replaced with another surety bond that meets the requirements of this section if 90 days' advance written notice is given to the Commissioner. If a self-insurer ceases to self-insure or desires to replace securities with an acceptable surety bond or bonds, the self-insurer shall notify the Commissioner, and may recover all or a portion of the securities deposited with the Commissioner upon posting instead an acceptable special release bond issued by a corporate surety in an amount equal to the total value of the securities. The special release bond shall cover all existing liabilities under the Act plus an amount to cover future loss development and shall remain in force until all obligations under the Act have been discharged fully.

(h) If a self-insurer ceases to self-insure, no deposits shall be released by the Commissioner until the self-insurer has discharged fully all of the self-insurer's obligations under the Act.

(i) An endorsement to a surety bond shall be filed with the Commissioner within 90 days after the effective date of the endorsement.

"**§ 97-190. Excess insurance.**

(a) Every self-insurer, as a prerequisite for licensure under this Article, shall maintain specific and aggregate excess loss coverage through an insurance policy. A self-insurer shall maintain limits and retentions commensurate with its risk. A self-insurer's retention shall be the lowest retention suitable for the self-insurer's exposures and level of annual premium. The Commissioner may require different levels, or waive the requirement, of specific and aggregate excess loss coverage consistent with the market availability of excess loss coverage, the self-insurer's claims experience, and the self-insurer's financial condition.

(b) An excess insurance policy required by this section shall be issued by either a licensed insurance company or an approved surplus lines insurance company and shall:

(1) Provide for at least 30 days' written notice of cancellation by registered or certified mail, return receipt requested, to the self-insurer and to the Commissioner.

(2) Be renewable automatically at its expiration, except upon 30 days' written notice of nonrenewal by certified mail, return receipt requested, to the self-insurer and to the Commissioner.

(c) Every self-insurer shall provide to the Commissioner evidence of coverage and any amendments within 30 days after their effective dates. Every self-insurer shall, at the request of the Commissioner, furnish copies of its excess insurance policies and amendments.

"**§ 97-195. Revocation of license.**

(a) The Commissioner summarily may revoke a license if there is satisfactory evidence for the revocation. In determining whether to revoke a license summarily, the Commissioner may consider any or all of the following:

(1) Determination of insolvency by a court of competent jurisdiction.

(2) Institution of bankruptcy proceedings.

(3) If the self-insurer is in a hazardous financial condition.

(b) The Commissioner, upon at least 45 days' notice, may revoke a license if there is satisfactory evidence for the revocation. In determining whether to revoke a license under this subsection, the Commissioner may consider any or all of the following:

(1) Whether the self-insurer has experienced a material loss or deteriorating operating trends, or reported a deficit financial position.

(2) Whether any affiliate or subsidiary is insolvent, threatened with insolvency, or delinquent in payment of its monetary or any other obligation.

(3) Whether the self-insurer has failed to pay premium taxes pursuant to Article 8B of Chapter 105 of the General Statutes.

(4) Whether the self-insurer has failed to pay an assessment under G.S. 97-100.

(5) Contingent liabilities, pledges, or guaranties that either individually or collectively involve a total amount that in the Commissioner's opinion may affect a self-insurer's solvency.

(6) Whether the management of a self-insurer has failed to respond to the Commissioner's inquiries about the condition of the self-

insurer or has furnished false and misleading information in response to an inquiry by the Commissioner.

(7) Whether the management of a self-insurer has filed any false or misleading sworn financial statement, has released a false or misleading financial statement to a lending institution or to the general public, or has made a false or misleading entry or omitted an entry of material amount in the filed financial information.

(8) Whether the self-insurer has experienced or will experience in the foreseeable future, cash flow or liquidity problems.

(9) Whether the self-insurer has not complied with the other provisions of this Article or the Act.

(10) Whether the self-insurer has failed to make proper and timely payment of claims as required by this Article.

(c) Any self-insurer subject to license revocation under subsection (a) or (b) of this section may request an administrative hearing before the Commissioner to review that order. If a hearing is requested, a notice of hearing shall be served, and the notice shall state the time and place of hearing and the conduct, condition, or ground on which the Commissioner based the order. Unless mutually agreed upon between the Commissioner and the self-insurer, the hearing shall occur not less than 10 days nor more than 30 days after notice is served and shall be either in Wake County or in some other place designated by the Commissioner. The Commissioner shall hold all hearings under this section privately unless the self-insurer requests a public hearing, in which case the hearing shall be public. The request for a hearing shall not stay the effect of the order.

"**§ 97-200. Claims administration.**

(a) A self-insurer shall not utilize any claims adjuster unless the adjuster is licensed under G.S. 58-33-25.

(b) Every self-insurer shall comply with the provisions of Article 47 of Chapter 58 of the General Statutes that are related to claims administration."

Section 5. G.S. 97-93 reads as rewritten:

"**§ 97-93. Employers required to carry insurance or prove financial ability to pay for benefits; employers required to post notice; self-insured employers regulated by Commissioner of Insurance.**

(a) Every employer subject to the provisions of this Article relative to the payment of compensation shall either:

(1) Insure and keep insured his liability under this Article in any authorized corporation, association, organization, or in any mutual insurance association formed by a group of employers so authorized; or

~~(2) Furnish to the Commissioner of Insurance satisfactory proof of the employer's financial ability, either alone or through membership in a group of two or more employers who are members of the same trade or professional association and who agree to pool their liabilities under this Article, to directly pay the compensation in the amount and manner and when due as provided for in this Article. The trade or professional association must have been incorporated in North Carolina and in existence at least five years prior to the date of application to the Commissioner of Insurance to form a self-insurer's fund and shall submit a written determination from the Internal Revenue Service that it is exempt from taxation under 26 U.S.C. § 501(c).~~

~~A group organized and approved under this subdivision prior to July 1, 1995, is not required to consist of employers of the same~~

~~trade or professional association, have existed for five years, have been incorporated in North Carolina, or furnish the determination of tax-exempt status under 26 U.S.C. § 501(c).~~

(3) Obtain a license from the Commissioner of Insurance under Article 5 of this Chapter or under Article 47 of Chapter 58 of the General Statutes.

~~(b) In the case of subdivision (a)(2) of this section, the Commissioner of Insurance may require the deposit of an acceptable security, indemnity, or bond to secure the payment of compensation liabilities as they are incurred. Any individual employer or group of employers who furnish proof of financial ability under subdivision (a)(2) of this section shall be governed in all respects by this Article and by rules adopted by the Commissioner of Insurance.~~

~~(c) Payment of dividends to the members of any group of employers who agree to pool their liabilities under subdivision (a)(2) of this section shall not be contingent upon the maintenance or continuance of membership in such pools.~~

~~(d) Groups of two or more employers who agree to pool their liabilities under subdivision (a)(2) of this section are subject, in addition to the provisions cited in G.S. 58-2-145(a), to G.S. 58-2-165, G.S. 58-3-81, 58-6-25, 58-7-50, 58-7-55, 58-7-140, 58-7-160, 58-7-162, 58-7-163, 58-7-165, 58-7-167, 58-7-168, 58-7-170, 58-7-172, 58-7-173, 58-7-177, 58-7-179, 58-7-180, 58-7-183, 58-7-185, 58-7-187, 58-7-188, 58-7-192, 58-7-193, 58-7-195, 58-7-197, 58-7-200, and Articles 13, 19, 30, and 34 of Chapter 58 of the General Statutes.~~

(e) Every employer who is in compliance with the provisions of subsection (a) of this section shall post in a conspicuous place in places of employment a notice stating that employment by this employer is subject to the North Carolina Workers' Compensation Act and stating whether the employer has a policy of insurance against liability or qualifies as a self-insured employer. In the event the employer allows its insurance to lapse or ceases to qualify as a self-insured employer, the employer shall, within five working days of this occurrence, remove any notices indicating otherwise."

Section 6. G.S. 97-143 reads as rewritten:

"**§ 97-143. Use of deposits made by insolvent member self-insurers.**

After the Commissioner has notified the Association, under G.S. 97-136(a), that a member is insolvent, the Commissioner shall assign and deliver to the Association, and the Association is authorized to expend the deposit made by the insolvent member ~~pursuant to G.S. 97-93(b),~~ under G.S. 58-47-90 or G.S. 97-185, to the extent the deposit is needed by the Association to pay covered claims against ~~the premium taxes owed by~~ the insolvent member as required by this Article, and to the extent the deposit is needed to pay expenses of the Association relating to covered claims against the insolvent member. The Association shall account to the Commissioner and the insolvent member or its successor for all deposits received from the Commissioner under this section."

Section 7. G.S. 58-2-145 and G.S. 97-96 are repealed.

Section 8. G.S. 97-130(6) reads as rewritten:

"(6) 'Member self-insurer' or 'member' means a self-insurer which is authorized by the Commissioner to self-insure pursuant to G.S. ~~97-93, 97-94 and 97-96.~~ 97-93 and G.S. 97-94."

Section 9. G.S. 97-131(b)(3) reads as rewritten:

"(3) In determining the membership of the Association pursuant to subdivisions (1) and (2) of this subsection for any date after the effective date of this Article, no employer or group of employers claiming self-insurer status may be deemed to be a member of the Association on any date after the effective date of this Article,

unless that employer or group of employers is at that time authorized as a self-insurer by the Commissioner pursuant to G.S. ~~97-93, 97-94, and 97-96.~~ 97-93 and G.S. 97-94."

Section 10. This act becomes effective December 1, 1997.

In the General Assembly read three times and ratified this the 28th day of July, 1997.

s/ Dennis A. Wicker
President of the Senate

s/ Harold J. Brubaker
Speaker of the House of Representatives

s/ James B. Hunt, Jr.
Governor

Approved 7:30 p.m. this 5th day of August, 1997

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

S 3

SENATE BILL 434
Corrected Copy 3/21/97
Pensions & Retirement and Insurance Committee Substitute Adopted 4/24/97

Short Title: National Guard Health Benefits. (Public)

Sponsors:

Referred to: Appropriations.

March 20, 1997

A BILL TO BE ENTITLED

AN ACT TO PROVIDE HEALTH BENEFITS FOR NATIONAL GUARD MEMBERS AND THEIR ELIGIBLE DEPENDENTS WHO DO NOT HAVE ACCESS TO COMPREHENSIVE GROUP HEALTH BENEFITS BY ALLOWING VOLUNTARY PARTICIPATION IN THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN.

The General Assembly of North Carolina enacts:

Section 1. G.S. 135-40 is amended by adding a new subsection to read:

"(a1) The State of North Carolina deems it to be in the public interest for members of the North Carolina national guard and certain of their dependents who are not eligible for any other type of comprehensive group health insurance or other comprehensive group health benefits to be given the opportunity to participate in the benefits provided by the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan. Coverage under the Plan shall be voluntary for eligible members of the national guard who elect participation in the Plan for themselves and their eligible dependents."

Section 2. G.S. 135-40.1(3) reads as rewritten:

"(3) Dependent Child. -- A natural, legally adopted, or foster child of the employee and/or spouse, unmarried, up to the first of the month following his or her 19th birthday, whether or not the child is living with the employee, as long as the employee is legally responsible for such child's maintenance and support. Dependent

child shall also include any child under age 19 who has reached his or her 18th birthday, provided the employee was legally responsible for such child's maintenance and support on his or her 18th birthday.

A foster child is covered (i) if living in a regular parent-child relationship with the expectation that the employee will continue to rear the child into adulthood, (ii) if at the time of enrollment, or at the time a foster child relationship is established, whichever occurs first, the employee applies for coverage for such child and submits evidence of a bona fide foster child relationship, identifying the foster child by name and setting forth all relevant aspects of the relationship, (iii) if the Claims Processor accepts the foster child as a participant through a separate written document identifying the foster child by name and specifically recognizing the foster child relationship, and (iv) if at the time a claim is incurred, the foster child relationship, as identified by the employee, continues to exist. Children placed in a home by a welfare agency which obtains control of, and provides for maintenance of, the child(ren), are not eligible participants.

Coverage may be extended beyond the 19th birthday under the following conditions:

a. If the dependent is a full-time student, between the ages of 19 and 26, who is pursuing a course of study that represents at least the normal workload of a full-time student at a school or college accredited by the state of jurisdiction.

b. The dependent is physically or mentally incapacitated to the extent that he or she is incapable of earning a living and (i) such handicap developed or began to develop before the dependent's 19th birthday, or (ii) such handicap developed or began to develop before the dependent's 26th birthday if the dependent was covered by the Plan in accordance with G.S. 135-40.1(3)a.

Dependent children of national guard members are subject to the same terms and conditions as are other dependent children covered by this subdivision."

Section 3. G.S. 135-40.1(6) reads as rewritten:

"(6) Employing Unit. -- A North Carolina School System; Community College; State Department, Agency or Institution; Administrative Office of the Courts; or Association or Examining Board whose employees are eligible for membership in a State-Supported Retirement System. An employing unit also shall mean a charter school in accordance with Part 6A of Chapter 115C of the General Statutes whose employees are deemed to be public employees and members of a State-Supported Retirement System. North Carolina

national guard units are deemed to be employing units for the purpose of providing benefits under this Article."

Section 4. G.S. 135-40.1(7) reads as rewritten:

"(7) Enrollment. -- New employees must enroll themselves and their dependents within 30 days from the date of employment. Coverage may become effective on the first day of the month following date of entry on payroll or on the first day of the following month. New employees not enrolling themselves and their dependents within 30 days, or not adding dependents when first eligible as provided herein may enroll on the first day of any month but will be subject to a 12-month waiting period for preexisting health conditions, except for employees who elect to change their coverage in accordance with rules established by the Executive Administrator and Board of Trustees for optional prepaid hospital and medical benefit plans. Children born to covered employees having coverage type (2), or (3), as outlined in G.S. 135-40.3(d) shall be automatically covered at the time of birth without any waiting period for preexisting health conditions. Children born to covered employees having coverage type (1) shall be automatically covered at birth without any waiting period for preexisting health conditions so long as the Claims Processor receives notification within 30 days of the date of birth that the employee desires to change from coverage (1) to coverage type (2), or (3), provided that the employee pays any additional premium required by the coverage type selected retroactive to the first day of the month in which the child was born. National guard members and their eligible dependents are subject to the same terms and conditions as are new employees and their dependents covered by this subdivision. Enrollments in these circumstances must occur within 30 days of eligibility to enroll."

Section 5. G.S. 135-40.1 is amended by adding a new subdivision to read:

"(13b) National guard members. -- Members of the North Carolina army and air national guard who are not eligible for any type of comprehensive group health insurance or other comprehensive group health benefit coverage. Members of the North Carolina army and air national guard include those who are actively serving in the national guard as well as former members of the national guard who have completed 20 or more years of service in the national guard but have not attained the minimum age to begin receipt of a uniformed service military retirement benefit. Comprehensive group health insurance and other benefit coverage consists of inpatient and outpatient hospital and medical benefits, as well as other outpatient medical services, prescription drugs, medical supplies and equipment that are generally available in the

health insurance market. Comprehensive group health insurance and other benefit coverage includes Medicare benefits, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) Benefits, and other Uniformed Service health benefits. North Carolina national guard units shall certify the eligibility of their members to the Plan for their participation in its benefits prior to enrollment."

Section 6. G.S. 135-40.2(b) is amended by adding a new subdivision to read:

"(13) National guard members, their eligible spouses, and eligible dependent children."

Section 7. G.S. 135-40.3 is amended by adding a new subsection to read:

"(f) National guard members are subject to the same terms and conditions of this section as are employees. Eligible dependents of national guard members are subject to the same terms and conditions of this section as are dependents of employees."

Section 8. G.S. 135-39.6A reads as rewritten:

"**§ 135-39.6A. Premiums set.**

The Executive Administrator and Board of Trustees shall, from time to time, establish premium rates for the Comprehensive Major Medical Plan except as they may be established by the General Assembly in the Current Operations Appropriations Act, and establish regulations for payment of the premiums. Premium rates shall be established for coverages where Medicare is the primary payer of health benefits separate and apart from the rates established for coverages where Medicare is not the primary payer of health benefits.

In setting premiums for national guard members and their eligible dependents, the Executive Administrator and Board of Trustees shall establish rates separate from those affecting other members of the Plan. These separate premium rates shall include rate factors for incurred but unreported claim costs, for the effects of adverse selection from voluntary participation in the Plan, and for any other actuarially determined measures needed to protect the financial integrity of the Plan for the benefit of its served employees, retired employees, and their eligible dependents."

Section 9. This act becomes effective July 1, 1998.

GENERAL ASSEMBLY OF NORTH CAROLINA
1997 SESSION

S.L. 1997-312
SENATE BILL 714

AN ACT TO REQUIRE HEALTH AND ACCIDENT INSURANCE POLICIES, HOSPITAL OR MEDICAL SERVICE PLANS, HMO PLANS, AND THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN TO PROVIDE COVERAGE FOR RECONSTRUCTIVE BREAST SURGERY RESULTING FROM MASTECTOMY.

The General Assembly of North Carolina enacts:

Section 1. Article 51 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-51-61. Coverage for reconstructive breast surgery resulting from mastectomy.**

(a) Every policy or contract of accident and health insurance, and every preferred provider contract, policy, or plan as defined and regulated under G.S. 58-50-50 and G.S. 58-50-55, that is issued, renewed, or amended on or after January 1, 1998, and that provides coverage for mastectomy shall provide coverage for reconstructive breast surgery resulting from a mastectomy. The coverage shall include coverage for all stages and revisions of reconstructive breast surgery performed on a nondiseased breast to establish symmetry when reconstructive surgery on a diseased breast is performed. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the policy, contract, or plan shall apply to coverage for reconstructive breast surgery. Reconstruction of the nipple/areolar complex following a mastectomy is covered without regard to the lapse of time between the mastectomy and the reconstruction, subject to the approval of the treating physician.

(b) As used in this section, the following terms have the meanings indicated:

(1) 'Mastectomy' means the surgical removal of all or part of a breast as a result of breast cancer or breast disease.

(2) 'Reconstructive breast surgery' means surgery performed as a result of a mastectomy to reestablish symmetry between the two breasts, and includes reconstruction of the mastectomy site, creation of a new breast mound, and creation of a new nipple/areolar complex. 'Reconstructive breast surgery' also includes augmentation mammoplasty, reduction mammoplasty, and mastopexy of the nondiseased breast.

(c) A policy, contract, or plan subject to this section shall not:

(1) Deny coverage described in subsection (a) of this section on the basis that the coverage is for cosmetic surgery;

(2) Deny to a woman eligibility or continued eligibility to enroll or to renew coverage under the terms of the contract, policy, or plan, solely for the purpose of avoiding the requirements of this section;

(3) Provide monetary payments or rebates to a woman to encourage her to accept less than the minimum protections available under this section;

(4) Penalize or otherwise reduce or limit the reimbursement of an attending provider because the provider provided care to an individual participant or beneficiary in accordance with this section; or

(5) Provide incentives, monetary or otherwise, to an attending provider to induce the provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section."

Section 2. Article 65 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-65-96. Coverage for reconstructive breast surgery following mastectomy.**

(a) Every insurance certificate or subscriber contract under any hospital service plan or medical service plan governed by this Article and Article 66 of this Chapter, and every preferred provider contract, policy, or plan as defined and regulated under G.S. 58-50-50 and G.S. 58-50-55, that is issued, renewed, or amended on or after January 1, 1998, that provides coverage for mastectomy shall provide coverage for reconstructive breast surgery resulting from a mastectomy. The coverage shall include coverage for all stages and revisions of reconstructive breast surgery performed on a nondiseased breast to establish symmetry when reconstructive surgery on a diseased breast is performed. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the policy, contract, or plan shall apply to coverage for reconstructive breast surgery. Reconstruction of the nipple/areolar complex following a mastectomy is covered without regard to the lapse of time between the mastectomy and the reconstruction, subject to the approval of the treating physician.

(b) As used in this section, the following terms have the meanings indicated:

(1) 'Mastectomy' means the surgical removal of all or part of a breast as a result of breast cancer or breast disease.

(2) 'Reconstructive breast surgery' means surgery performed as a result of a mastectomy to reestablish symmetry between the two breasts, and includes reconstruction of the mastectomy site, creation of a new breast mound, and creation of a new nipple/areolar complex. 'Reconstructive breast surgery' also includes augmentation mammoplasty, reduction mammoplasty, and mastopexy of the nondiseased breast.

(c) A policy, contract, or plan subject to this section shall not:

(1) Deny coverage described in subsection (a) of this section on the basis that the coverage is for cosmetic surgery;

(2) Deny to a woman eligibility or continued eligibility to enroll or to renew coverage under the terms of the contract, policy, or plan, solely for the purpose of avoiding the requirements of this section;

(3) Provide monetary payments or rebates to a woman to encourage her to accept less than the minimum protections available under this section;

(4) Penalize or otherwise reduce or limit the reimbursement of an attending provider because the provider provided care to an individual participant or beneficiary in accordance with this section; or

(5) Provide incentives, monetary or otherwise, to an attending provider to induce the provider to provide care to an individual

participant or beneficiary in a manner inconsistent with this section."

Section 3. Article 67 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-67-79. Coverage for reconstructive breast surgery following mastectomy.**

(a) Every health care plan written by a health maintenance organization and in force, issued, renewed, or amended on or after January 1, 1998, that is subject to this Article and that provides coverage for mastectomy shall provide coverage for reconstructive breast surgery resulting from a mastectomy. The coverage shall include coverage for all stages and revisions of reconstructive breast surgery performed on a nondiseased breast to establish symmetry when reconstructive surgery on a diseased breast is performed. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the policy, contract, or plan shall apply to coverage for reconstructive breast surgery. Reconstruction of the nipple/areolar complex following a mastectomy is covered without regard to the lapse of time between the mastectomy and the reconstruction, subject to the approval of the treating physician.

(b) As used in this section, the following terms have the meanings indicated:

(1) 'Mastectomy' means the surgical removal of all or part of a breast as a result of breast cancer or breast disease.

(2) 'Reconstructive breast surgery' means surgery performed as a result of a mastectomy to reestablish symmetry between the two breasts, and includes reconstruction of the mastectomy site, creation of a new breast mound, and creation of a new nipple/areolar complex. 'Reconstructive breast surgery' also includes augmentation mammoplasty, reduction mammoplasty, and mastopexy of the nondiseased breast.

(c) A policy, contract, or plan subject to this section shall not:

(1) Deny coverage described in subsection (a) of this section on the basis that the coverage is for cosmetic surgery;

(2) Deny to a woman eligibility or continued eligibility to enroll or to renew coverage under the terms of the contract, policy, or plan, solely for the purpose of avoiding the requirements of this section;

(3) Provide monetary payments or rebates to a woman to encourage her to accept less than the minimum protections available under this section;

(4) Penalize or otherwise reduce or limit the reimbursement of an attending provider because the provider provided care to an individual participant or beneficiary in accordance with this section; or

(5) Provide incentives, monetary or otherwise, to an attending provider to induce the provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section."

Section 4. Effective January 1, 1998, G.S. 58-50-155 reads as rewritten:

"**§ 58-50-155. Standard and basic health care plan coverages.**

(a) Notwithstanding G.S. 58-50-125(c), the standard health plan developed and approved under G.S. 58-50-125 shall provide coverage for mammograms and pap smears at least equal to the coverage required by G.S. 58-51-57.

(a1) Notwithstanding G.S. 58-50-125(c), the standard health plan developed and approved under G.S. 58-50-125 shall provide coverage for prostate-specific antigen (PSA) tests or equivalent tests for the presence of prostate cancer at least equal to the coverage required by G.S. 58-51-58.

(a2) Notwithstanding G.S. 58-50-125(c), the standard health plan developed and approved under G.S. 58-50-125 shall provide coverage for reconstructive breast surgery resulting from a mastectomy at least equal to the coverage required by G.S. 58-51-61.

(b) Notwithstanding G.S. 58-50-125(c), in developing and approving the plans under G.S. 58-50-125, the Committee and Commissioner shall give due consideration to cost-effective and life-saving health care services and to cost-effective health care providers. This section shall be effective after July 10, 1991."

Section 5. Effective January 1, 1998, G.S. 135-40.6(5) is amended by adding the following new sub-subdivision to read:

"h. Reconstructive Breast Surgery: Reconstructive breast surgery resulting from a mastectomy. The coverage shall include all stages and revisions of reconstructive breast surgery performed on a nondiseased breast to establish symmetry when reconstructive surgery on a diseased breast is performed. As used in this sub-subdivision, (i) 'mastectomy' means the surgical removal of all or part of a breast as a result of breast cancer or breast disease; (ii) 'reconstructive breast surgery' means surgery performed as a result of a mastectomy to reestablish symmetry between the two breasts, and includes reconstruction of the mastectomy site, creation of a new breast mound, and creation of a new nipple/areolar complex. 'Reconstructive breast surgery' also includes augmentation mammoplasty, reduction mammoplasty, and mastopexy of the nondiseased breast. Coverage described under this sub-subdivision shall not be denied on the basis that the coverage is for cosmetic surgery. Reconstruction of the nipple/areolar complex following a mastectomy is covered without regard to the lapse of time between the mastectomy and the reconstruction, subject to the approval of the treating physician."

Section 6. Nothing in this act shall apply to specified accident, specified disease, hospital indemnity, or long-term care health insurance policies.

Section 7. This act is effective when it becomes law.

In the General Assembly read three times and ratified this the 10th day of July, 1997.

s/ Dennis A. Wicker
President of the Senate

s/ Harold J. Brubaker
Speaker of the House of Representatives

s/ James B. Hunt, Jr.
Governor

Approved 10:55 a.m. this 17th day of July, 1997

GENERAL ASSEMBLY OF NORTH CAROLINA
1997 SESSION

S.L. 1997-197
SENATE BILL 785

AN ACT TO REMOVE THE SUNSET ON CERTAIN DIRECT PAYMENTS UNDER HEALTH INSURANCE POLICIES AND PLANS.

The General Assembly of North Carolina enacts:

Section 1. Section 5 of Chapter 347 of the 1993 Session Laws reads as rewritten:

"Sec. 5. This act becomes effective October 1, 1993, and applies to all plans and policies with an inception, renewal, or anniversary date on or after October 1, 1993. ~~This act expires October 1, 1998.~~"

Section 2. Section 8 of Chapter 464 of the 1993 Session Laws reads as rewritten:

"Sec. 8. Sections 1, 2, 3.1, 4, 5, 6, 7, and 8 of this act become effective October 1, 1993. Section 3 of this act becomes effective and expires as provided in subsection (b) of that section. ~~Sections 2 and 3.1 of this act expire on June 30, 1999.~~"

Section 3. This act is effective when it becomes law.

In the General Assembly read three times and ratified this the 11th day of June, 1997.

s/ Dennis A. Wicker
President of the Senate

s/ Harold J. Brubaker
Speaker of the House of Representatives

s/ James B. Hunt, Jr.
Governor

Approved 5:05 p.m. this 19th day of June, 1997

North Carolina General Assembly
Legislative Services Agency

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MEMORANDUM

TO: Senator Jim Forrester

FROM: Sam Byrd, Fiscal Research Division

DATE: April 15, 1997

SUBJECT: Actuarial Note (Senate Bill 434)

Re: National Guard Members and Their Dependents Not Eligible for Other Comprehensive Group Health Benefits Provided the Option of Coverage under the Teachers' & State Employees' Health Benefit Plan on a Fully Contributory Basis.

In accordance with North Carolina General Statute 120-114 and applicable Rules of the North Carolina Senate and House of Representatives, attached is a certified copy of an original actuarial note on the above subject as prepared by the General Assembly's Consulting Actuary. A certified copy of an original actuarial note on the same subject from the Plan Administrator's Consulting Actuary is also attached for your review.

cc: Sen. Tommy Jenkins, Committee on Pensions & Retirement and Insurance.
Principal Clerk, Senate

Attachment(s):
(1) Senate Bill 434.
(2) Actuarial Note, Dilts, Umstead & Dunn, Senate Bill 434, April 8, 1997.
(3) Actuarial Note, Aon Consulting, Senate Bill 434, April 14, 1997.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

S 2

SENATE BILL 434
Corrected Copy 3/21/97

Short Title: National Guard Health Benefits. (Public)

Sponsors: Senators Forrester; Albertson, Cochrane, East, Garwood, Hoyle, Jenkins, Lee, Page, Plyler, Rand, Reeves, and Soles.

Referred to: Pensions & Retirement and Insurance.

March 20, 1997

A BILL TO BE ENTITLED

AN ACT TO PROVIDE HEALTH BENEFITS FOR NATIONAL GUARD MEMBERS AND THEIR ELIGIBLE DEPENDENTS WHO DO NOT HAVE ACCESS TO COMPREHENSIVE GROUP HEALTH BENEFITS BY ALLOWING VOLUNTARY PARTICIPATION IN THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN.

The General Assembly of North Carolina enacts:

Section 1. G.S. 135-40 is amended by adding a new subsection to read:

"(a1) The State of North Carolina deems it to be in the public interest for members of the North Carolina national guard and certain of their dependents who are not eligible for any other type of comprehensive group health insurance or other comprehensive group health benefits to be given the opportunity to participate in the benefits provided by the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan. Coverage under the Plan shall be voluntary for eligible members of the national guard who elect participation in the Plan for themselves and their eligible dependents."

Section 2. G.S. 135-40.1(3) reads as rewritten:

"(3) Dependent Child. -- A natural, legally adopted, or foster child of the employee and/or spouse, unmarried, up to the first of the month following his or her 19th birthday, whether or not the child is living with the employee, as long as the employee is legally responsible for such child's maintenance and support. Dependent

child shall also include any child under age 19 who has reached his or her 18th birthday, provided the employee was legally responsible for such child's maintenance and support on his or her 18th birthday.

A foster child is covered (i) if living in a regular parent-child relationship with the expectation that the employee will continue to rear the child into adulthood, (ii) if at the time of enrollment, or at the time a foster child relationship is established, whichever occurs first, the employee applies for coverage for such child and submits evidence of a bona fide foster child relationship, identifying the foster child by name and setting forth all relevant aspects of the relationship, (iii) if the Claims Processor accepts the foster child as a participant through a separate written document identifying the foster child by name and specifically recognizing the foster child relationship, and (iv) if at the time a claim is incurred, the foster child relationship, as identified by the employee, continues to exist. Children placed in a home by a welfare agency which obtains control of, and provides for maintenance of, the child(ren), are not eligible participants.

Coverage may be extended beyond the 19th birthday under the following conditions:

a. If the dependent is a full-time student, between the ages of 19 and 26, who is pursuing a course of study that represents at least the normal workload of a full-time student at a school or college accredited by the state of jurisdiction.

b. The dependent is physically or mentally incapacitated to the extent that he or she is incapable of earning a living and (i) such handicap developed or began to develop before the dependent's 19th birthday, or (ii) such handicap developed or began to develop before the dependent's 26th birthday if the dependent was covered by the Plan in accordance with G.S. 135-40.1(3)a.

Dependent children of national guard members are subject to the same terms and conditions as are other dependent children covered by this subdivision."

Section 3. G.S. 135-40.1(6) reads as rewritten:

"(6) Employing Unit. -- A North Carolina School System; Community College; State Department, Agency or Institution; Administrative Office of the Courts; or Association or Examining Board whose employees are eligible for membership in a State-Supported Retirement System. An employing unit also shall mean a charter school in accordance with Part 6A of Chapter 115C of the General Statutes whose employees are deemed to be public employees and members of a State-Supported Retirement System. North Carolina

national guard units are deemed to be employing units for the purpose of providing benefits under this Article."

Section 4. G.S. 135-40.1(7) reads as rewritten:

"(7) Enrollment. -- New employees must enroll themselves and their dependents within 30 days from the date of employment. Coverage may become effective on the first day of the month following date of entry on payroll or on the first day of the following month. New employees not enrolling themselves and their dependents within 30 days, or not adding dependents when first eligible as provided herein may enroll on the first day of any month but will be subject to a 12-month waiting period for preexisting health conditions, except for employees who elect to change their coverage in accordance with rules established by the Executive Administrator and Board of Trustees for optional prepaid hospital and medical benefit plans. Children born to covered employees having coverage type (2), or (3), as outlined in G.S. 135-40.3(d) shall be automatically covered at the time of birth without any waiting period for preexisting health conditions. Children born to covered employees having coverage type (1) shall be automatically covered at birth without any waiting period for preexisting health conditions so long as the Claims Processor receives notification within 30 days of the date of birth that the employee desires to change from coverage (1) to coverage type (2), or (3), provided that the employee pays any additional premium required by the coverage type selected retroactive to the first day of the month in which the child was born. National guard members and their eligible dependents are subject to the same terms and conditions as are new employees and their dependents covered by this subdivision. Enrollments in these circumstances must occur within 30 days of eligibility to enroll."

Section 5. G.S. 135-40.1 is amended by adding a new subdivision to read:

"(13b) National guard members. -- Members of the North Carolina army and air national guard who are not eligible for any type of comprehensive group health insurance or other comprehensive group health benefit coverage. Members of the North Carolina army and air national guard include those who are actively serving in the national guard as well as former members of the national guard who have completed 20 or more years of service in the national guard but have not attained the minimum age to begin receipt of a uniformed service military retirement benefit. Comprehensive group health insurance and other benefit coverage consists of inpatient and outpatient hospital and medical benefits, as well as other outpatient medical services, prescription drugs, medical supplies and equipment that are generally available in the

health insurance market. North Carolina national guard units shall certify the eligibility of their members to the Plan for their participation in its benefits prior to enrollment."

Section 6. G.S. 135-40.2(b) is amended by adding a new subdivision to read:

"(13) National guard members, their eligible spouses, and eligible dependent children."

Section 7. G.S. 135-40.3 is amended by adding a new subsection to read:

"(f) National guard members are subject to the same terms and conditions of this section as are employees. Eligible dependents of national guard members are subject to the same terms and conditions of this section as are dependents of employees."

Section 8. G.S. 135-39.6A reads as rewritten:

"**§ 135-39.6A. Premiums set.**

The Executive Administrator and Board of Trustees shall, from time to time, establish premium rates for the Comprehensive Major Medical Plan except as they may be established by the General Assembly in the Current Operations Appropriations Act, and establish regulations for payment of the premiums. Premium rates shall be established for coverages where Medicare is the primary payer of health benefits separate and apart from the rates established for coverages where Medicare is not the primary payer of health benefits.

In setting premiums for national guard members and their eligible dependents, the Executive Administrator and Board of Trustees shall establish rates separate from those affecting other members of the Plan. These separate premium rates shall include rate factors for incurred but unreported claim costs, for the effects of adverse selection from voluntary participation in the Plan, and for any other actuarially determined measures needed to protect the financial integrity of the Plan for the benefit of its served employees, retired employees, and their eligible dependents."

Section 9. This act becomes effective July 1, 1998.

DILTS, UMSTEAD & DUNN

ACTUARIAL CONSULTING

MARK V. HARTMAN, FSA, MAAA, MCA, EA

Phone: (910) 731-4038
Fax: (910) 731-2583

668 Link Road
Lexington, NC 27295

ACTUARIAL NOTE
True & Exact Copy of Original
Certified By: [signature] Date: 4-15-97
Legislative Fiscal Research

April 8, 1997

Mr. Sam Byrd
Fiscal Research Division
North Carolina General Assembly
300 N. Salisbury Street
Raleigh, NC 27603-5925

Re: Senate Bill 434: An Act to Provide Optional Coverage to National Guard Members in the Teachers' and State Employees' Comprehensive Major Medical Plan

Dear Mr. Byrd:

This bill would amend G.S. 135-40 through 135-40.3 to provide health benefits to certain national guard members. Under this bill, members of the national guard and their dependents would be eligible to participant in the Teachers' and State Employees' Major Medical Plan if they are not eligible for any other comprehensive group health insurance or group health benefit coverage. National guard members must be actively serving in the army or air national guard or former members who have completed 20 or more years of service in the national guard but have not attained the minimum age to receive a uniformed service military retirement benefit.

This bill provides that participation of national guard members is on an optional basis, and premiums for the members and their dependents will be on a fully contributory basis. This act becomes effective July 1, 1998. National guard members would have an initial 30 day period to enroll without being subject to the 12 month waiting period for pre-existing health conditions.

This bill requires the Executive Administrator and Board of Trustees to establish separate premium rates for national guard members and their dependents. These rates will include the effects of adverse selection from voluntary participation, loading for incurred but not reported claims, and any other actuarial measures needed to protect the financial integrity of the plan. Under this premium basis, the expected financial impact on the plan is negligible. However, the plan would remain liable for any adverse deviation in experience and for the impact of any extreme antiselection.

If you have any questions, let me know.

Sincerely,

Mark Hartman

Mark V. Hartman, FSA, MAAA, MCA, EA
Consulting Actuary

MVH/jj

NORTH CAROLINA TEACHERS' & STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN

• • •

SENATE BILL 434
National Guard Health Benefits

ACTUARIAL NOTE

True & Exact Copy of Original
Certified By: _____ Date: 4-15-97
Legislative Fiscal Research

Prepared by:

Aon Consulting
One Piedmont Center
3565 Piedmont Road, N.E.
Atlanta, Georgia 30363

April 1997

Alexander & Alexander
Consulting Group

ACTUARIAL STATEMENT

The State of North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan (Plan) has requested that Aon Consulting prepare an Actuarial Note in response to an Actuarial Note Request entitled National Guard Members and Their Dependents Not Eligible for Other Comprehensive Group Health Benefit Coverage Provided the Option of Coverage under the Teachers' and State Employees' Health Benefit Plan on a Fully Contributory Basis.

The Actuarial Note was prepared according to generally accepted actuarial principles and practices, in compliance with General Statute 120-114, and within the confidentiality requirements of General Statute 120-129 through 120-134. As required by statute, the Note includes an explanatory statement of the proposed change(s) and, to the extent possible, an estimate of the financial and actuarial effect of the proposed change(s) on the Plan. The Actuarial Note makes no comment or opinion with regard to the merits of the measure for which the Note is prepared; however, any identified technical or mechanical defects have been noted.

We have reviewed the input and results of our analysis for reasonableness, and relied upon the data and information provided by the Plan and their Claims Processing Contractor.

Kenneth C. Vieira, F.S.A., M.A.A.A., E.A.
Consulting Actuary

4/14/97
Date

Professional Peer Review by:

Fred W. Munzenmaier, F.S.A., M.A.A.A., E.A.
Managing Director

April 14, 1997
Date

Alexander & Alexander
Consulting Group

NATIONAL GUARD ALLOWED TO PARTICIPATE

PLAN CHANGE

Senate Bill 434 proposes that the North Carolina Teachers' & State Employees' Comprehensive Major Medical Plan (Plan) provide members of the North Carolina National Guard and certain of their dependents who are not eligible for any other type of comprehensive group health insurance to be given the opportunity to participate in the Plan on a fully contributory basis.

The premium rate set for National Guard members and their eligible dependents shall be an established rate separate from those affecting other members of the Plan. The separate rate factors shall include factors for incurred but unreported claims costs, the affects of adverse selection from voluntary participation in the Plan and other actuarially determined measures needed to protect the financial integrity of the Plan for the benefits of its served employees, retired employees and their eligible dependents.

The proposed act becomes law effective July 1, 1998

PROJECTED COST IMPACT

	% Increase			Based on "Midpoint" Increase (in 000's)		
Plan Design Change	Low	Mid	High	First Year Cost $	Second Year Cost $	Third Year Cost $
National guard members provided the option of coverage on a fully contributory actuarially determined basis	None - The premium rate will be a separate rate specific to national guard members and be sufficient to cover all their costs.					

PRICING APPROACH

- The number of National Guard members expected to enroll in the Plan will be substantially less than the number of members due to the provision in the bill requiring that the members must not be eligible for any other comprehensive group health insurance. Like individual insurance, this provision makes it highly probable that claims per enrolled member will be substantially higher than those of the current Plan members and that "adverse selection" will exist.

- Due to the possibility of "adverse selection" and a low number of enrollees, a claims factor will be added to the current premium rate to ensure that the Plan will not be subsidizing the National Guard members. Claims factors for these types of risk typically range from 150-200% of expected Plan costs, with some instances being as high as 300%. Due to the uncertainty, primarily in the first year of enrollment, a rate of 200% may be appropriate with future factors reflecting on the available experience of the prior years.

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April 23, 1997

MEMORANDUM

To: Senate Committee on Pensions & Retirement and Insurance

From: M. Lynn Marshbanks, Committee Counsel

Re: Senate Bill 434: National Guard Health Benefits

Senate Bill 434 would allow national guard members, their spouses, and their dependents to participate voluntarily in the State Employees' Health Plan. These members and dependents would be eligible if they were not eligible for any other comprehensive group health insurance. Members of the national guard include not only those who are actively serving, but also former members of the national guard who have 20 or more years of service but have not reached the minimum age to begin receiving a uniform service military retirement benefit.

The Executive Administrator and Board of Trustees of the Plan would establish premium rates separate from those for other members of the Plan. The stated purpose is to protect the financial integrity of the Plan.

Effective date: July 1, 1998.

S434-SMRS-001

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

North Carolina General Assembly
Legislative Services Office

George R. Hall, Legislative Services Officer
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April 23, 1997

MEMORANDUM

TO: Senate Insurance Committee

FROM: Linwood Jones
Staff Counsel

RE: Senate Bill 714
(Reconstructive Surgery/Coverage)

Senate Bill 714 requires insurers, HMOs, and hospital and medical service corporations (Blue Cross) to provide coverage for breast reconstruction resulting from a mastectomy if they cover the mastectomy. The standard health plan offered in the small employer group market must also include this coverage if it covers mastectomies. In addition, there cannot be different deductibles or coinsurance amounts for breast reconstruction than for similar services.

"Reconstructive breast surgery" means surgery performed as a result of a mastectomy to re-establish symmetry between the two breasts, including reconstruction of the mastectomy site, creation of a new breast mound, and creation of a new nipple areolar complex. The term also includes reduction mammoplasty, augmentation mammoplasty, and mastopexy of the nondiseased breast.

The bill (*see Section 5*) also requires the State Health Plan to cover reconstructive breast surgery that results from a mastectomy.

The coverage is required in all insurance policies that are issued or renewed on or after January 1, 1998. The coverage in the State Health Plan also would begin January 1, 1998.

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

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MEMORANDUM

TO: Senator Jim Forrester

FROM: Sam Byrd, Fiscal Research Division

DATE: April 25, 1997

SUBJECT: Actuarial Note (Senate Bill 714, Section 5)

Re: Mammoplasties for Non-Diseased Breasts Covered Following Mastectomies under the Teachers' and State Employees' Comprehensive Major Medical Plan.

In accordance with North Carolina General Statute 120-114 and applicable Rules of the North Carolina Senate and House of Representatives, attached is a certified copy of an original actuarial note on the above subject as prepared by the General Assembly's Consulting Actuary. A certified copy of an original actuarial note on the same subject from the Plan Administrator's Consulting Actuary is also attached for your review.

cc: Sen. Tommy Jenkins, Committee on Pensions & Retirement and Insurance.
Principal Clerk, Senate

Attachment(s):
(1) Senate Bill 714.
(2) Actuarial Note, Dilts, Umstead & Dunn, Senate Bill 714, Section 5, April 22, 1997.
(3) Actuarial Note, Aon Consulting, Senate Bill 714, Section 5, April 24, 1997.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

S 1

SENATE BILL 714

Short Title: Coverage for Reconstr. Surgery. (Public)

Sponsors: Senators Forrester; Ballantine, Cochrane, Hoyle, Lucas, Martin of Pitt, Martin of Guilford, Odom, Page, and Winner.

Referred to: Pensions & Retirement and Insurance.

April 7, 1997

A BILL TO BE ENTITLED

AN ACT TO REQUIRE HEALTH AND ACCIDENT INSURANCE POLICIES, HOSPITAL OR MEDICAL SERVICE PLANS, HMO PLANS, AND THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN, TO PROVIDE COVERAGE FOR RECONSTRUCTIVE BREAST SURGERY RESULTING FROM MASTECTOMY.

The General Assembly of North Carolina enacts:

Section 1. Article 51 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-51-61. Coverage for reconstructive breast surgery resulting from mastectomy.**

(a) Every policy or contract of accident and health insurance, and every preferred provider contract, policy, or plan as defined and regulated under G.S. 58-50-50 and G.S. 58-50-55, that is issued, renewed, or amended on or after January 1, 1998, and that provides coverage for mastectomy shall provide coverage for reconstructive breast surgery resulting from a mastectomy. The coverage shall include coverage for all stages and revisions of reconstructive breast surgery performed on a nondiseased breast to establish symmetry when reconstructive surgery on a diseased breast is performed. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the policy, contract, or plan shall apply to coverage for reconstructive breast surgery.

(b) As used in this section, the following terms have the meanings indicated:

(1) 'Mastectomy' means the surgical removal of all or part of a breast as a result of breast cancer or breast disease.

(2) 'Reconstructive breast surgery' means surgery performed as a result of a mastectomy to reestablish symmetry between the two breasts, and includes reconstruction of the mastectomy site, creation of a new breast mound, and creation of a new nipple areolar complex. 'Reconstructive breast surgery' also includes augmentation mammoplasty, reduction mammoplasty, and mastopexy of the nondiseased breast."

Section 2. Article 65 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-65-96. Coverage for reconstructive breast surgery following mastectomy.**

(a) Every insurance certificate or subscriber contract under any hospital service plan or medical service plan governed by this Article and Article 66 of this Chapter, and every preferred provider contract, policy, or plan as defined and regulated under G.S. 58-50-50 and G.S. 58-50-55, that is issued, renewed, or amended on or after January 1, 1998, that provides coverage for mastectomy shall provide coverage for reconstructive breast surgery resulting from a mastectomy. The coverage shall include coverage for all stages and revisions of reconstructive breast surgery performed on a nondiseased breast to establish symmetry when reconstructive surgery on a diseased breast is performed. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the policy, contract, or plan shall apply to coverage for reconstructive breast surgery.

(b) As used in this section, the following terms have the meanings indicated:

(1) 'Mastectomy' means the surgical removal of all or part of a breast as a result of breast cancer or breast disease.

(2) 'Reconstructive breast surgery' means surgery performed as a result of a mastectomy to reestablish symmetry between the two breasts, and includes reconstruction of the mastectomy site, creation of a new breast mound, and creation of a new nipple areolar complex. 'Reconstructive breast surgery' also includes augmentation mammoplasty, reduction mammoplasty, and mastopexy of the nondiseased breast."

Section 3. Article 67 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-67-79. Coverage for reconstructive breast surgery following mastectomy.**

(a) Every health care plan written by a health maintenance organization and in force, issued, renewed, or amended on or after January 1, 1998, that is subject to this Article and that provides coverage for mastectomy shall provide coverage for reconstructive breast surgery resulting from a mastectomy. The coverage shall include coverage for all stages and revisions of reconstructive breast surgery performed on a nondiseased breast to establish symmetry when reconstructive surgery on a diseased breast is performed. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the policy, contract, or plan shall apply to coverage for reconstructive breast surgery.

(b) As used in this section, the following terms have the meanings indicated:

(1) 'Mastectomy' means the surgical removal of all or part of a breast as a result of breast cancer or breast disease.

(2) 'Reconstructive breast surgery' means surgery performed as a result of a mastectomy to reestablish symmetry between the two breasts, and includes reconstruction of the mastectomy site, creation of a new breast mound, and creation of a new nipple areolar complex. 'Reconstructive breast surgery' also includes augmentation mammoplasty, reduction mammoplasty, and mastopexy of the nondiseased breast."

Section 4. G.S. 58-50-155 reads as rewritten:

"**§ 58-50-155. Standard and basic health care plan coverages.**

(a) Notwithstanding G.S. 58-50-125(c), the standard health plan developed and approved under G.S. 58-50-125 shall provide coverage for mammograms and pap smears at least equal to the coverage required by G.S. 58-51-57.

(a1) Notwithstanding G.S. 58-50-125(c), the standard health plan developed and approved under G.S. 58-50-125 shall provide coverage for prostate-specific antigen (PSA) tests or equivalent tests for the presence of prostate cancer at least equal to the coverage required by G.S. 58-51-58.

(a2) Notwithstanding G.S. 58-50-125(c), the standard health plan developed and approved under G.S. 58-50-125 shall provide coverage for reconstructive breast surgery resulting from a mastectomy at least equal to the coverage required by G.S. 58-51-61.

(b) Notwithstanding G.S. 58-50-125(c), in developing and approving the plans under G.S. 58-50-125, the Committee and Commissioner shall give due consideration to cost-effective and life-saving health care services and to cost-effective health care providers. This section shall be effective after July 10, 1991."

Section 5. Effective January 1, 1998, G.S. 135-40.6(5) is amended by adding the following new sub-subdivision to read:

"h. Reconstructive Breast Surgery: Reconstructive breast surgery resulting from a mastectomy. The coverage shall include all stages and revisions of reconstructive breast surgery performed on a nondiseased breast to establish symmetry when reconstructive surgery on a diseased breast is performed. As used in this sub-subdivision, (i) 'mastectomy' means the surgical removal of all or part of a breast as a result of breast cancer or breast disease; (ii) 'reconstructive breast surgery' means surgery performed as a result of a mastectomy to reestablish symmetry between the two breasts, and includes reconstruction of the mastectomy site, creation of a new breast mound, and creation of a new nipple areolar complex. 'Reconstructive breast surgery' also includes augmentation mammoplasty, reduction mammoplasty, and mastopexy of the nondiseased breast. Coverage described under this sub-subdivision shall not be

denied on the basis that the coverage is for cosmetic surgery."

Section 6. Nothing in this act shall apply to specified accident, specified disease, hospital indemnity, or long-term care health insurance policies.

Section 7. This act is effective when it becomes law.

DILTS, UMSTEAD & DUNN

ACTUARIAL CONSULTING

ARK V. HARTMAN, FSA, MAAA, MCA, EA

Phone: (910) 731-4038
Fax: (910) 731-2583

668 Link Road
Lexington, NC 27295

April 22, 1997

Mr. Sam Byrd
Fiscal Research Division
North Carolina General Assembly
300 N. Salisbury Street
Raleigh, NC 27603-5925

Re: Senate Bill 714: An Act to Require Coverage for Reconstructive Breast Surgery Resulting from Mastectomy

Dear Mr. Byrd:

This bill would amend G.S. 135-40.6(5) by adding a new subdivision to provide coverage for reconstructive breast surgery. Coverage is provided for reconstructive surgery following a mastectomy to remove all or part of the breast due to breast cancer or disease. Coverage is provided for reconstruction of the mastectomy site as well as mammoplasty for the nondiseased breast. The bill also provides coverage for revisions of reconstructive surgery. This provision of this act is effective January 1, 1998.

The estimated cost of this bill will vary with the utilization rate of the reconstruction surgery allowed by the bill. An estimated range of this cost for an entire year is from a low of $2,258,000 to a high of $3,392,000. Based on the midpoint of $2,825,000, and assuming a 3 month lag between the effective date of the bill and the incidence of claims, the estimated cost for the fiscal year beginning July 1, 1997 is $763,000. The estimated cost for the fiscal year beginning July 1, 1998 is $3,295,000. These costs estimates are based on the plan's claim data over the past three years and an 8% annual trend factor.

If you have any questions, let me know.

Sincerely,

Mark Hartman

Mark V. Hartman, FSA, MAAA, MCA, EA
Consulting Actuary

MVH/jj

ACTUARIAL NOTE
True & Exact Copy of Original
Certified By: _____ Date: 4-25-97
Legislative Fiscal Research

NORTH CAROLINA TEACHERS' & STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN

• • •

SENATE BILL 714, Section 5
Coverage for Reconstructive Surgery

ACTUARIAL NOTE

True & Exact Copy of Original
Certified By: _____ Date: 4-25-97
Legislative Fiscal Research

Prepared by:

Aon Consulting
One Piedmont Center
3565 Piedmont Road, N.E.
Atlanta, Georgia 30363

April 1997

Alexander & Alexander
Consulting Group

ACTUARIAL STATEMENT

The State of North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan (Plan) has requested that Aon Consulting prepare an Actuarial Note in response to an Actuarial Note Request entitled Mammoplasties for Non-Diseased Breasts Covered Following Mastectomies under the Teachers' and State Employees' Comprehensive Major Medical Plan.

The Actuarial Note was prepared according to generally accepted actuarial principles and practices, in compliance with General Statute 120-114, and within the confidentiality requirements of General Statute 120-129 through 120-134. As required by statute, the Note includes an explanatory statement of the proposed change(s) and, to the extent possible, an estimate of the financial and actuarial effect of the proposed change(s) on the Plan. The Actuarial Note makes no comment or opinion with regard to the merits of the measure for which the Note is prepared; however, any identified technical or mechanical defects have been noted.

We have reviewed the input and results of our analysis for reasonableness, and relied upon the data and information provided by the Plan and their Claims Processing Contractor.

Kenneth C. Vieira, F.S.A., M.A.A.A., E.A.
Consulting Actuary

4/24/97
Date

Professional Peer Review by:

Fred W. Munzenmaier, F.S.A., M.A.A.A., E.A.
Managing Director

April 24, 1997
Date

Alexander & Alexander
Consulting Group

Mammoplasty For Non-Diseased Breast Following Mastectomies

PLAN CHANGE

Currently the North Carolina Teachers' & State Employees' Comprehensive Major Medical Plan (Plan) does not provide coverage for mammoplasties for non-diseased breasts following mastectomies.

Senate Bill 714 proposes to cover mammoplasties for non-diseased breast in addition to the diseased breasts.

The proposed act is effective when it becomes law.

PROJECTED COST IMPACT

	% Increase			Based on Midpoint Increase (in 000's)		
Plan Design Change	Low	Mid	High	First Year Cost $	Second Year Cost $	Total Biennium Cost $
Mammoplasty For Non-Diseased Breast Following Mastectomies	0.20%	0.27%	0.34%	$1,296	$1,866	$3,162

Based on projected claims of $639,857,853 and $691,046,481 for the 1998 and 1999 fiscal years respectively. First year cost assumes an implementation date of July 1, 1997.

PRICING APPROACH AND COMMENTS

- A report from the Claims Processing Contractor (CPC) detailed the amount of benefits that were paid for breast diseases over the three year period from 1994 to 1996. The report was detailed by procedure code and broken up by mastectomy and reconstructive procedures.

- A report from the American Cancer Society (ACS) detailed the expected new cases of female breast cancer in the state of North Carolina. Using their statistics we would expect approximately 370 cases of breast cancer in 1996 for a membership distribution of the Plan. The CPC report showed 442, which is slightly higher than expected but in line with estimates.

- The CPC report shows that approximately 45-55% of all mastectomy procedures would have a component of breast reconstruction required. This assumes a higher percentage for radical mastectomy and a lower percentage for partial mastectomy. Assuming an expected incidence of breast cancer of 450 to 500 cases, we would expect 202 to 275 cases of mammoplasty for the diseased breast.

- Through consultations with Medical Doctors we assumed that 50% to 75% of reconstuctive procedures would require some form of mammoplasty on the non-diseased breast with an expected cost to the Plan of $10,000 to $12,000 each.

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April 23, 1997

MEMORANDUM

To: Senate Committee on Pensions & Retirement and Insurance

From: M. Lynn Marshbanks, Committee Counsel

Re: Senate Bill 785: Direct Payment Sunsets Off

Senate Bill 785 would remove sunsets on the following:

1. An October 1, 1998, sunset on the act allowing direct payment to advanced practice registered nurses.
2. A June 30, 1999, sunset on the provisions in an act that allow direct payment to certified clinical social workers.

Effective date: When bill becomes law.

S785-SMRS-001

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

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April 23, 1997

MEMORANDUM

TO: Senate Insurance Committee

FROM: Linwood Jones, Staff Counsel

RE: Senate Bill 975 (Workers' Compensation Self-Insurance)

Senate Bill 975 revises the laws governing employers and groups of employers that self-insure for workers' compensation. The bill expands on changes that were first made in 1995 and codifies many of the existing Department of Insurance regulations that regulate these groups. The purpose of the bill is to ensure that self-insured employers and groups of employers are financially solvent and can pay their claims under the Workers' Compensation Act. The bill also regulates the third party administrators and service companies that handle claims for the employers and employer groups.

The bill repeals an unused law from the 1970s (Health Care Excess Liability Fund, Article 47 of Chapter 58 of the General Statutes) so that the its statute numbers can be used for the new laws on self-insured employers, employer groups, and TPAs.

Self-insured employer groups must be licensed by the Commissioner of Insurance. They must also prove that they have the financial capacity to pay workers' compensation claims. The bill sets out the information required for a license, restricts how funds are invested, requires a minimum surplus to be maintained, and requires excess loss coverage through insurance or reinsurance. The bill also allows self-insured groups to use the loss costs methodology for workers' compensation rates that was adopted in 1995 for insurance companies.

Part 2 of the bill (beginning on page 15 at line 22) regulates third party administrators and service companies that contract with individually self-insured employers to handle claims and related functions. The bill requires the TPA or service company to post a bond with the self-insurer, maintain liability coverage, and contractually agree in writing to the functions it will perform. There are additional record-keeping requirements and disclosure requirements.

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The bill also regulates individually self-insured employers to ensure that they have the financial capacity to pay their workers' compensation claims. The employer must have at least $500,000 in assets to apply to become self-insured. The bill sets out requirements for bonds or deposits, excess insurance, and record-keeping for these entities.

This bill becomes effective January 1, 1998.

VISITOR REGISTRATION SHEET

Name of Committee

Date

VISITORS: Please sign below and return to Committee Clerk.

NAME	FIRM OR STATE AGENCY AND ADDRESS
Wayne Woodard	NC National Guard
RALPH F LYON	" " "
Elizabeth Fuller	NASW - NC Intern
Betty Brown	NC Clinical Social Workers
Mike Carlton	NCOSA
Robert Pritchard	Young, Moore & Henderson
JULIAN PHILPOTT	NCFB
[illegible]	Lobbyist
B F SEALE	TRAVELERS
STEVE KEENE	NORTH CAROLINA MEDICAL SOCIETY
Lucia Bell	NC Medical Society
[illegible]	[illegible]
Ralph Bailey	A I I
Harry Taylor	
Jimmy G. Hutchens	Winston Salem Firefighter
Benny Langley	WSPFFA
Brad Wilcox	BCBSNC
Otis Carter	Carter & Associates

VISITOR REGISTRATION SHEET

Pensions & Retirement & Insurance Com. 4-23-97

Name of Committee Date

VISITORS: Please sign below and return to Committee Clerk.

NAME	FIRM OR STATE AGENCY AND ADDRESS
Myra Rubin	NASW-NC
Megan Carney	BSW Intern - NASW-NC
Gail Pruett	NCNA
Sandy Barker	NC Nurses Association
Ken Mitchell	NCSIGA
Jim Stuart	N.C Self Insurance Guaranty Assn.
Mike Carpenter	N.C. State Builders Assn
Janice Petersen	N.C. Comm. on Substance Abuse
Nancy Bradley	NCCBD
David Simmons	Zeb Alley, PA
Tommy Wall	Carolinas Health Care System
Adam Searing	NC Health Access Coalition
C.C. Dawson	N.C. Retired personnel
Lacy Pennell	" " " "
Leigh H Hammond	N.C. Retired Govt Emps. Assn.
Michael Crowell	NC Nurses Assn
Evelyn Terry	NC State Health Plan
David G. DeVries	NC State Health Plan
Sam Byrd	Fiscal Research
Becky Stuart	PORAB
Patricia Speckard	Comptroller

Pension &Retirement/ Insurance Committee
15 minutes after session
April 23,1997
1124 LOB

Sen. Jenkins, Chairman

AGENDA

SB345 Update Mortality Tables
Sen. Reeves

SB 297 Amend Charter Sch. Laws
Sen. Gulley

SB 538 Prof. Firefighters' Retirement
Sen. Ballance

SB 673 Amend LEO Retirement Def'n
Sen. Odom

SB 400 Mental Health Parity
Sen. Winner

Pensions& Retirement/ Insurance Committee

MINUTES

The Committee met at 5:45 pm Wednesday April 23 in room 1124 LB. There were ten members in attendance including Sen. Jenkins , chairman. The following bills were acted upon:

SB 345 Update Mortality Tables which was presented by Sen. Reeves. Sen. Wellons moved for a favorable report. The motion carried.

SB 297 Amend Charter Sch. Laws was presented by Sen. Gulley. Sen. McDaniel moved for unfavorable as to bill, but favorable as to committee substitute. The motion carried. The bill was referred to Appropriations by Sen. Jenkins, chairman.

SB 538 Prof. Firefighters' Retirement was presented by Sen. Ballance. Andy Romanet League of Municipalities spoke against the bill. David Anders spoke in favor of the bill. Sen Odom moved for unfavorable as to bill, but favorable to committee substitute. The motion carried The bill was referred to Appropriations by Sen. Jenkins, chairman.

SB 673 Amend LEO Retirement Def'n committee substitute bill was explained by Sen . Odom . Sen. Odom moved for unfavorable as tothe original bill, but favorable as to committee substitute. The motion carried

SB 400 Mental Health Parity was presented by Sen. Winner. Terry Morgan, Federation of Small Business spoke against the bill. Paul Mahoney of HMO Asso. spoke against the bill. Sen McDaniel sent forth an amendment. The amendment carried and was rolled into a committee substitute. Sen. Odom moved for unfavorable as to original bill, but favorable as to committee substitute. The motion carried..

The meeting was adjourned.

Sen Tommy Jenkins, Chairman

Katy Haynes, Clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

PENSIONS & RETIREMENT/INSURANCE COMMITTEE REPORT
Senator Tommy Jenkins, Chairman

Monday, April 28, 1997

SENATOR JENKINS,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO C.S. BILL

S.B. **400** Mental Health Parity.

Draft Number:	PCS1789
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

S.B. **538** Professional Firefighters' Retirement.

Draft Number:	PCS8666
Sequential Referral:	None
Recommended Referral:	Appropriations
Long Title Amended:	No

S.B. **673** Amend LEO Retirement Def'n.

Draft Number:	PCS4587
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 1,
BUT FAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 2

S.B.(CS #1)**297** Amend Charter Sch. Laws.

Draft Number:	PCSA741
Sequential Referral:	None
Recommended Referral:	Finance
Long Title Amended:	No

TOTAL REPORTED: 4

Committee Clerk Comment:

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

PENSIONS & RETIREMENT/ INSURANCE COMMITTEE REPORT
Senator Tommy Jenkins, Chairman

Thursday, April 24, 1997

SENATOR TOMMY JENKINS,
submits the following with recommendations as to passage:

FAVORABLE

S.B. 345 Update Mortality Tables
Sequential Referral: None
Recommended Referral: None

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO C.S. BILL

S.B. 118 Accident Preven. Course Reduction
Draft Number: PCS7642
Sequential Referral: None
Recommended Referral: None
Long Title Amended: No

S.B. 434 National Guard Health Benefits
Draft Number: PCS2732
Sequential Referral: None
Recommended Referral: Appropriations
Long Title Amended: No

TOTAL REPORTED: 3

Committee Clerk Comment: None

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

S 1

SENATE BILL 345

Short Title: Update Mortality Tables. (Public)

Sponsors: Senators Reeves; and Hartsell.

Referred to: Pensions & Retirement and Insurance.

March 10, 1997

A BILL TO BE ENTITLED

AN ACT UPDATING THE STATUTORY MORTALITY TABLES USED AS EVIDENCE TO ESTABLISH THE EXPECTANCY OF CONTINUED LIFE.

The General Assembly of North Carolina enacts:

Section 1. G.S. 8-46 reads as rewritten:

"**§ 8-46. ~~Mortuary~~ Mortality tables as evidence.**

Whenever it is necessary to establish the expectancy of continued life of any person from any period of ~~such~~ the person's life, whether ~~he be~~ the person is living at the time or not, the table hereto appended shall be received in all courts and by all persons having power to determine litigation, as evidence, with other evidence as to the health, constitution and habits of ~~such~~ the person, of such expectancy represented by the figures in the columns headed by the words 'completed age' and 'expectation' respectively:

Completed Age	Expectation
0	~~68.40~~ 75.8
1	~~69.64~~ 75.4
2	~~68.78~~ 74.5
3	~~67.86~~ 73.5
4	~~66.92~~ 72.5
5	~~65.98~~ 71.6
6	~~65.02~~ 70.6
7	~~64.06~~ 69.6
8	~~63.09~~ 68.6
9	~~62.12~~ 67.6
10	~~61.15~~ 66.6
11	~~60.18~~ 65.6

~~59.20~~	64.6
~~58.22~~	63.7
~~57.25~~	62.7
~~56.29~~	61.7
~~55.34~~	60.7
~~54.39~~	59.8
~~53.45~~	58.8
~~52.52~~	57.9
~~51.58~~	56.9
~~50.65~~	56.0
~~49.72~~	55.1
~~48.80~~	54.1
~~47.87~~	53.2
~~46.94~~	52.2
~~46.02~~	51.3
~~45.09~~	50.4
~~44.17~~	49.4
~~43.25~~	48.5
~~42.33~~	47.5
~~41.41~~	46.6
~~40.49~~	45.7
~~39.58~~	44.7
~~38.67~~	43.8
~~37.76~~	42.9
~~36.85~~	42.0
~~35.95~~	41.0
~~35.06~~	40.1
~~34.17~~	39.2
~~33.29~~	38.3
~~32.42~~	37.4
~~31.57~~	36.5
~~30.72~~	35.6
~~29.87~~	34.7
~~29.04~~	33.8
~~28.21~~	32.9
~~27.38~~	32.0
~~26.56~~	31.1
~~25.76~~	30.2
~~24.96~~	29.3
~~24.18~~	28.5
~~23.40~~	27.6
~~22.64~~	26.8
~~21.89~~	25.9
~~21.15~~	25.1
~~20.42~~	24.3
~~19.70~~	23.5
~~18.99~~	22.7
~~18.29~~	21.9
~~17.61~~	21.1
~~16.94~~	20.4
~~16.29~~	19.7
~~15.65~~	18.9
~~15.02~~	18.2

65		~~14.40~~ 17.5
66		~~13.79~~ 16.8
67		~~13.20~~ 16.1
68		~~12.61~~ 15.5
69		~~12.04~~ 14.8
70		~~11.48~~ 14.2
71		~~10.93~~ 13.5
72		~~10.39~~ 12.9
73		~~9.86~~ 12.3
74		~~9.35~~ 11.7
75		~~8.84~~ 11.2
76		~~8.35~~ 10.6
77		~~7.87~~ 10.0
78		~~7.40~~ 9.5
79		~~6.96~~ 9.0
80		~~6.53~~ 8.5
81		~~6.12~~ 8.0
82		~~5.75~~ 7.5
83		~~5.39~~ 7.1
84		~~5.05~~ 6.6
85	and over	~~4.70~~ 6.6
~~86~~		~~4.38~~ 6.2
~~87~~		~~4.08~~
~~88~~		~~3.79~~
~~89~~		~~3.54~~
~~90~~		~~3.30~~
~~91~~		~~3.08~~
~~92~~		~~2.89~~
~~93~~		~~2.72~~
~~94~~		~~2.56~~
~~95~~		~~2.43~~
~~96~~		~~2.32~~
~~97~~		~~2.21~~
~~98~~		~~2.10~~
~~99~~		~~2.01~~
~~100~~		~~1.91~~
~~101~~		~~1.83~~
~~102~~		~~1.75~~
~~103~~		~~1.67~~
~~104~~		~~1.60~~
~~105~~		~~1.53~~
~~106~~		~~1.46~~
~~107~~		~~1.40~~
~~108~~		~~1.35~~
~~109~~		~~1.29~~".

Section 2. G.S. 8-47 reads as rewritten:

"**§ 8-47. Present worth of annuities.**

Whenever it is necessary to establish the present worth or cash value of an annuity to a person, payable annually during ~~his~~ the person's life, such present worth or cash value may be ascertained by the use of the following table in connection with the ~~mortuary~~ mortality tables established by law, the first column representing the

number of years the annuity is to run and the second column representing the present cash value of an annuity of one dollar for such number of years, respectively:

No. of Years Annuity is to Run	Cash Value of the Annuity of $1
1	$ 0.943
2	1.833
3	2.673
4	3.465
5	4.212
6	4.917
7	5.582
8	6.210
9	6.802
10	7.360
11	7.887
12	8.384
13	8.853
14	9.295
15	9.712
16	10.106
17	10.477
18	10.828
19	11.158
20	11.470
21	11.764
22	12.042
23	12.303
24	12.550
25	12.783
26	13.003
27	13.211
28	13.406
29	13.591
30	13.765
31	13.929
32	14.084
33	14.230
34	14.368
35	14.498
36	14.621
37	14.737
38	14.846
39	14.949
40	15.046

41	15.138
42	15.225
43	15.306
44	15.383
45	15.456
46	15.524
47	15.589
48	15.650
49	15.708
50	15.762
51	15.813
52	15.861
53	15.907
54	15.950
55	15.991
56	16.029
57	16.065
58	16.099
59	16.131
60	16.161
61	16.190
62	16.217
63	16.242
64	16.266
65	16.289
66	16.310
67	16.331

The present cash value of the annuity for a fraction of a year may be ascertained as follows: Multiply the difference between the cash value of the annuities for the preceding and succeeding full years by the fraction of the year in decimals and add the sum to the present cash value for the preceding full year. When a person is entitled to the use of a sum of money for life, or for a given time, the interest thereon for one year, computed at four and one half percent (4 1/2%), may be considered as an annuity and the present cash value be ascertained as herein provided: Provided, the interest rate in computing the present cash value of a life interest in land shall be six percent (6%).

Whenever the ~~mortuary~~ mortality tables set out in G.S. 8-46 are admissible in evidence in any action or proceeding to establish the expectancy of continued life of any person from any period of ~~such~~ the person's life, whether ~~he be~~ the person is living at the time or not, the annuity tables herein set forth shall be evidence, but not conclusive, of the loss of income during the period of life expectancy of ~~such~~ the person."

Section 3. G.S. 46-25 reads as rewritten:

"**§ 46-25. Sale of standing timber on partition; valuation of life estate.**

When two or more persons own, as tenants in common, joint tenants or copartners, a tract of land, either in possession, or in remainder or reversion, subject to a life estate, or where one or more persons own a remainder or reversionary interest in a tract of land, subject to a life estate, then in any such case in which there is standing timber upon any such land, a sale of said timber trees, separate from the land, may be had upon the petition of one or more of said owners, or the life tenant, for partition among the owners thereof, including the life tenant, upon such terms as the court may order, and under like proceedings as are now prescribed by law for the sale of land for partition: Provided, that when the land is subject to a life estate, the life tenant shall be made a party to the proceedings, and shall be entitled to receive his or her portion of the net proceeds of sales, to be ascertained under the ~~mortuary~~ mortality tables established by law: Provided further, that prior to a judgment allowing a life tenant to sell the timber there must be a finding that the cutting is in keeping with good husbandry and that no substantial injury will be done to the remainder interest."

Section 4. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
1997 SESSION

S.L. 1997-430
SENATE BILL 297

AN ACT TO AMEND THE LAWS GOVERNING CHARTER SCHOOLS.

The General Assembly of North Carolina enacts:

Section 1. G.S. 115C-238.29B reads as rewritten:

"**§ 115C-238.29B. Eligible applicants; contents of applications; submission of applications for approval.**

(a) Any person, group of persons, or nonprofit corporation seeking to establish a charter school ~~within a local school administrative unit~~ may apply to establish a charter ~~school on behalf of a private nonprofit corporation.~~ school. If the applicant seeks to convert a public school to a charter school, the application shall include a statement signed by a majority of the teachers and instructional support personnel currently employed at the school indicating that they favor the conversion and evidence that a significant number of parents of children enrolled in the school favor conversion.

(b) The application shall contain at least the following information:

(1) A description of a program that implements one or more of the purposes in G.S. 115C-238.29A.

(2) A description of student achievement goals for the school's educational program and the method of demonstrating that students have attained the skills and knowledge specified for those student achievement goals.

(3) The governance structure of the school including the names of the proposed initial members of the board of directors of the nonprofit, tax-exempt corporation and the process to be followed by the school to ensure parental involvement.

(3a) The local school administrative unit in which the school will be located.

(4) Admission policies and procedures.

(5) A proposed budget for the school and evidence that the financial plan for the school is economically sound.

(6) Requirements and procedures for program and financial audits.

(7) A description of how the school will comply with G.S. 115C-238.29F.

(8) Types and amounts of insurance coverage, including bonding insurance for the principal officers of the school, to be obtained by the charter school.

(9) The term of the ~~contract.~~ charter.

(10) The qualifications required for individuals employed by the school.

(11) The procedures by which students can be excluded from the charter school and returned to a public school. Notwithstanding

any law to the contrary, any local board may refuse to admit any student who is suspended or expelled from a charter school due to actions that would lead to suspension or expulsion from a public school under G.S. 115C-391 until the period of suspension or expulsion has expired.

(12) The number of students to be served, which number shall be at least 65, and the minimum number of teachers to be employed at the school, which number shall be at least three. However, the charter school may serve fewer than 65 students or employ fewer than three teachers if the application contains a compelling reason, such as the school would serve a geographically remote and small student population.

(13) Information regarding the facilities to be used by the school and the manner in which administrative services of the school are to be provided.

~~(14) A description of whether the school will operate independently of the local board of education or whether it agrees to be subject to some supervision and control of its administrative operations by the local board of education. In the event the charter school elects to operate independently of the local board of education, the application must specify which employee benefits will be offered to its employees and how the benefits will be funded.~~

(c) An applicant shall submit the application to a chartering entity for preliminary approval. A chartering entity may be:

(1) The local board of education of the local school administrative unit in which the charter school will be located;

(2) The board of trustees of a constituent institution of The University of North Carolina, so long as the constituent institution is involved in the planning, operation, or evaluation of the charter school; or

(3) The State Board of Education.

Regardless of which chartering entity receives the application for preliminary approval, the State Board of Education shall have final approval of the charter school.

Notwithstanding the provisions of this subsection, if the State Board of Education finds that an applicant (i) submitted an application to a local board of education and received final approval from the State Board of Education, but (ii) is unable to find a suitable location within that local school administrative unit to operate, the State Board of Education may authorize the charter school to operate within an adjacent local school administrative unit for one year only. The charter school cannot operate for more than one year unless it reapplies, in accordance with subdivision (1), (2), or (3) of this subsection, and receives final approval from the State Board of Education.

(c1) Unless an applicant submits its application under subsection (c) of this section to the local board of education of the local school administrative unit in which the charter school will be located, the applicant shall submit a copy of its application to that local board within seven days of its submission under subsection (c) of this section. The local board may offer any information or comment concerning the application it considers appropriate to the chartering entity. The local board shall deliver this information to the chartering entity no later than January 1 of the next calendar year. The applicant shall not be required to obtain or deliver this information to the chartering entity on behalf of the local board. The State Board shall consider any information or comment it receives from a local board and shall consider the impact on the local school administrative unit's ability to provide a

sound basic education to its students when determining whether to grant preliminary and final approval of the charter school."

Section 2. Part 6A of Article 16 of Chapter 115C of the General Statutes is amended by adding the following new section to read:

"**§ 115C-238.29K. Criminal history checks.**

(a) As used in this section:

(1) 'Criminal history' means a county, state, or federal criminal history of conviction of a crime, whether a misdemeanor or a felony, that indicates an individual (i) poses a threat to the physical safety of students or personnel, or (ii) has demonstrated that he or she does not have the integrity or honesty to fulfill his or her duties as school personnel. These crimes include the following North Carolina crimes contained in any of the following Articles of Chapter 14 of the General Statutes: Article 5A, Endangering Executive and Legislative Officers; Article 6, Homicide; Article 7A, Rape and Kindred Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction; Article 13, Malicious Injury or Damage by Use of Explosive or Incendiary Device or Material; Article 14, Burglary and Other Housebreakings; Article 15, Arson and Other Burnings; Article 16, Larceny; Article 17, Robbery; Article 18, Embezzlement; Article 19, False Pretense and Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit Device or Other Means; Article 20, Frauds; Article 21, Forgery; Article 26, Offenses Against Public Morality and Decency; Article 26A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery; Article 31, Misconduct in Public Office; Article 35, Offenses Against the Public Peace; Article 36A, Riots and Civil Disorders; Article 39, Protection of Minors; and Article 60, Computer-Related Crime. These crimes also include possession or sale of drugs in violation of the North Carolina Controlled Substances Act, Article 5 of Chapter 90 of the General Statutes, and alcohol-related offenses such as sale to underage persons in violation of G.S. 18B-302 or driving while impaired in violation of G.S. 20-138.1 through G.S. 20-138.5. In addition to the North Carolina crimes listed in this subdivision, such crimes also include similar crimes under federal law or under the laws of other states.

(2) 'School personnel' means any:

a. Member of the board of directors of a charter school,

b. Employee of a charter school, or

c. Independent contractor or employee of an independent contractor of a charter school if the independent contractor carries out duties customarily performed by school personnel,

whether paid with federal, State, local, or other funds, who has significant access to students or who has responsibility for the fiscal management of a charter school.

(b) The State Board of Education shall adopt a policy on whether and under what circumstances school personnel shall be required to be checked for a criminal history. The policy shall not require school personnel to be checked for a criminal history check before preliminary approval is granted under G.S. 115C-238.29B. The Board shall apply its policy uniformly in requiring school personnel to be checked for a criminal history. The Board may grant conditional approval of an application while

the Board is checking a person's criminal history and making a decision based on the results of the check.

The State Board shall not require members of boards of directors of charter schools or employees of charter schools to pay for the criminal history check authorized under this section.

(c) The Board of Education shall require the person to be checked by the Department of Justice to (i) be fingerprinted and to provide any additional information required by the Department of Justice to a person designated by the State Board, or to the local sheriff or the municipal police, whichever is more convenient for the person, and (ii) sign a form consenting to the check of the criminal record and to the use of fingerprints and other identifying information required by the repositories. The State Board shall consider refusal to consent when deciding whether to grant final approval of an application under G.S. 115C-238.29D and when making an employment recommendation. The fingerprints of the individual shall be forwarded to the State Bureau of Investigation for a search of the State criminal history record file, and the State Bureau of Investigation shall forward a set of fingerprints to the Federal Bureau of Investigation for a national criminal history record check. The Department of Justice shall provide to the State Board of Education the criminal history from the State and National Repositories of Criminal Histories of any school personnel for which the Board requires a criminal history check.

The State Board shall not require members of boards of directors of charter schools or employees of charter schools to pay for the fingerprints authorized under this section.

(d) The State Board shall review the criminal history it receives on an individual. The State Board shall determine whether the results of the review indicate that the individual (i) poses a threat to the physical safety of students or personnel, or (ii) has demonstrated that he or she does not have the integrity or honesty to fulfill his or her duties as school personnel and shall use the information when deciding whether to grant final approval of an application for a charter school under G.S. 115C-238.29D and for making an employment recommendation to the board of directors of a charter school. The State Board shall make written findings with regard to how it used the information when deciding whether to grant final approval under G.S. 115C-238.29D and when making an employment recommendation.

(e) The State Board shall notify in writing the board of directors of the charter school of the determination by the State Board as to whether the school personnel is qualified to operate or be employed by a charter school based on the school personnel's criminal history. At the same time, the State Board shall provide to the charter school's board of directors the written findings the Board makes in subsection (d) of this section and its employment recommendation. If the State Board recommends dismissal or nonemployment of any person, the board of directors of the charter school shall dismiss or refuse to employ that person. In accordance with the law regulating the dissemination of the contents of the criminal history file furnished by the Federal Bureau of Investigation, the State Board shall not release nor disclose any portion of the school personnel's criminal history to the charter school's board of directors or employees. The State Board also shall notify the school personnel of the procedure for completing or challenging the accuracy of the criminal history and the personnel's right to contest the State Board's determination in court.

(f) All the information received by the State Board of Education or the charter school in accordance with subsection (e) of this section through the checking of the criminal history is privileged information and is not a public record but is for the exclusive use of the State Board of Education or the board of directors of the charter school. The State Board of Education or the board of directors of the charter school

may destroy the information after it is used for the purposes authorized by this section after one calendar year.

(g) There shall be no liability for negligence on the part of the State Board of Education or the board of directors of the charter school, or their employees, arising from any act taken or omission by any of them in carrying out the provisions of this section. The immunity established by this subsection shall not extend to gross negligence, wanton conduct, or intentional wrongdoing that would otherwise be actionable. The immunity established by this subsection shall be deemed to have been waived to the extent of indemnification by insurance, indemnification under Articles 31A and 31B of Chapter 143 of the General Statutes, and to the extent sovereign immunity is waived under the Tort Claims Act, as set forth in Article 31 of Chapter 143 of the General Statutes."

Section 3. G.S. 115C-238.29D(d) reads as rewritten:

"(d) The State Board of Education may grant ~~a~~ the initial charter for a period not to exceed five years and may renew the charter upon the request of the chartering entity for subsequent periods not to exceed five years each. A material revision of the provisions of a charter application shall be made only upon the approval of the State Board of Education. Beginning with the charter school's second year of operation and annually thereafter, the State Board shall allow a charter school to increase its enrollment by ten percent (10%) of the school's previous year's enrollment or as is otherwise provided in the charter. This enrollment growth shall not be considered a material revision of the charter application and shall not require the prior approval of the State Board."

Section 4. G.S. 115C-238.29E reads as rewritten:

"**§ 115C-238.29E. Charter school operation.**

(a) A charter school that is approved by the State shall be a public school within the local school administrative unit in which it is located. It shall be accountable to the local board of education if it applied for and received preliminary approval from that local board for purposes of ensuring compliance with applicable laws and the provisions of its ~~charter.~~ charter. All other charter schools shall be accountable to the State Board for ensuring compliance with applicable laws and the provisions of their charters, except that any of these charter schools may agree to be accountable to the local board of the school administrative unit in which the charter school is located rather than to the State Board.

(b) A charter school shall be operated by a private nonprofit corporation that shall have received federal tax-exempt status no later than 24 months following final approval of the application.

(c) A charter school shall operate under ~~a written contract~~ the written charter signed by the ~~local board of education~~ entity to which it is accountable under subsection (a) of this section and the applicant. A charter school is not required to enter into any other contract. The ~~contract~~ charter shall incorporate ~~at a minimum~~ the information provided in the application, as modified during the charter approval process, and any terms and conditions imposed on the charter school by the State Board of Education. No other terms may be imposed on the charter school as a condition for receipt of local funds.

~~If the local board of education does not sign the contract, the State Board may sign on behalf of the local board.~~

(d) The board of directors of the charter school shall decide matters related to the operation of the school, including budgeting, curriculum, and operating procedures.

(e) ~~A charter school shall be located in the local school administrative unit with which it signed the contract. Its~~ A charter school's specific location shall not be prescribed or limited by a local board or other authority except a zoning authority. The school may lease space from a local board of ~~education, from a public or private~~

~~nonsectarian organization,~~ education or as is otherwise lawful in the local school administrative unit in which the charter school is located. If a charter school leases space from a sectarian organization, the charter school classes and students shall be physically separated from any parochial students, and there shall be no religious artifacts, symbols, iconography, or materials on display in the charter school's entrance, classrooms, or hallways. Furthermore, if a charter school leases space from a sectarian organization, the charter school shall not use the name of that organization in the name of the charter school.

At the request of the charter school, the local board of education of the local school administrative unit in which the charter school will be located shall lease any available building or land to the charter school unless the board demonstrates that the lease is not economically or practically feasible or that the local board does not have adequate classroom space to meet its enrollment needs. Notwithstanding any other law, a local board of education may provide a school facility to a charter school free of charge; however, the charter school is responsible for the maintenance of and insurance for the school facility.

(f) Except as provided in this Part and pursuant to the provisions of its ~~contract,~~ charter, a charter school is exempt from statutes and rules applicable to a local board of education or local school administrative unit."

Section 5. G.S. 115C-238.29F reads as rewritten:

"**§ 115C-238.29F. General requirements.**

(a) Health and Safety Standards. -- A charter school shall meet the same health and safety requirements required of a local school administrative unit.

(b) School Nonsectarian. -- A charter school shall be nonsectarian in its programs, admission policies, employment practices, and all other operations and shall not charge ~~tuition.~~ tuition or fees. A charter school shall not be affiliated with a nonpublic sectarian school or a religious institution.

(c) Civil Liability and Insurance. --

(1) The board of directors of a charter school may sue and be sued. The State Board of Education shall adopt rules to establish reasonable amounts and types of liability insurance that the board of directors shall be required by the charter to obtain. The board of directors shall obtain at least the amount of and types of insurance required by these rules to be included in the ~~contract.~~ charter. Any sovereign immunity of the charter school, of the organization that operates the charter school, or its members, officers, or directors, or of the employees of the charter school or the organization that operates the charter school, is waived to the extent of indemnification by insurance.

(2) No civil liability shall attach to any chartering entity, to the State Board of Education, or to any of their members or employees, individually or collectively, for any acts or omissions of the charter school. ~~In the event a charter school has not elected total independence from the local board of education under subsection (e) of this section, the immunity established by this subsection shall be deemed to have been waived to the extent of indemnification by insurance, indemnification under Articles 31A and 31B of Chapter 143 of the General Statutes, and to the extent sovereign immunity is waived under the Tort Claims Act, as set forth in Article 31 of Chapter 143 of the General Statutes.~~

(d) Instructional Program. --

(1) The school shall provide instruction each year for at least 180 days.

(2) The school shall design its programs to at least meet the student performance standards adopted by the State Board of Education and the student performance standards contained in the ~~contract with the local board of education.~~ charter.

(3) A charter school shall conduct the student assessments required for charter schools by the State Board of Education.

(4) The school shall comply with policies adopted by the State Board of Education for charter schools relating to the education of children with special needs.

(5) The school is subject to and shall comply with Article 27 of Chapter 115C of the General ~~Statutes;~~ Statutes, except that a charter school may also exclude a student from the charter school and return that student to another school in the local school administrative unit in accordance with the terms of its ~~contract.~~ charter.

(e) Employees. --

(1) An employee of a charter school is not an employee of the local school administrative unit in which the charter school is located. The charter school's board of directors shall employ and contract with necessary teachers to perform the particular service for which they are employed in the school; at least seventy-five percent (75%) of these teachers in grades kindergarten through five, at least fifty percent (50%) of these teachers in grades six through eight, and at least fifty percent (50%) of these teachers in grades nine through 12 shall hold teacher certificates. The board also may employ necessary employees who are not required to hold teacher certificates to perform duties other than teaching and may contract for other services. The board may discharge teachers and noncertificated employees.

(2) No local board of education shall require any employee of the local school administrative unit to be employed in a charter school.

(3) If a teacher employed by a local school administrative unit makes a written request for an extended leave of absence to teach at a charter school, the local school administrative unit shall grant the leave. The local school administrative unit shall grant a leave for any number of years requested by the teacher, shall extend the leave for any number of years requested by the teacher, and shall extend the leave at the teacher's request. ~~The~~ For the initial year of a charter school's operation, the local school administrative unit may require that the request for a leave or extension of leave be made up to 45 days before the teacher would otherwise have to report for duty. For subsequent years, the local school administrative unit may require that the request for a leave or extension of leave be made up to 90 days before the teacher would otherwise have to report for duty. A teacher who has career status under G.S. 115C-325 prior to receiving an extended leave of absence to teach at a charter school may return to a public school in the local school administrative unit with career status at the end of the leave of absence or upon the end of employment at the charter school if an appropriate position is available. If an appropriate position is unavailable, the teacher's name shall be placed on a list of available teachers and that teacher shall have

priority on all positions for which that teacher is qualified in accordance with G.S. 115C-325(e)(2).

(4) ~~In the event a charter school, in its application, elects total independence from the local board of education, its employees shall not be deemed to be employees of the local school administrative unit and shall not be entitled to any State-funded employee benefits, including membership in the North Carolina Teachers' and State Employees' Retirement System or the Teachers' and State Employees' Comprehensive Major Medical Plan. In the event a charter school, in its application, agrees to be subject to some supervision and control of its administrative operations by the local board of education, the~~ The employees of the charter school shall be deemed employees of the local school administrative unit for purposes of providing certain State-funded employee benefits, including membership in the Teachers' and State Employees' Retirement System and the Teachers' and State Employees' Comprehensive Major Medical Plan. ~~The Board of Trustees of the Teachers' and State Employees' Retirement System, in consultation with the State Board of Education, shall determine the degree of supervision and control necessary to qualify the employees of the applicant for membership in the Retirement System.~~ The State Board of Education provides funds to charter schools, approves the original members of the boards of directors of the charter schools, has the authority to grant, supervise, and revoke charters, and demands full accountability from charter schools for school finances and student performance. Accordingly, it is the determination of the General Assembly that charter schools are public schools and that the employees of charter schools are public school employees and are 'teachers' for purposes of membership in the North Carolina Teachers' and State Employees' Retirement System and State Employees' Comprehensive Major Medical Plan. In no event shall anything contained in this Part require the North Carolina Teachers' and State Employees' Retirement System to accept employees of a private employer as members or participants of the System.

(f) Accountability. --

(1) The school is subject to the financial audits, the audit procedures, and the audit requirements adopted by the State Board of Education for charter schools.

(2) The school shall comply with the reporting requirements established by the State Board of Education in the Uniform Education Reporting System.

(3) The school shall report at least annually to the chartering entity and the State Board of Education the information required by the chartering entity or the State Board.

(g) Admission Requirements. --

(1) Any child who is qualified under the laws of this State for admission to a public school is qualified for admission to a charter school.

(2) No local board of education shall require any student enrolled in the local school administrative unit to attend a charter school.

(3) Admission to a charter school shall not be determined according to the school attendance area in which a student resides, except that

any local school administrative unit in which a public school converts to a charter school shall give admission preference to students who reside within the former attendance area of that school.

(4) Admission to a charter school shall not be determined according to the local school administrative unit in which a student ~~resides, except that the provisions of G.S. 115C-366(d) shall apply to a student who wishes to attend a charter school in a county other than the county in which the student~~ resides.

(5) A charter school shall not discriminate against any student on the basis of ethnicity, national origin, gender, or disability. Except as otherwise provided by law or the mission of the school as set out in the ~~contract,~~ charter, the school shall not limit admission to students on the basis of intellectual ability, measures of achievement or aptitude, athletic ability, disability, race, creed, gender, national origin, religion, or ancestry. The charter school may give enrollment priority to siblings of currently enrolled students who were admitted to the charter school in a previous year and to children of the school's principal, teachers, and teacher assistants. In addition, and only for its first year of operation, the charter school may give enrollment priority to children of the initial members of the charter school's board of directors, so long as (i) these children are limited to no more than ten percent (10%) of the school's total enrollment or to 20 students, whichever is less, and (ii) the charter school is not a former public or private school. Within one year after the charter school begins operation, the population of the school shall reasonably reflect the racial and ethnic composition of the general population residing within the local school administrative unit in which the school is located or the racial and ethnic composition of the special population that the school seeks to serve residing within the local school administrative unit in which the school is located. The school shall be subject to any court-ordered desegregation plan in effect for the local school administrative unit.

(6) ~~The~~ During each period of enrollment, the charter school shall enroll an eligible student who submits a timely application, unless the number of applications exceeds the capacity of a program, class, grade level, or building. In this case, students shall be accepted by lot. Once enrolled, students are not required to reapply in subsequent enrollment periods.

(7) Notwithstanding any law to the contrary, a charter school may refuse admission to any student who has been expelled or suspended from a public school under G.S. 115C-391 until the period of suspension or expulsion has expired.

(h) Transportation. -- The charter school ~~shall provide transportation for students enrolled at the school who reside in the local school administrative unit in which the school is located. The charter school~~ may provide transportation for students enrolled at the ~~school who reside in different local school administrative units.~~ school. The charter school shall develop a transportation plan so that transportation is not a barrier to any student who resides in the local school administrative unit in which the school is located. The charter school is not required to provide transportation to any student who lives within one and one-half miles of the school. At the request of the charter school and if the local board of the local school administrative unit in which

the charter school is located operates a school bus system, then that local board may contract with the charter school to provide transportation in accordance with the charter school's transportation plan to students who reside in the local school administrative unit and who reside at least one and one-half miles of the charter school. A local board may charge the charter school a reasonable charge that is sufficient to cover the cost of providing this transportation. Furthermore, a local board may refuse to provide transportation under this subsection if it demonstrates there is no available space on buses it intends to operate during the term of the contract or it would not be practically feasible to provide this transportation.

(i) Assets. -- Upon dissolution of the charter school or upon the nonrenewal of the charter, all net assets of the charter school purchased with public funds shall be deemed the property of the local school administrative unit in which the charter school is located."

Section 6. G.S. 115C-238.29G reads as rewritten:

"**§ 115C-238.29G. Causes for nonrenewal or ~~termination.~~ termination; disputes.**

(a) The State Board of Education, or a chartering entity subject to the approval of the State Board of Education, may terminate or not renew a ~~contract~~ charter upon any of the following grounds:

(1) Failure to meet the requirements for student performance contained in the ~~contract;~~ charter;
(2) Failure to meet generally accepted standards of fiscal management;
(3) Violations of law;
(4) Material violation of any of the conditions, standards, or procedures set forth in the ~~contract;~~ charter;
(5) Two-thirds of the faculty and instructional support personnel at the school request that the ~~contract~~ charter be terminated or not renewed; or
(6) Other good cause identified.

(b) The State Board of Education shall develop and implement a process to address contractual and other grievances between a charter school and its chartering ~~entity~~ entity or the local board of education during the time of its charter.

(c) The State Board and the charter school are encouraged to make a good-faith attempt to resolve the differences that may arise between them. They may agree to jointly select a mediator. The mediator shall act as a neutral facilitator of disclosures of factual information, statements of positions and contentions, and efforts to negotiate an agreement settling the differences. The mediator shall, at the request of either the State Board or a charter school, commence a mediation immediately or within a reasonable period of time. The mediation shall be held in accordance with rules and standards of conduct adopted under Chapter 7A of the General Statutes governing mediated settlement conferences but modified as appropriate and suitable to the resolution of the particular issues in disagreement.

Notwithstanding Article 33C of Chapter 143 of the General Statutes, the mediation proceedings shall be conducted in private. Evidence of statements made and conduct occurring in a mediation are not subject to discovery and are inadmissible in any court action. However, no evidence otherwise discoverable is inadmissible merely because it is presented or discussed in a mediation. The mediator shall not be compelled to testify or produce evidence concerning statements made and conduct occurring in a mediation in any civil proceeding for any purpose, except disciplinary hearings before the State Bar or any agency established to enforce standards of conduct for mediators. The mediator may determine that an impasse exists and discontinue the mediation at any time. The mediator shall not make any recommendations or public statement of findings or conclusions. The State Board and the charter school shall share equally the mediator's compensation and expenses.

The mediator's compensation shall be determined according to rules adopted under Chapter 7A of the General Statutes."

Section 7. G.S. 115C-238.29H(a) reads as rewritten:

"(a) The State Board of Education shall allocate to each charter school (i) an amount equal to the average per pupil allocation for average daily membership from the local school administrative unit allotments in which the charter school is located for each child attending the charter school except for the allocation for children with special needs and (ii) an additional amount for each child attending the charter school who is a child with special needs. In accordance with G.S. 115C-238.29D(d), the State Board shall allow for annual adjustments to the amount allocated to a charter school based on its enrollment growth in school years subsequent to the initial year of operation.

In the event a child with special needs leaves the charter school and enrolls in a public school during the first 60 school days in the school year, the charter school shall return a pro rata amount of funds allocated for that child to the State Board, and the State Board shall reallocate those funds to the local school administrative unit in which the public school is located. In the event a child with special needs enrolls in a charter school during the first 60 school days in the school year, the State Board shall allocate to the charter school the pro rata amount of additional funds for children with special needs.

(a1) Funds allocated by the State Board of Education ~~shall not be used to purchase land or buildings.~~ may be used to enter into operational and financing leases for real property or mobile classroom units for use as school facilities for charter schools and may be used for payments on loans made to charter schools for facilities or equipment. However, State funds shall not be used to obtain any other interest in real property or mobile classroom units. No indebtedness of any kind incurred or created by the charter school shall constitute an indebtedness of the State or its political subdivisions, and no indebtedness of the charter school shall involve or be secured by the faith, credit, or taxing power of the State or its political subdivisions. Every contract or lease into which a charter school enters shall include the previous sentence. The school also may own land and buildings it ~~obtained~~ obtains through non-State sources."

Section 8. G.S. 115C-238.29I(d) reads as rewritten:

"(d) The State Board of Education may establish a Charter School Advisory Committee to assist with the implementation of this Part. The Charter School Advisory Committee may (i) provide technical assistance to chartering entities or to potential applicants, (ii) review applications for preliminary approval, (iii) make recommendations as to whether the State Board should approve applications for charter schools, (iv) make recommendations as to whether the State Board should terminate or not renew a ~~contract,~~ charter, (v) make recommendations concerning grievances between a charter school and its chartering entity, the State Board, or a local board, (vi) assist with the review under subsection (c) of this section, and (vii) provide any other assistance as may be required by the State Board."

Section 9. G.S. 115C-238.29I is amended by adding the following new subsection to read:

"(e) Notwithstanding the dates set forth in this Part, the State Board of Education may establish an alternative time line for the submission of applications, preliminary approvals, criminal record checks, appeals, and final approvals so long as the Board grants final approval by March 15 of each calendar year."

Section 10. G.S. 115C-238.29J(a) reads as rewritten:

"(a) Local boards of education are authorized and encouraged to provide administrative and evaluative support to charter schools located within their local

school administrative ~~units and to contract with those charter schools to provide student transportation.~~ units."

Section 11. G.S. 135-8(b) reads as rewritten:

"(b) Annuity Savings Fund. -- The annuity savings fund shall be a fund in which shall be accumulated contributions from the compensation of members to provide for their annuities. Contributions to any payments from the annuity savings fund shall be made as follows:

(1) Prior to the first day of July, 1947, each employer shall cause to be deducted from the salary of each member on each and every payroll of such employer for each and every payroll period four per centum (4%) of his actual compensation; and the employer also shall deduct four per centum (4%) of any compensation received by any member for teaching in public schools, or in any of the institutions, agencies or departments of the State, from salaries other than the appropriations from the State of North Carolina. On and after such date the rate so deducted shall be five per centum (5%) of actual compensation except that, with respect to each member who is eligible for coverage under the Social Security Act in accordance with the agreement entered into during 1955 in accordance with the provisions of Article 2 of Chapter 135 of Volume 17 of the General Statutes, as amended, and with respect to members covered under G.S. 135-27, with such coverage retroactive to January 1, 1955, such deduction shall, commencing with the first day of the period of service with respect to which such agreement is effective, be at the rate of three per centum (3%) of the part of his actual compensation not in excess of the amount taxable to him under the Federal Insurance Contributions Act as from time to time in effect plus five per centum (5%) of the part of his earnable compensation not so taxable; provided that in the case of any member so eligible and receiving compensation from two or more employers such deductions may be adjusted under such rules as the Board of Trustees may establish so as to be as nearly equivalent as practicable to the deductions which would have been made had the member received all of such compensation from one employer. Notwithstanding the foregoing, the Board of Trustees may in its discretion cause such portion as it may determine of deductions made between January 1, 1955, and December 1, 1955, to be transferred into the contribution fund established under G.S. 135-24; such amounts so transferred shall in that event be deemed to be taxes contributed by employees as required under Article 2, Chapter 135 of Volume 17 of the General Statutes as amended, and shall be in lieu of contributions otherwise payable in the same amount as so required.

Notwithstanding the foregoing, effective July 1, 1963, with respect to the period of service commencing on July 1, 1963, and ending December 31, 1965, the rates of such deduction shall be four per centum (4%) of the portion of compensation not in excess of forty-eight hundred dollars ($4,800) and six per centum (6%) of the portion of compensation in excess of forty-eight hundred dollars ($4,800); and with respect to the period of service commencing January 1, 1966, and ending June 30, 1967, the rate of such deductions shall be four per centum (4%) of the portion of compensation not in excess of fifty-six hundred dollars ($5,600)

and six per centum (6%) of the portion of compensation in excess of fifty-six hundred dollars ($5,600); and with respect to the period of service commencing July 1, 1967, and ending June 30, 1975, the rate of such deductions shall be five per centum (5%) of the portion of compensation not in excess of fifty-six hundred dollars ($5,600) and six per centum (6%) of the portion of compensation in excess of fifty-six hundred dollars ($5,600). Such rates shall apply uniformly to all members of the Retirement System, without regard to their coverage under the Social Security Act.

Notwithstanding the foregoing, effective July 1, 1975, with respect to the period of service commencing on July 1, 1975, the rate of such deductions shall be six per centum (6%) of the compensation received by any member. Such rates shall apply uniformly to all members of the Retirement System, without regard to their coverage under the Social Security Act.

(2) The deductions provided for herein shall be made notwithstanding that the minimum compensation provided for by law for any member shall be reduced thereby. Every member shall be deemed to consent and agree to the deductions made and provided for herein and shall receipt for his full salary or compensation, and payment of salary or compensation less said deduction shall be a full and complete discharge and acquittance of all claims and demands whatsoever for the services rendered by such person during the period covered by such payment, except as to the benefits provided under this Chapter. The employer shall certify to the Board of Trustees on each and every payroll or in such other manner as the Board of Trustees may prescribe, the amounts to be deducted; and each of said amounts shall be deducted, and when deducted shall be paid into said annuity savings fund, and shall be credited, together with regular interest thereon, to the individual account of the member from whose compensation said deduction was made.

(3) Each board of education of each county and each board of education of each city, and the employer in any department, agency or institution of the State, in which any teacher receives compensation from sources other than appropriations of the State of North Carolina shall deduct from the salaries of these teachers paid from sources other than State appropriations an amount equal to that deducted from the salaries of the teachers whose salaries are paid from State funds, and remit this amount to the State Retirement System. City boards of education and county boards of education in each and every county and city which has employees compensated from other than the State appropriation shall pay to the State Retirement System the same per centum of the compensation that the State of North Carolina pays and shall transmit same to the State Retirement System monthly: Provided, that for the purpose of enabling the boards of education to make such payment, the tax-levying authorities are hereby authorized, empowered and directed to provide the necessary funds therefor. In case the salary is paid in part from State funds and in part from local funds, the local authorities shall not be relieved of providing and remitting the same per centum of the salary paid from local funds as is paid from State funds. In case the entire salary of any

teacher, as defined in this Chapter, is paid from county or local funds, the county or city paying such salary shall provide and remit to the Retirement System the same per centum that would be required if the salary were provided by the State of North Carolina.

(4) In addition to contributions deducted from compensation as hereinbefore provided, subject to the approval of the Board of Trustees, any member may redeposit in the annuity savings fund by a single payment an amount equal to the total amount which he previously withdrew therefrom, as provided in this Chapter. Such amounts so redeposited shall become a part of his accumulated contributions as if such amounts had initially been contributed within the calendar year of such redeposit. In no event, however, shall any member be permitted to redeposit any amount withdrawn after July 1, 1959, except as provided for in G.S. 135-4(e).

(5) The Board of Trustees may approve the purchase of creditable service by any member for leaves of absence or for interrupted service to an employer for the sole purpose of acquiring knowledge, talents, or abilities and to increase the efficiency of service to the employer. This approval shall be made prior to the purchase of the creditable service, is limited to a career total of six years for each member, and may be obtained in the following manner:

a. Approved leave of absence. -- Where the employer grants an approved leave of absence, a member may make monthly contributions to the annuity savings fund on the basis of compensation the member was earning immediately prior to such leave of absence. The employer shall make monthly contributions equal to the normal and accrued liability contribution on such compensation or, in lieu thereof, the member may pay into the annuity savings fund monthly an amount equal to the employer's normal and accrued liability contribution when the policy of the employer is not to make such payment.

b. No educational leave policy. -- Where the employer has a policy of not granting educational leaves of absence or the member has unsuccessfully petitioned for leave of absence and the member has interrupted service for educational purposes, the member may make monthly contributions into the annuity savings fund in an amount equal to the employee contribution plus the employer normal and accrued liability contribution on the basis of the compensation the member was earning immediately prior to the interrupted service.

c. Educational program prior to July 1, 1981. -- Creditable service for leaves of absence or interrupted service for educational purposes prior to July 1, 1981, may be purchased by a member, before or after retirement, who returned as a contributing employee or teacher within 12 months after completing the educational program and completed 10 years of subsequent membership service, by making a lump sum payment into the annuity savings fund equal to the full cost of the service credits calculated on the

basis of the assumptions used for purposes of the actuarial valuation of the system's liabilities and shall take into account the retirement allowance arising on account of the additional service credit commencing at the earliest age at which the member could retire on an unreduced retirement allowance as determined by the Board of Trustees upon the advice of the consulting actuary, plus a fee to be determined by the Board of Trustees.

d. Employment in a charter school. -- Notwithstanding subparagraph a. of this subdivision, where the employer grants an approved leave of absence for the member to be employed in a charter school or where the member's service is interrupted by employment in a charter school, authorized under Part 6A of Article 16 of Chapter 115C of the General Statutes, the member may make monthly contributions into the annuity savings fund in an amount equal to the employee contribution plus the employer normal and accrued liability contribution on the basis of the compensation the member was earning immediately prior to the interrupted service.

Payments required to be made by the ~~member and/or the employer~~ member, the employer, or both under subparagraphs a or b are due by the 15th of the month following the month for which the service credit is allowed and payments made after the due date shall be assessed a penalty, in lieu of interest, of one percent (1%) per month or fraction thereof the payment is made beyond the due date; provided, that these payments shall be made prior to retirement and provided further, that if the member did not become a contributing member within 12 months after completing the educational program and failed to complete three years of subsequent membership service, except in the event of death or disability, any payment made by the member including penalty shall be refunded with regular interest thereon and the service credits cancelled prior to or at retirement.

(6) The contributions of a member, and such interest as may be allowed thereon, paid upon his death or withdrawn by him as provided in this Chapter, shall be paid from the annuity savings fund, and any balance of the accumulated contributions of such a member shall be transferred to the pension accumulation fund."

Section 12. The Board of Trustees of the North Carolina Teachers' and State Employees' Retirement System through the Office of the Attorney General shall request a letter of determination or ruling from the Internal Revenue Service, United States Department of Treasury, as to whether the status of the North Carolina Teachers' and State Employees' Retirement System as a governmental plan would be adversely affected by the participation of employees of charter schools. The request shall be made to the Internal Revenue Service after it is approved by the Speaker of the House of Representatives and the President Pro Tempore of the Senate or their designees and no later than 30 days after the effective date of this act. Employees of charter schools are eligible for participation in the North Carolina Teachers' and State Employees' Retirement System upon the first day of the calendar month following the State's receipt of a favorable letter of determination or ruling.

Section 13. G.S. 115C-238.29F(e)(4), as amended by Section 5 of this act, is effective on the first day of the calendar month following the State's receipt of a favorable letter of determination or ruling from the Internal Revenue Service, United States Department of Treasury, under Section 12 of this act. The remainder of this act is effective when it becomes law.

In the General Assembly read three times and ratified this the 13th day of August, 1997.

s/ Dennis A. Wicker
President of the Senate

s/ Harold J. Brubaker
Speaker of the House of Representatives

s/ James B. Hunt, Jr.
Governor

Approved 2:25 p.m. this 22nd day of August, 1997

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

S 3

SENATE BILL 400*
Pensions & Retirement and Insurance Committee Substitute Adopted 4/28/97
Third Edition Engrossed 4/30/97

Short Title: Mental Health Parity. (Public)

Sponsors:

Referred to:

March 17, 1997

A BILL TO BE ENTITLED

AN ACT TO REQUIRE PARITY IN HEALTH INSURANCE FOR MENTAL ILLNESS.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-50-155 is amended by adding the following new subsection to read:

"(a2) Notwithstanding G.S. 58-50-125(c), the standard health plan developed and approved under G.S. 58-50-125 shall provide coverage for the treatment of mental illness that is at least equal to the coverage required by G.S. 58-51-55. The plan may use a case management program in accordance with G.S. 58-51-55.

Section 2. G.S. 58-51-55 reads as rewritten:

"**§ 58-51-55. No discrimination against the mentally ill and chemically dependent.**

(a) As used in this section, the term:

(1) 'Mental illness' has the same meaning as defined in G.S. 122C-3(21); and

(2) 'Chemical dependency' has the same meaning as defined in G.S. 58-51-50

with a diagnosis found in the Diagnostic and Statistical Manual of Mental Disorders ~~DSM-3-R~~ DSM-IV or the International Classification of Diseases ICD/9/CM, or a later edition of those manuals.

(b) No insurance company licensed in this State under ~~the provisions of Articles 1 through 64 of~~ this Chapter shall, solely because an individual to be insured has or had a mental illness or chemical dependency:

(1) Refuse to issue or deliver to that individual any policy that affords benefits or coverages for any medical treatment or service for physical illness or injury;

(2) Have a higher premium rate or charge for physical illness or injury coverages or benefits for that individual; or

(3) Reduce physical illness or injury coverages or benefits for that individual.

(c) Nothing in this section prevents any insurance company from excluding from coverage any physical illness or injury ~~or mental illness~~ or chemical dependency which has existed previous to coverage of the individual by the insurance company or from refusing to issue or deliver to that individual any policy because of the underwriting of any physical condition whether or not related to ~~mental illness or~~ chemical dependency.

~~(d) This section applies only to group health insurance contracts covering 20 or more employees.~~

(d) Every insurer that writes a policy or contract of group or blanket health insurance or group or blanket accident and health insurance shall provide to its insureds benefits for the necessary care and treatment of mental illness that are not less favorable than benefits for physical illness generally. Benefits for treatment of mental illness shall be subject to the same limits as are benefits for physical illness generally. For purposes of this subdivision, 'limits' includes durational limits, deductibles, coinsurance factors, copayments, maximum out-of-pocket limits, annual and lifetime dollar limits, and any other dollar limits or fees for covered services.

(e) An insurer may use a case management program for mental illness benefits to evaluate and determine medically necessary and medically appropriate care and treatment for each patient, provided that the program complies with rules adopted by the Commissioner of Insurance. These rules shall ensure that case management programs are not designed to avoid the requirements of this section concerning parity between the benefits for mental illness and those for physical illness generally.

(f) Subsections (d) and (e) of this section apply only to group health insurance contracts covering 5 or more employees. The remainder of this section applies only to group health insurance contracts covering 20 or more employees.

(g) Subsections (d) and (e) of this section shall not apply to a policy or contract if the insurer demonstrates to the Commissioner that compliance has increased the cost of the policy by two percent (2%) or more on an annual basis."

Section 3. G.S. 58-65-90 reads as rewritten:

"**§ 58-65-90. No discrimination against the mentally ill and chemically dependent.**

(a) As used in this section, the term:

(1) 'Mental illness' has the same meaning as defined in G.S. 122C-3(21); and

(2) 'Chemical dependency' has the same meaning as defined in G.S. 58-65-75

with a diagnosis found in the Diagnostic and Statistical Manual of Mental Disorders ~~DSM-3-R~~ DSM-IV or the International Classification of Diseases ICD/9/CM, or a later edition of those manuals.

(b) No ~~hospital, medical, dental or health service~~ corporation governed by this Chapter shall, solely because an individual to be insured has or had a mental illness or chemical dependency:

(1) Refuse to issue or deliver to that individual any individual or group hospital, dental, medical or health service contract in this State that affords benefits or coverage for medical treatment or service for physical illness or injury;

(2) Have a higher premium rate or charge for physical illness or injury coverages or benefits for that individual; or

(3) Reduce physical illness or injury coverages or benefits for that individual.

(c) Nothing in this section prevents any hospital or medical plan from excluding from coverage any physical illness or injury ~~or mental illness~~ or chemical dependency which has existed previous to coverage of the individual by the hospital or medical plan or from refusing to issue or deliver to that individual any policy because of the underwriting of any physical condition whether or not related to ~~mental illness or~~ chemical dependency.

~~(d) This section applies only to group contracts covering 20 or more employees.~~

(d) Every group insurance certificate or group subscriber contract under a hospital or medical plan subject to this Article shall provide to its insureds benefits for the necessary care and treatment of mental illness that are not less favorable than benefits for physical illness generally. Benefits for treatment of mental illness shall be subject to the same limits as are benefits for physical illness generally. For purposes of this subsection, 'limits' includes durational limits, deductibles, coinsurance factors, copayments, maximum out-of-pocket limits, annual and lifetime dollar limits, and any other dollar limits or fees for covered services.

(e) The service corporation may use a case management program for mental illness benefits to evaluate and determine medically necessary and medically appropriate care and treatment for each patient, provided that the program complies with rules adopted by the Commissioner of Insurance. These rules shall ensure that case management programs are not designed to avoid the requirements of this section concerning parity between the benefits for mental illness and those for physical illness generally.

(f) Subsections (d) and (e) of this section apply only to group contracts covering 5 or more employees. The remainder of this section applies only to group contracts covering 20 or more employees.

(g) Subsections (d) and (e) of this section shall not apply to a subscriber contract or certificate if the service corporation demonstrates to the Commissioner that

compliance has increased the cost of the contract or certificate by two percent (2%) or more on an annual basis."

Section 4. G.S. 58-67-75 reads as rewritten:

"**§ 58-67-75. No discrimination against the mentally ill and chemically dependent.**

(a) As used in this section, the term:

(1) 'Mental illness' has the same meaning as defined in G.S. 122C-3(21); and

(2) 'Chemical dependency' has the same meaning as defined in G.S. 58-67-70

with a diagnosis found in the Diagnostic and Statistical Manual of Mental Disorders ~~DSM-3-R~~ DSM-IV or the International Classification of Diseases ICD/9/CM, or a later edition of those manuals.

(b) No health maintenance organization governed by this Chapter shall, solely because an individual has or had a mental illness or chemical dependency:

(1) Refuse to enroll that individual in any health care plan covering physical illness or injury;

(2) Have a higher premium rate or charge for physical illness or injury coverages or benefits for that individual; or

(3) Reduce physical illness or injury coverages or benefits for that individual.

(c) Nothing in this section prevents any health maintenance organization from excluding from coverage any physical illness or injury ~~or mental illness~~ or chemical dependency which has existed previous to coverage of the individual by the health maintenance organization or from refusing to issue or deliver to that individual any policy because of the underwriting of any physical condition whether or not related to ~~mental illness or~~ chemical dependency.

~~(d) This section applies only to group contracts covering 20 or more employees.~~

(d) Every health maintenance organization that issues a health care plan on a group basis for medical and hospitalization care shall provide to its insureds benefits for the necessary care and treatment of mental illness that are not less favorable than benefits for physical illness generally. Benefits for treatment of mental illness shall be subject to the same limits as are benefits for physical illness generally. For purposes of this subsection, 'limits' includes durational limits, deductibles, coinsurance factors, copayments, maximum out-of-pocket limits, annual and lifetime dollar limits, and any other dollar limits or fees for covered services.

(e) A health maintenance organization may use a case management program for mental illness benefits to evaluate and determine medically necessary and medically appropriate care and treatment for each patient, provided that the program complies with rules adopted by the Commissioner of Insurance. These rules shall ensure that case management programs are not designed to avoid the requirements of this section concerning parity between the benefits for mental illness and those for physical illness generally.

(f) This section applies only to group contracts covering five or more employees.

(g) Subsections (d) and (e) of this section shall not apply to a health care plan if the HMO demonstrates to the Commissioner that compliance has increased the cost of the plan by two percent (2%) or more on an annual basis."

Section 5. This act is effective when it becomes law and applies to contracts issued, delivered, or renewed on or after January 1, 1998. This act expires October 1, 2001.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

S 2

SENATE BILL 538
Pensions & Retirement and Insurance Committee Substitute Adopted 4/28/97

Short Title: Professional Firefighters' Retirement. (Public)

Sponsors:

Referred to: Appropriations.

March 27, 1997

A BILL TO BE ENTITLED

AN ACT TO DEFINE A PROFESSIONAL FIREFIGHTERS' BENEFIT ACCRUAL RATE FOR MEMBERS AND BENEFICIARIES OF THE LOCAL GOVERNMENTAL EMPLOYEES' RETIREMENT SYSTEM.

The General Assembly of North Carolina enacts:

Section 1. G.S. 128-21 is amended by adding a new subdivision to read:

"(17a) 'Professional firefighter' means a full-time, paid employee of an employer, maintaining a fire department certified by the North Carolina Department of Insurance, who is actively serving in a position with assigned primary duties and responsibilities for the prevention, detection, and suppression of fire."

Section 2. G.S. 128-24(5) reads as rewritten:

"(5) The provisions of this subdivision (5) shall apply to any member whose membership is terminated on or after July 1, 1965, and who becomes entitled to benefits hereunder in accordance with the provisions hereof.

a. Notwithstanding any other provision of this Chapter, any member who separates from service prior to the attainment of the age of 60 years for any reason other than death or retirement for disability as provided in G.S. 128-27(c), after completing 15 or more years of creditable service, and who leaves his total accumulated contributions in said System shall have the right to retire on a deferred retirement

allowance upon attaining the age of 60 years; provided that such member may retire only upon written application to the Board of Trustees setting forth at what time, not less than one day nor more than 90 days subsequent to the execution and filing thereof, he desires to be retired; and further provided that in the case of a member who so separates from service on or after July 1, 1967, the aforestated requirement of 15 or more years of creditable service shall be reduced to 12 or more years of creditable service; and further provided that in the case of a member who so separates from service on or after July 1, 1971, or whose account is active on July 1, 1971, the aforestated requirement of 12 or more years of creditable service shall be reduced to five or more years of creditable service. Such deferred retirement allowance shall be computed in accordance with the service retirement provisions of this Article pertaining to a member who is not a law enforcement officer or eligible former law enforcement officer.

b. In lieu of the benefits provided in paragraph a of this subdivision, any member who separates from service prior to the attainment of the age of 60 years, for any reason other than death or retirement for disability as provided in G.S. 128-27(c), after completing 20 or more years of creditable service, and who leaves his total accumulated contributions in said System may elect to retire on an early retirement allowance upon attaining the age of 50 years or at any time thereafter; provided that such member may so retire only upon written application to the Board of Trustees setting forth at what time, not less than one day nor more than 90 days subsequent to the execution and filing thereof, he desires to be retired. Such early retirement allowance so elected shall be equal to the deferred retirement allowance otherwise payable at the attainment of the age of 60 years reduced by the percentage thereof indicated below.

Age at Retirement	Percentage Reduction
59	7
58	14
57	20
56	25
55	30
54	35
53	39

52	43
51	46
50	50

b1. In lieu of the benefits provided in paragraphs a and b of this subdivision, any member who is a law enforcement officer or a professional firefighter at the time of separation from service prior to the attainment of the age of 50 years, for any reason other than death or disability as provided in this Article, after completing 15 or more years of creditable service in this capacity immediately prior to separation from service, and who leaves his total accumulated contributions in this System, may elect to retire on a deferred early retirement allowance upon attaining the age of 50 years or at any time thereafter; provided, that the member may commence retirement only upon written application to the Board of Trustees setting forth at what time, as of the first day of a calendar month, not less than one day nor more than 90 days subsequent to the execution and filing thereof, he desires to commence retirement. The deferred early retirement allowance shall be computed in accordance with the service retirement provisions of this Article pertaining to law enforcement ~~officers.~~ officers or professional firefighters.

b2. In lieu of the benefits provided in paragraphs a and b of this subdivision, any member who is a law enforcement officer or professional firefighter at the time of separation from service prior to the attainment of the age of 55 years, for any reason other than death or disability as provided in this Article, after completing five or more years of creditable service in this capacity immediately prior to separation from service, and who leaves his total accumulated contributions in this System may elect to retire on a deferred service retirement allowance upon attaining the age of 55 years or at any time thereafter; provided, that the member may commence retirement only upon written application to the Board of Trustees setting forth at what time, as of the first day of a calendar month not less than one day nor more than 90 days subsequent to the execution and filing thereof, he desires to commence retirement. The deferred service retirement allowance shall be computed in accordance with the service retirement provisions of this Article pertaining to law enforcement ~~officers.~~ officers or professional firefighters.

b3. Deferred retirement allowance of members retiring on or after July 1, 1995. -- In lieu of the benefits provided in paragraphs a. and b. of this subdivision, any member who

separates from service prior to attainment of age 60 years, after completing 20 or more years of creditable service, and who leaves his total accumulated contributions in said System, may elect to retire on a deferred retirement allowance upon attaining the age of 50 years or any time thereafter; provided that such member may so retire only upon written application to the Board of Trustees setting forth at what time, not less than one day nor more than 90 days subsequent to the execution and filing thereof, he desires to be retired. Such deferred retirement allowance shall be computed in accordance with the service retirement provisions of this Article pertaining to a member who is not a law enforcement officer or an eligible former law enforcement officer.

c. Should a beneficiary who retired on an early or service retirement allowance be reemployed, or otherwise engaged to perform services, by an employer participating in the Retirement System on a part-time, temporary, interim, or on fee-for-service basis, whether contractual or otherwise, and if such beneficiary earns an amount in any calendar year which exceeds fifty percent (50%) of the reported compensation, excluding terminal payments, during the 12 months of service preceding the effective date of retirement, or twenty thousand dollars ($20,000), whichever is greater, as hereinafter indexed, then the retirement allowance shall be suspended as of the first day of the month following the month in which the reemployment earnings exceed the amount above, for the balance of the calendar year. The retirement allowance of the beneficiary shall be reinstated as of January 1 of each year following suspension. The amount that may be earned before suspension shall be increased on January 1 of each year by the ratio of the Consumer Price Index to the Index one year earlier, calculated to the nearest tenth of a percent (1/10 of 1%).

d. Should a beneficiary who retired on an early or service retirement allowance be restored to service as an employee, then the retirement allowance shall cease as of the first day of the month following the month in which the beneficiary is restored to service and the beneficiary shall become a member of the Retirement System and shall contribute thereafter as allowed by law at the uniform contribution payable by all members.

Upon his subsequent retirement, he shall be paid a retirement allowance determined as follows:

1. For a member who earns at least three years' membership service after restoration to service, the retirement allowance shall be computed on the basis of his compensation and service before and after the period of prior retirement without restriction; provided, that if the prior allowance was based on a social security leveling payment option, the allowance shall be adjusted actuarially for the difference between the amount received under the optional payment and what would have been paid if the retirement allowance had been paid without optional modification.
2. For a member who does not earn three years' membership service after restoration to service, the retirement allowance shall be equal to the sum of the retirement allowance to which he would have been entitled had he not been restored to service, without modification of the election of an optional allowance previously made, and the retirement allowance that results from service earned since being restored to service; provided, that if the prior retirement allowance was based on a social security leveling payment option, the prior allowance shall be adjusted actuarially for the difference between the amount that would have been paid for each month had the payment not been suspended and what would have been paid if the retirement allowance had been paid without optional modification."

Section 3. G.S. 128-27(a) reads as rewritten:

"(a) Service Retirement Benefits. --

(1) Any member may retire upon written application to the Board of Trustees setting forth at what time, as of the first day of a calendar month, not less than one day nor more than 90 days subsequent to the execution and filing thereof, he desires to be retired: Provided, that the said member at the time so specified for his retirement shall have attained the age of 60 years and have at least five years of creditable service or shall have completed 30 years of creditable service, or if a ~~fireman, he~~ professional firefighter, the member shall have ~~attained the age of 55 years and have at least five years of creditable service.~~ completed at least 25 years of creditable service provided that the last five years of creditable service is as a professional firefighter.

(2) Repealed by Session Laws 1983 (Regular Session, 1984), c. 1019, s. 1.

(3) Repealed by Session Laws 1971, c. 325, s. 12.

(4) Any member who was in service October 8, 1981, who had attained 60 years of age, may retire upon written application to the Board of Trustees setting forth at what time, as of the first day of a calendar month, not less than one day nor more than 90 days subsequent to the execution and filing thereof, he desires to be retired.

(5) Any member who is a law enforcement ~~officer,~~ officer or professional firefighter, and who attains age 50 and completes 15 or more years of creditable service in this capacity or who attains age 55 and completes five or more years of creditable service in this capacity, may retire upon written application to the Board of Trustees setting forth at what time, as of the first day of a calendar month, not less than one day nor more than 90 days subsequent to the execution and filing thereof, ~~he~~ the member desires to be retired; provided, also, any member who has met the conditions required by this ~~subdivision~~ section but does not retire, and later becomes an employee other than as a law enforcement ~~officer,~~ officer or professional firefighter, continues to have the right to commence retirement.

Section 4. G.S. 128-27 is amended by adding a new subsection to read:

"(b16) Service Retirement Allowance of Professional Firefighters Retiring on or After July 1, 1997. -- Upon retirement from service, in accordance with subsection (a) of this section, on or after July 1, 1997, a member who is a professional firefighter or an eligible former professional firefighter shall receive the following service retirement allowance:

(1) If the member's service retirement date occurs on or after the member's 55th birthday, and completion of five years of creditable service as a professional firefighter, or after the completion of 25 years of creditable service, provided that the last five years of creditable service are as a professional firefighter, the allowance shall be equal to the sum of:

a. One and seventy-two hundredths percent (1.72%) of the member's average final compensation, multiplied by the number of years of creditable service earned by the member in service other than as a professional firefighter and for service as a professional firefighter earned prior to July 1, 1987, plus

b. Two and fifty hundredths percent (2.50%) of the member's average final compensation, multiplied by the number of years of creditable service earned as a professional firefighter on or after July 1, 1987.

(2) If the member's service retirement date occurs after the member's 50th birthday and before the member's 55th birthday with 15 or

more years of creditable service as a professional firefighter and prior to completion of 25 years of creditable service, the member's retirement allowance shall be equal to the greater of:

a. The service retirement allowance payable under G.S. 128-27(b16)(1) reduced by one-third of one percent (1/3 of 1%) thereof for each month by which his retirement date precedes the first day of the month coincident with or next following the month the member would have attained his 55th birthday; or

b. The service retirement allowance as computed under G.S. 128-27(b16)(1) reduced by five percent (5%) times the difference between 25 years and the member's creditable service at retirement."

Section 5. G.S. 128-30(d) is amended by adding a new subdivision to read:

"(10) Notwithstanding the foregoing provisions of this subsection, beginning with the December 31, 1996, valuation, the actuary shall determine an additional 'accrued liability contribution' on account of each employer's professional firefighters. This contribution shall be that percentage of the professional firefighters' compensation necessary to liquidate the 'existing unfunded accrued liability' over a period of years to be determined by the Board of Trustees. The 'existing unfunded accrued liability' for each employer shall be equal to the accrued liability for additional benefits payable to each employer's professional firefighters who are members of the Retirement System on June 30, 1997. The 'accrued liability contribution' determined on the basis of this subdivision shall be added to that determined under subdivisions (3) and (9) of this subsection and shall be included in the total amount payable under subdivision (5) of this subsection."

Section 6. This act becomes effective July 1, 1997, and applies to persons retiring on or after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA
1997 SESSION

S.L. 1997-144
SENATE BILL 673

AN ACT TO AMEND THE DEFINITION OF LAW ENFORCEMENT OFFICER FOR PURPOSES OF ELIGIBILITY FOR BENEFITS UNDER THE LOCAL GOVERNMENTAL EMPLOYEES' RETIREMENT SYSTEM.

The General Assembly of North Carolina enacts:

Section 1. G.S. 128-21(11b) reads as rewritten:

"(11b) 'Law Enforcement Officer' means a full-time paid employee of an ~~employer who is actively serving in a position with assigned primary duties and responsibilities for prevention and detection of crime or for the general enforcement of the criminal laws of the State or for serving civil processes, and who possesses the power of arrest by virtue of an oath administered under the authority of the State.~~ employer, who possesses the power of arrest, who has taken the law enforcement oath administered under the authority of the State as prescribed by G.S. 11-11, and who is certified as a law enforcement officer under the provisions of Chapter 17C of the General Statutes or certified as a deputy sheriff under the provisions of Chapter 17E of the General Statutes. 'Law enforcement officer' also means the sheriff of the county. The number of paid personnel employed as law enforcement officers by a law enforcement agency may not exceed the number of law enforcement positions approved by the applicable local governing board."

Section 2. G.S. 143-166.50(a)(3) reads as rewritten:

"(3) 'Law-enforcement officer' means a full-time paid employee of an employer, who ~~is actively serving in a position with assigned primary duties and responsibilities for prevention and detection of crime or the general enforcement of the criminal laws of the State or serving civil processes, and who possesses the power of arrest by virtue of an oath administered under the authority of the State.~~ possesses the power of arrest, who has taken the law enforcement oath administered under the authority of the State as prescribed by G.S. 11-11, and who is certified as a law enforcement officer under the provisions of Chapter 17C of the General Statutes or certified as a deputy sheriff under the provisions of Chapter 17E of the General Statutes. 'Law enforcement officer' also means the sheriff of the county. The number of paid personnel employed as law enforcement officers by a law enforcement agency may not exceed the number of law enforcement positions approved by the applicable local governing board."

Section 3. This act becomes effective July 1, 1997, and applies to all persons enrolled in the Local Governmental Employees' Retirement System on or after that date.

In the General Assembly read three times and ratified this the 27th day of May, 1997.

s/ Dennis A. Wicker
President of the Senate

s/ Harold J. Brubaker
Speaker of the House of Representatives

s/ James B. Hunt, Jr.
Governor

Approved 3:36 p.m. this 4th day of June, 1997

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MEMORANDUM

TO: Senator Leslie Winner

FROM: Sam Byrd, Fiscal Research Division

DATE: April 25, 1997

SUBJECT: Actuarial Note (Senate Bill 400, Sections 8 & 9)

Re: Daily, Fiscal Year, and Lifetime Chemical Dependency Benefit Limits Removed and Mental Health Benefits Provided by Social Workers under Supervision of Psychiatrists and Psychologists Eliminated in the Teachers' and State Employees' Comprehensive Major Medical Plan.

In accordance with North Carolina General Statute 120-114 and applicable Rules of the North Carolina Senate and House of Representatives, attached is a certified copy of an original actuarial note on the above subject as prepared by the General Assembly's Consulting Actuary. A certified copy of an original actuarial note on the same subject from the Plan Administrator's Consulting Actuary is also attached for your review.

cc: Sen. Tommy Jenkins, Committee on Pensions & Retirement and Insurance.
Principal Clerk, Senate

Attachment(s):
(1) Senate Bill 400.
(2) Actuarial Note, Dilts, Umstead & Dunn, Senate Bill 400, Sections 8 & 9, April 22, 1997.
(3) Actuarial Note, Aon Consulting, Senate Bill 400, Sections 8 & 9, April 23, 1997.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

S 1

SENATE BILL 400*

Short Title: Mental Health Parity. (Public)

Sponsors: Senators Winner; Carpenter, Conder, Dannelly, Forrester, Gulley, Kinnaird, Ledbetter, Martin of Guilford, Phillips, and Rucho.

Referred to: Pensions & Retirement and Insurance.

March 17, 1997

A BILL TO BE ENTITLED

AN ACT TO REQUIRE PARITY IN HEALTH INSURANCE FOR MENTAL ILLNESS AND CHEMICAL DEPENDENCY.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-50-155 is amended by adding the following new subsection to read:

"(a2) Notwithstanding G.S. 58-50-125(c), the standard health plan developed and approved under G.S. 58-50-125 shall provide coverage for the treatment of chemical dependency and mental illness that is at least equal to the coverage required by G.S. 58-51-50 and G.S. 58-51-55, respectively."

Section 2. G.S. 58-51-50 reads as rewritten:

"**§ 58-51-50. Coverage for chemical dependency treatment.**

(a) As used in this section, the term 'chemical dependency' means the pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces an impairment in personal, social or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal.

(b) Every insurer that writes a policy or contract of group or blanket health insurance or group or blanket accident and health insurance that is issued, renewed, or amended on or after January 1, 1985, shall ~~offer~~ provide to its insureds benefits for the necessary care and treatment of chemical dependency that are not less favorable than benefits for physical illness generally. ~~Except as provided in subsection (c) of this section, benefits~~ Benefits for treatment of chemical dependency shall be subject

to the same durational limits, dollar limits, deductibles, and coinsurance factors as are benefits for physical illness generally.

~~(c) Every group policy or group contract of insurance that provides benefits for chemical dependency treatment and that provides total annual benefits for all illnesses in excess of eight thousand dollars ($8,000) is subject to the following conditions:~~

~~(1) The policy or contract shall provide, for each 12-month period, a minimum benefit of eight thousand dollars ($8,000) for the necessary care and treatment of chemical dependency.~~

~~(2) The policy or contract shall provide a minimum benefit of sixteen thousand dollars ($16,000) for the necessary care and treatment of chemical dependency for the life of the policy or contract.~~

(d) Provisions for benefits for necessary care and treatment of chemical dependency in group policies or group contracts of insurance shall provide benefit payments for the following providers of necessary care and treatment of chemical dependency:

(1) The following units of a general hospital licensed under Article 5 of General Statutes Chapter 131E:
   a. Chemical dependency units in facilities licensed after October 1, 1984;
   b. Medical units;
   c. Psychiatric units; and

(2) The following facilities or programs licensed after July 1, 1984, under Article 2 of General Statutes Chapter 122C:
   a. Chemical dependency units in psychiatric hospitals;
   b. Chemical dependency hospitals;
   c. Residential chemical dependency treatment facilities;
   d. Social setting detoxification facilities or programs;
   e. Medical detoxification or programs; and

(3) Duly licensed physicians and duly licensed practicing psychologists and certified professionals working under the direct supervision of such physicians or psychologists in facilities described in (1) and (2) above and in day/night programs or outpatient treatment facilities licensed after July 1, 1984, under Article 2 of General Statutes Chapter 122C.

Provided, however, that nothing in this subsection shall prohibit any policy or contract of insurance from requiring the most cost effective treatment setting to be utilized by the person undergoing necessary care and treatment for chemical dependency.

~~(e) Coverage for chemical dependency treatment as described in this section shall not be applicable to any group policy holder or group contract holder who rejects the coverage in writing.~~"

Section 3. G.S. 58-51-55 reads as rewritten:

"**§ 58-51-55. No discrimination against the mentally ill and chemically dependent.**

(a) As used in this section, the term:

(1) 'Mental illness' has the same meaning as defined in G.S. 122C-3(21); and

(2) 'Chemical dependency' has the same meaning as defined in G.S. 58-51-50

with a diagnosis found in the Diagnostic and Statistical Manual of Mental Disorders ~~DSM-3-R~~ DSM-IV or the International Classification of Diseases ICD/9/CM, or a later edition of those manuals.

(b) No insurance company licensed in this State under ~~the provisions of Articles 1 through 64 of~~ this Chapter shall, solely because an individual to be insured has or had a mental illness or chemical dependency:

(1) Refuse to issue or deliver to that individual any policy that affords benefits or coverages for any medical treatment or service for physical illness or injury;

(2) Have a higher premium rate or charge for physical illness or injury coverages or benefits for that individual; or

(3) Reduce physical illness or injury coverages or benefits for that individual.

~~(c) Nothing in this section prevents any insurance company from excluding from coverage any physical illness or injury or mental illness or chemical dependency which has existed previous to coverage of the individual by the insurance company or from refusing to issue or deliver to that individual any policy because of the underwriting of any physical condition whether or not related to mental illness or chemical dependency.~~

~~(d) This section applies only to group health insurance contracts covering 20 or more employees.~~

(e) Every insurer that writes a policy or contract of group or blanket health insurance or group or blanket accident and health insurance that is issued, renewed, or amended on or after January 1, 1998, shall provide to its insureds benefits for the necessary care and treatment of mental illness that are not less favorable than benefits for physical illness generally. Benefits for treatment of mental illness shall be subject to the same durational limits, dollar limits, deductibles, and coinsurance factors as are benefits for physical illness generally."

Section 4. G.S. 58-65-75 reads as rewritten:

"**§ 58-65-75. Coverage for chemical dependency treatment.**

(a) As used in this section, the term 'chemical dependency' means the pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces an impairment in personal, social, or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal.

(b) Every group insurance certificate or group subscriber contract under any hospital or medical plan governed by this Article and Article 66 of this Chapter that is issued, renewed, or amended on or after January 1, 1985, shall ~~offer~~ provide to its insureds benefits for the necessary care and treatment of chemical dependency that are not less favorable than benefits for physical illness generally. ~~Except as provided~~

~~in subsection (c) of this section, benefits~~ Benefits for chemical dependency shall be subject to the same durational limits, dollar limits, deductibles, and coinsurance factors as are benefits for physical illness generally.

~~(e) Every group insurance certificate or group subscriber contract that provides benefits for chemical dependency treatment and that provides total annual benefits for all illnesses in excess of eight thousand dollars ($8,000) is subject to the following conditions:~~

~~(1) The certificate or contract shall provide, for each 12-month period, a minimum benefit of eight thousand dollars ($8,000) for the necessary care and treatment of chemical dependency.~~

~~(2) The certificate or contract shall provide a minimum benefit of sixteen thousand dollars ($16,000) for the necessary care and treatment of chemical dependency for the life of the certificate or contract.~~

(d) Provisions for benefits for necessary care and treatment of chemical dependency in group certificates or group contracts shall provide for benefit payments for the following providers of necessary care and treatment of chemical dependency:

(1) The following units of a general hospital licensed under Article 5 of General Statutes Chapter 131E:
   a. Chemical dependency units in facilities licensed after October 1, 1984;
   b. Medical units;
   c. Psychiatric units; and

(2) The following facilities or programs licensed after July 1, 1984, under Article 2 of General Statutes Chapter 122C:
   a. Chemical dependency units in psychiatric hospitals;
   b. Chemical dependency hospitals;
   c. Residential chemical dependency treatment facilities;
   d. Social setting detoxification facilities or programs;
   e. Medical detoxification facilities or programs; and

(3) Duly licensed physicians and duly licensed psychologists and certified professionals working under the direct supervision of such physicians or psychologists in facilities described in (1) and (2) above and in day/night programs or outpatient treatment facilities licensed after July 1, 1984, under Article 2 of General Statutes Chapter 122C. After January 1, 1995, 'duly licensed psychologists' shall be defined as licensed psychologists who hold permanent licensure and certification as health services provider psychologist issued by the North Carolina Psychology Board.

Provided, however, that nothing in this subsection shall prohibit any certificate or contract from requiring the most cost effective treatment setting to be utilized by the person undergoing necessary care and treatment for chemical dependency.

~~(c) Coverage for chemical dependency treatment as described in this section shall not be applicable to any group certificate holder or group subscriber contract holder who rejects the coverage in writing.~~"

Section 5. G.S. 58-65-90 reads as rewritten:

"**§ 58-65-90. No discrimination against the mentally ill and chemically dependent.**

(a) As used in this section, the term:

(1) 'Mental illness' has the same meaning as defined in G.S. 122C-3(21); and

(2) 'Chemical dependency' has the same meaning as defined in G.S. 58-65-75

with a diagnosis found in the Diagnostic and Statistical Manual of Mental Disorders ~~DSM-3-R~~ DSM-IV or the International Classification of Diseases ICD/9/CM, or a later edition of those manuals.

(b) No ~~hospital, medical, dental or health service~~ corporation governed by this Chapter shall, solely because an individual to be insured has or had a mental illness or chemical dependency:

(1) Refuse to issue or deliver to that individual any individual or group hospital, dental, medical or health service contract in this State that affords benefits or coverage for medical treatment or service for physical illness or injury;

(2) Have a higher premium rate or charge for physical illness or injury coverages or benefits for that individual; or

(3) Reduce physical illness or injury coverages or benefits for that individual.

~~(c) Nothing in this section prevents any hospital or medical plan from excluding from coverage any physical illness or injury or mental illness or chemical dependency which has existed previous to coverage of the individual by the hospital or medical plan or from refusing to issue or deliver to that individual any policy because of the underwriting of any physical condition whether or not related to mental illness or chemical dependency.~~

~~(d) This section applies only to group contracts covering 20 or more employees.~~

(e) Every insurer that writes a policy or contract of group or blanket health insurance or group or blanket accident and health insurance that is issued, renewed, or amended on or after January 1, 1998, shall provide to its insureds benefits for the necessary care and treatment of mental illness that are not less favorable than benefits for physical illness generally. Benefits for treatment of mental illness shall be subject to the same durational limits, dollar limits, deductibles, and coinsurance factors as are benefits for physical illness generally."

Section 6. G.S. 58-67-70 reads as rewritten:

"**§ 58-67-70. Coverage for chemical dependency treatment.**

(a) As used in this section, the term 'chemical dependency' means the pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces an impairment in personal, social or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal.

(b) On and after January 1, 1985, every health maintenance organization that writes a health care plan on a group basis and that is subject to this Article shall ~~offer~~ provide benefits for the necessary care and treatment of chemical dependency that are not less favorable than benefits under the health care plan generally. ~~Except as provided in subsection (c) of this section, benefits~~ Benefits for chemical dependency shall be subject to the same durational limits, dollar limits, deductibles, and coinsurance factors as are benefits under the health care plan generally.

~~(c) Every group health care plan that provides benefits for chemical dependency treatment and that provides total annual benefits for all illnesses in excess of eight thousand dollars ($8,000) is subject to the following conditions:~~

~~(1) The plan shall provide, for each 12-month period, a minimum benefit of eight thousand dollars ($8,000) for the necessary care and treatment of chemical dependency.~~

~~(2) The plan shall provide a lifetime minimum benefit of sixteen thousand dollars ($16,000) for the necessary care and treatment of chemical dependency for each enrollee.~~

(d) Provisions for benefits for necessary care and treatment of chemical dependency in group health care plans shall provide for benefit payments for the following providers of necessary care and treatment of chemical dependency:

(1) The following units of a general hospital licensed under Article 5 of General Statutes Chapter 131E:
   a. Chemical dependency units in facilities licensed after October 1, 1984;
   b. Medical units;
   c. Psychiatric units; and

(2) The following facilities or programs licensed after July 1, 1984, under Article 2 of General Statutes Chapter 122C:
   a. Chemical dependency units in psychiatric hospitals;
   b. Chemical dependency hospitals;
   c. Residential chemical dependency treatment facilities;
   d. Social setting detoxification facilities or programs;
   e. Medical detoxification facilities or programs; and

(3) Duly licensed physicians and duly licensed practicing psychologists and certified professionals working under the direct supervision of such physicians or psychologists in facilities described in (1) and (2) above and in day/night programs or outpatient treatment facilities licensed after July 1, 1984, under Article 2 of General Statutes Chapter 122C.

Provided, however, that nothing in this subsection shall prohibit any plan from requiring the most cost effective treatment setting to be utilized by the person undergoing necessary care and treatment for chemical dependency.

~~(e) Coverage for chemical dependency treatment as described in this section shall not be applicable to any group that rejects the coverage in writing.~~

(f) Notwithstanding any other provision of this section or Article, any health maintenance organization subject to this Article that becomes a qualified health maintenance organization under Title XIII of the United States Public Health Service Act shall provide the benefits required under that federal Act, which shall be deemed to constitute compliance with the provisions of this section; and any health maintenance organization may provide that the benefits provided under this section must be obtained through providers affiliated with the health maintenance organization."

Section 7. G.S. 58-67-75 reads as rewritten:

"**§ 58-67-75. No discrimination against the mentally ill and chemically dependent.**

(a) As used in this section, the term:

(1) 'Mental illness' has the same meaning as defined in G.S. 122C-3(21); and

(2) 'Chemical dependency' has the same meaning as defined in G.S. 58-67-70

with a diagnosis found in the Diagnostic and Statistical Manual of Mental Disorders ~~DSM-3-R~~ DSM-IV or the International Classification of Diseases ICD/9/CM, or a later edition of those manuals.

(b) No health maintenance organization governed by this Chapter shall, solely because an individual has or had a mental illness or chemical dependency:

(1) Refuse to enroll that individual in any health care plan covering physical illness or injury;

(2) Have a higher premium rate or charge for physical illness or injury coverages or benefits for that individual; or

(3) Reduce physical illness or injury coverages or benefits for that individual.

~~(c) Nothing in this section prevents any health maintenance organization from excluding from coverage any physical illness or injury or mental illness or chemical dependency which has existed previous to coverage of the individual by the health maintenance organization or from refusing to issue or deliver to that individual any policy because of the underwriting of any physical condition whether or not related to mental illness or chemical dependency.~~

~~(d) This section applies only to group contracts covering 20 or more employees.~~

(e) Every insurer that writes a policy or contract of group or blanket health insurance or group or blanket accident and health insurance that is issued, renewed, or amended on or after January 1, 1998, shall provide to its insureds benefits for the necessary care and treatment of mental illness that are not less favorable than benefits for physical illness generally. Benefits for treatment of mental illness shall be subject to the same durational limits, dollar limits, deductibles, and coinsurance factors as are benefits for physical illness generally."

Section 8. G.S. 135-40.7A reads as rewritten:

"**§ 135-40.7A. Special provisions for chemical dependency.**

(a) ~~Except as otherwise provided in this section, benefits~~ Benefits for treatment of chemical dependency are covered by the Plan and shall be subject to the same

deductibles, durational limits, and coinsurance factors as are benefits for physical illness generally.

~~(b) Notwithstanding any other provisions of this Part, the maximum benefit for each covered individual for treatment of chemical dependency is as follows:~~

~~Fiscal Year $ 8,000~~

~~Lifetime 25,000~~

~~Daily benefits are limited to two hundred dollars ($200.00) except for medical detoxification treatment under rules established by the Executive Administrator and Board of Trustees.~~

(c) Notwithstanding any other provision of this Part, provisions for benefits for necessary care and treatment of chemical dependency under this Part shall provide for benefit payments for the following providers of necessary care and treatment of chemical dependency:

(1) The following units of a general hospital licensed under Article 5 of General Statutes Chapter 131E:
   a. Chemical dependency units in facilities licensed after October 1, 1984;
   b. Medical units;
   c. Psychiatric units; and

(2) The following facilities licensed after July 1, 1984, under Article 2 of General Statutes Chapter 122C:
   a. Chemical dependency units in psychiatric hospitals;
   b. Chemical dependency hospitals;
   c. Residential chemical dependency treatment facilities;
   d. Social setting detoxification facilities or programs;
   e. Medical detoxification facilities or programs; and

(3) Duly licensed physicians and duly licensed practicing psychologists, certified clinical social workers, licensed professional counselors, certified fee-based practicing pastoral counselors, certified clinical specialists in psychiatric and mental health nursing, and certified professionals working under the direct supervision of such physicians or psychologists in facilities described in (1) and (2) above and in day/night programs or outpatient treatment facilities licensed after July 1, 1984, under Article 2 of General Statutes Chapter 122C.

Provided, however, that nothing in this subsection shall prohibit the Plan from requiring the most cost effective treatment setting to be utilized by the person undergoing necessary care and treatment for chemical dependency."

Section 9. G.S. 135-40.7B reads as rewritten:

"**§ 135-40.7B. Special provisions for mental health benefits.**

(a) Except as otherwise provided in this section, benefits for the treatment of mental illness are covered by the Plan and shall be subject to the same deductibles, durational limits, and coinsurance factors as are benefits for physical illness generally.

(b) Notwithstanding any other provision of this Part, the following necessary services for the care and treatment of mental illness shall be covered under this section: allowable institutional and professional charges for inpatient psychiatric care, outpatient psychotherapy, intensive outpatient crisis management, partial hospitalization treatment, and residential care and treatment. The benefits provided by this section are separate and apart from those provided by G.S. 135-40.7A.

(c) Notwithstanding any other provisions of this Part, the following providers are authorized to provide necessary care and treatment for mental illness under this section:

(1) Licensed psychiatrists;

(2) Licensed or certified doctors of psychology;

(3) Certified clinical social workers;

(3a) Licensed professional counselors;

(4) Psychiatric ~~nurses;~~ nurse specialists;

~~(5) Other social workers under the direct employment and supervision of a licensed psychiatrist or licensed doctor of psychology;~~

(6) Psychological associates with a master's degree in psychology under the direct employment and supervision of a licensed psychiatrist or licensed or certified doctor of psychology;

(7) Licensed psychiatric hospitals and licensed general hospitals providing psychiatric treatment programs;

(8) Certified residential treatment facilities, community mental health centers, and partial hospitalization facilities; and

(9) Certified fee-based practicing pastoral counselors.

(d) Benefits provided under this section shall be subject to a managed, individualized care component consisting of (i) inpatient utilization review through preadmission and length-of-stay certification for scheduled inpatient admissions and length-of-stay reviews for unscheduled inpatient admissions, and (ii) a network of qualified, available providers of inpatient and outpatient psychiatric treatment psychotherapy. Where qualified preferred providers of inpatient and outpatient care are reasonably available, use of providers outside of the preferred network shall be subject to a twenty percent (20%) coinsurance rate up to five thousand dollars ($5,000) per fiscal year to be assessed against each covered individual in addition to the general coinsurance percentage and maximum fiscal year amount specified by G.S. 135-40.4 and G.S. 135-40.6."

Section 10. This act is effective when it becomes law and applies to contracts issued, delivered, or renewed on or after January 1, 1998.

DILTS, UMSTEAD & DUNN

ACTUARIAL CONSULTING

MARK V. HARTMAN, FSA, MAAA, MCA, EA

Phone: (910) 731-4038
Fax: (910) 731-2583

668 Link Road
Lexington, NC 27295

April 22, 1997

Mr. Sam Byrd
Fiscal Research Division
North Carolina General Assembly
300 N. Salisbury Street
Raleigh, NC 27603-5925

Re: Senate Bill 400: An Act to Require Parity in Health Insurance for Mental Illness and Chemical Dependency

Dear Mr. Byrd:

This bill modifies G.S. 135-40.7A to provide the same benefits for care and treatment of chemical dependency as are provided for physical illness. Currently, the plan provides a maximum benefit for treatment of chemical dependency equal to $200 per day, $8,000 per fiscal year, and $25,000 over a covered individual's lifetime. This bill would remove these maximum limitations.

This bill would also amend G.S. 135-40.7B to eliminate social workers under the direct employment and supervision of a licensed psychiatrist or psychologist as an authorized provider of care and treatment for mental illness. Both provisions of this act will become effective January 1, 1998.

Assuming a 3 month lag between the effective date of the bill and the payment of claims, the estimated cost for the fiscal year beginning July 1, 1997 is $363,000. The estimated cost for the fiscal year beginning July 1, 1998 is $1,560,000. These costs estimates are based on the plan's claim data over the past three years and an 8% annual trend factor.

If you have any questions, let me know.

Sincerely,

Mark Hartman

Mark V. Hartman, FSA, MAAA, MCA, EA
Consulting Actuary

MVH/jj

ACTUARIAL NOTE
True & Exact Copy of Original
Certified By: _____ Date: 4-25-97
Legislative Fiscal Research

NORTH CAROLINA TEACHERS' & STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN

•••

HOUSE BILL 563, SECTIONS 8 & 9 and SENATE BILL 400, SECTIONS 8 & 9
Mental Health Parity

ACTUARIAL NOTE

True & Exact Copy of Original
Certified By: _____ Date: 4-25-97
Legislative Fiscal Research

Prepared by:

Aon Consulting
One Piedmont Center
3565 Piedmont Road, N.E.
Atlanta, Georgia 30363

April 1997

Alexander & Alexander
Consulting Group

ACTUARIAL STATEMENT

The State of North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan (Plan) has requested that Aon Consulting prepare an Actuarial Note in response to an Actuarial Note Request entitled Daily, Fiscal Year, and Lifetime Chemical Dependency Benefit Limits Removed and Mental Health Benefits Provided by Social Workers under Supervision of Psychiatrists and Psychologists Eliminated in the Teachers' and State Employees' Comprehensive Major Medical Plan.

The Actuarial Note was prepared according to generally accepted actuarial principles and practices, in compliance with General Statute 120-114, and within the confidentiality requirements of General Statute 120-129 through 120-134. As required by statute, the Note includes an explanatory statement of the proposed change(s) and, to the extent possible, an estimate of the financial and actuarial effect of the proposed change(s) on the Plan. The Actuarial Note makes no comment or opinion with regard to the merits of the measure for which the Note is prepared; however, any identified technical or mechanical defects have been noted.

We have reviewed the input and results of our analysis for reasonableness, and relied upon the data and information provided by the Plan and their Claims Processing Contractor.

Kenneth C. Vieira, F.S.A., M.A.A.A., E.A.
Consulting Actuary

4/23/97
Date

Professional Peer Review by:

Fred W. Munzenmaier, F.S.A., M.A.A.A., E.A.
Managing Director

April 23, 1997
Date

Alexander & Alexander
Consulting Group

SECTIONS 8 & 9
Provisions For Chemical Dependency

PLAN CHANGE

House Bill 563 and Senate Bill 400 Sections 8 & 9 propose that the North Carolina Teachers' & State Employees' Comprehensive Major Medical Plan (Plan) change the limitations and exclusions on chemical dependency. The proposed bills will remove the daily, fiscal year and lifetime chemical dependency benefits limitations and remove other social workers under the direct employment and supervision of a licensed psychiatrist or licensed doctor of psychology.

The proposed act is effective January 1, 1998.

PROJECTED COST IMPACT

	% Increase			Based on Midpoint Increase (in 000's)		
Plan Design Change	Low	Mid	High	First Year Cost $	Second Year Cost $	Total Biennium Cost $
Provisions For Chemical Dependency	0.10%	0.13%	0.16%	$208	$898	$1,106

Based on projected claims of $639,857,853 and $691,046,481 for the 1998 and 1999 fiscal years respectively. First year cost assumes an implementation date of January 1, 1998.

PRICING APPROACH AND COMMENTS

- Aon's proprietary rating manual was used to determine the effect of removing the chemical dependency limitations. The rating methodology is very conservative and results in the net increase to expected Plan costs of approximately 0.5%. Given the history of chemical dependency and mental health benefits paid by the Plan, these figures are extremely high.

- A report from the Claims Processing Contractor detailed the amount of benefits that were denied due to benefit limitations from 1994 through 1996. The values ranged from $300,000 to $750,000. For the low end of the increase we used the average amount over the past 2 years that would have been paid or $575,000. We have assumed a moderate utilization increase to estimate the high end with the midpoint being the average of the two.

- It is fairly common for health plans to maintain additional limitations on chemical dependency benefits to minimize higher cost claimants. Implementing a case management would help to minimize the large cases but there are no provisions in these bills to do so.

STATE OF NORTH CAROLINA
DEPARTMENT OF STATE TREASURER
RETIREMENT SYSTEMS DIVISION

HARLAN E. BOYLES
TREASURER

DENNIS DUCKER
DEPUTY TREASURER

April 14, 1997

The Honorable Thomas K. Jenkins
Chairman of the Senate Committee on
Pension & Retirement and Insurance
Suite 622 of the Legislative Office Building
Raleigh, North Carolina

Re: Actuarial Note/Proposed Committee Substitute for Senate Bill 297

Dear Senator Jenkins:

In accordance with North Carolina General Statute 120-114, we herewith submit a certified copy of an actuarial note on Proposed Committee Substitute for Senate Bill 297, which affects the Teachers' and State Employees' Retirement System.

Please let me know if you have any questions about this actuarial note.

Sincerely yours,

Dennis Ducker

Dennis Ducker
Director

DD/dsp

Enclosure

325 NORTH SALISBURY STREET, RALEIGH, NORTH CAROLINA 27603-1385
COURIER #56-20-45 (919) 733-4191 (FAX 919-715-4334)
An Equal Opportunity / Affirmative Action Employer

BUCK CONSULTANTS
200 Galleria Parkway, N.W. Suite 1200
Atlanta, Georgia 30339-5945

April 11, 1997

Mr. Dennis Ducker
Deputy Treasurer and Director
Retirement Systems Division
Department of State Treasurer
325 North Salisbury Street
Raleigh, North Carolina 27603-1385

Re: **Proposed Committee Substitute for Senate Bill 297**

Dear Mr. Ducker:

We have received your letter of April 9 regarding the Proposed Committee Substitute for Senate Bill 297 which affects the Teachers' and State Employees' Retirement System.

This legislation appears to amend the existing law, enacted in 1996, which created and governs charter schools. The 1996 act provides that the Retirement Systems' Board of Trustees shall determine the degree of supervision and control necessary to qualify the employees of applicant charter schools for membership in the Retirement System. The 1996 act further provides that nothing contained therein would require the Retirement System to accept employees of a private employer as members. Inasmuch as the 1996 act requires all charter schools to be operated by private nonprofit corporations, the membership of such charter schools' employees in the Retirement System, which is a "governmental plan" under the Internal Revenue Code, is problematic.

The proposed legislation appears to provide for the establishment of two types of charter schools. One type would be "operated by a private nonprofit corporation." Another type would be "operated by a board of directors approved by the State Board of Education." This legislation further appears to provide that employees of charter schools operated by nonprofit corporations shall not be entitled to membership in the Retirement System; but, employees of charter schools operated by a board of directors approved by the State Board of Education shall be deemed "public employees and 'teachers' within the meaning of G.S. 135-1(25)" and therefore, included in the membership of the Retirement System. Thus, this legislation appears to resolve the issues surrounding the membership of charter schools' employees in a "governmental

plan" by restricting membership in the Retirement System to the employees of charter schools operated by boards of directors approved by the State Board of Education.

There is no data or projected data with regard to the number or composition of current members who would discontinue membership on account of employment with nonprofit corporate charter schools or current members and future members who would be included in membership on account of employment with charter schools operated by boards approved by the State Board of Education. Therefore, we are unable to determine the impact of this legislation. It should be noted that for charter schools operated by boards approved by the State Board of Education, the employer and employee contributions payable generally to the Retirement System would apply.

If we can be of further assistance, please do not hesitate to call.

Sincerely,

Edward A. Macdonald
Principal and Consulting Actuary

EAM:jq
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THIS IS TO CERTIFY THAT THIS IS A TRUE AND EXACT COPY OF AN ORIGINAL ACTUARIAL NOTE

Dennis Ducker

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TO: Senator Gulley
FROM: Robin S. Johnson, Staff Attorney
DATE: April 23, 1997
RE: **Proposed Committee Substitute for SB 297: AMEND CHARTER SCH. LAWS. (S297-PCSRH-011)**

The Proposed Committee Substitute for Senate Bill 297 makes the following changes to the laws governing charter schools:

- Under current law, charter schools are to be operated by private, nonprofit corporations. However, if they want their teachers to be eligible for participation in the State Teachers' and State Employees' Retirement System, then the application for a charter must include a description of whether the school agrees to be subject to some supervision and control of its administrative operations by the local board. For federal tax purposes, participants in qualified retirement plans must be public employees. There is concern that a "private, nonprofit corporation" cannot be made into a public entity, and, therefore, no charter school will be able to have its employees eligible for participation. The committee substitute would allow applicants to declare whether they want to be operated by a non-profit, tax-exempt corporation or by a board of directors whose members are approved by the State Board. Employees of charter schools operated by a board of directors whose members are approved by the State Board would be eligible for participation in the State Retirement System. Employees of charter schools operated by private, nonprofit corporations would not be eligible for participation. In the case of a board of directors whose members are approved by the State Board, there can be no more than 25 members. The terms for the initial members can be no longer than the term of the charter that the State Board grants (i.e., no more than 5 years); subsequent members' terms can be no more than 5 years. No member may serve more than two full terms. Appointments, including those to fill vacancies, shall be recommended by the current board of directors and approved by the State Board. Nonrenewal of a charter operated by this board of directors shall constitute a termination of that body.
- The committee substitute provides that the local board of education of the local school administrative unit in which the charter school is proposed to be located may offer any information or comment concerning an application for a charter. The board must deliver the information to the chartering entity by January 1 following the date applications must be submitted for preliminary approval (November 1). The bill provides specifically that the applicant is not required to obtain or deliver this information. Currently, the State Board's policy is that applicants must include an "impact statement" from the local board as part of their applications.
- Section 2 creates a new G.S. 115C-238.29C1 to direct the State Board to adopt a uniform policy on whether and under what circumstances it will require operators of a charter school

and their employees and independent contractors who have significant access to students or who have responsibility for the fiscal management of the schools to be subject to a criminal history check. The criminal history check must occur after preliminary approval is given. Funds allocated or to be allocated to the charter school by the State Board may be used to reimburse persons for the criminal history checks and the fingerprinting. This section is virtually identical to G.S. 115C-332, which directs local boards to adopt a similar policy for their school personnel. The check is to be done for purposes of deciding whether to grant final approval of a charter and for the State Board to make employment recommendations to charter schools. If the State Board recommends dismissal or nonemployment of a person, then the charter school shall dismiss or refuse to employ that person.

- Section 4 amends G.S. 115C-238.29E(a) to provide that charter schools denied preliminary approval from the local board of the school unit in which the school will be located shall be accountable to the State Board for purposes of ensuring compliance with applicable laws and their respective charters. All other charter schools will be accountable to that local board for these purposes. Currently, a charter school is to be accountable to the local board of the local school administrative unit in which the school is to be located. This change also removes the requirement that the State Board may sign on behalf of the local board the contract under which the school is to be operated.
- Also, Section 4 directs the State Board to provide the opportunity for charter who received final approval of their applications by March 31, 1997, the opportunity for them to be operated by a board of directors whose members are approved by the State Board.
- Section 4 also amends G.S. 115C-238.29E(e) to require local boards to lease any available building or land to the charter school, upon its request, unless it is not "economically or practically feasible" or the local board does not have adequate classroom space to meet its enrollment needs.
- Section 5 amends G.S. 115C-238.29F(c) to direct the State Board to adopt rules to set a reasonable amount and types of liability insurance that a charter school must be required by contract to obtain. In addition, this change would exempt charter schools from the State Tort Claims Act and would provide that the State will not defend the charter schools in the defense of any civil or criminal action or proceeding. For any charter school that possibly could have any sovereign immunity, this immunity is waived to the extent of indemnification by insurance.
- In addition, Section 5 requires local boards to allow teachers, during the first year of a charter school's operation, to make a request for a leave of absence up to 45 days before the teacher would otherwise have to report for duty. In subsequent years, teachers can be required to make this request up to 90 days before they would otherwise have to report for duty. Under current law, there is no distinction between the initial and subsequent years of the charter school's operation, and boards can require 90 days' notice.
- Section 5 also removes the requirement that students who reside in a local school administrative unit other than the one where the charter school is located must have the approval of both local boards. This requirement also allowed the local board of the unit in which the school is located to charge the student tuition.
- In addition, Section 5 amends G.S. 115C.29F(h) to direct the charter school to develop a transportation plan so that transportation is not a barrier to any student who resides in the local school administrative unit in which the school is located. The school is not required to provide transportation to any student who lives within 1-1/2 miles of the school. The bill also requires the local board of the unit in which the school is located to contract with the school, upon the school's request, for the provision of transportation in accordance with the

transportation plan for students who reside at least 1-1/2 miles of the school in that school unit. The local board may refuse to provide the transportation if it demonstrates there is no available space on buses it intends to operate during the term of the contract or it would not be practically feasible. The board may charge a reasonable fee sufficient to cover the cost of providing this transportation. Currently, charter schools receive the State funds for transportation for each student. In addition, the charter schools are required to provide transportation for students who reside in the local school administrative unit in which the school is located. Also, local boards are not required to provide transportation for students who live within 1-1/2 miles of the public school to which they are assigned.

- Finally, Section 5 amends G.S. 115C-238.29F(i) to limit the assets to "net assets" that are considered property of the local school administrative unit upon dissolution of the school or upon nonrenewal of the charter. Net assets are obtained by subtracting the liabilities from the total assets.
- Section 6 would create a new G.S. 115C-238.29F1 to enumerate the powers of a board of directors that operates a charter school and whose members are approved by the State Board. These powers do not include the power to levy taxes, issue bonds, or acquire property by eminent domain. The enumerated powers include: (i) sue and be sued; (ii) make contracts; (iii) adopt, alter, and use a seal: (iv) purchase, lease, rent, dispose of, own, mortgage, or encumber real or personal property; (v) establish, construct, purchase, maintain, equip, and operate facilities necessary for the operation of the school; (vi) pay costs and expenses in the formation, organization, administration, and operation of the school; (vii) apply for, accept, and administer loans and grants, to expend the money in accordance with the lender's or donor's requirements, and give any required evidences of indebtedness; (viii) execute financing agreements, security documents, and other instruments; (ix) employ, elect, or appoint personnel, define their duties, and fix their compensation; (x) receive and use allocations from the State Board and local board; and (xi) pay pensions and establish pension plans, pension trusts, and other benefit and incentive plans for current and former directors, officers, employees, and agents. This section provides that any indebtedness incurred or created by the board of directors is not an indebtedness of the State or its political subdivisions and shall not involve or be secured by the faith, credit, or taxing power of the State or its political subdivisions.
- Section 7 amends G.S. 115C-238.29G, which currently directs the State Board to develop and implement a process to resolve grievances between a charter school and its chartering entity. The amendment requires the process also to address disputes between charter schools and local boards or the State Board.
- Section 8 amends G.S. 115C-238.29H(a) to allow funds allocated by the State Board to be used to enter into operational leases for real property or mobile classroom units for use as school facilities for charter schools. This law currently prohibits using these funds "to purchase land or buildings". Legally, the word "purchase" means any type of acquisition of property, which includes leasing. Using State funds to obtain any other interest in real property will still be prohibited.
- Section 9 allows the State Board to establish an alternative timeline for the application, approval, and appeals process. Currently, the law gives specific dates for specific steps in the process. The Board's alternative timeline must still provide for final approval by March 15 of each calendar year.
- Section 13 allows the State Board to use a streamlined procedure for adopting rules directly related to the implementation of this legislation. The Board may publish the text of any proposed rule as the first step in the rulemaking procedure, and a rule may take effect without waiting for submission to the General Assembly.

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April 23, 1997

MEMORANDUM

TO: Senate Insurance Committee

FROM: Linwood Jones, Staff Counsel

RE: Proposed Committee Substitute for Senate Bill 400
(Mental Parity)

Senate Bill 400 provides for "comprehensive parity" in benefits for mental health treatment and chemical dependency treatment. Insurers, HMOs, and hospital/medical service corporations (Blue Cross) must provide mental health benefits and chemical dependency benefits under group health policies, and they must provide those benefits to the same extent that they provide benefits for physical illnesses generally. Deductibles, copayment amounts, coinsurance factors, and similar cost-sharing mechanisms must be the same for mental health and chemical dependency benefits as they are for physical illness benefits generally. Limits on the number of visits to a provider or a particular type of treatment ("durational" limits) must be the same. Annual and lifetime policy limits must also be the same.

The bill sets out these requirements in various parts of the law because insurance companies, HMOs, and hospital/medical service corporations are regulated separately in North Carolina. Sections 2 and 3 cover commercial insurers. Sections 4 and 5 cover hospital/medical service corporations. Sections 6 and 7 cover HMOs.

Section 1 of the bill applies to the "standard" plan in the market known as the "small employer group market." Small employers are currently defined as those with 49 or fewer employees. (This will move to 50 or fewer employees on July 1, 1997, as a result of pending legislation that will conform North Carolina law to the Kennedy-Kassebaum legislation enacted by Congress last year). There is also a "basic" plan available to small employers that would not have to meet the parity requirements of this legislation.

The parity provisions apply to health insurance policies issued, delivered, or renewed on or after January 1, 1998.

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

The proposed committee substitute (the second committee substitute presented to this committee) makes the following changes from the original bill. The first two of these changes were made in the first committee substitute. These two changes are carried forward into the new substitute and changes 3 through 6 below are also made:

(1) The provisions relating to the State Health Plan are deleted.

(2) The parity provisions are clarified to ensure that they apply to all types of dollar limits, fees, and cost-sharing mechanisms that are used in a policy.

(3) The parity requirements are changed so that they do not apply to the very small employers (those with less than 5 employees).

(4) The act sunsets October 1, 2001, the same date on which the federal mental parity law requirement will sunset.

(5) Case management is expressly authorized in the bill as a tool for insurers to use to ensure that the mental health and substance abuse treatment that is rendered is medically necessary and medically appropriate. However, to guard against the misuse of case management as a way to avoid the parity requirements, each insurer's case management program must be approved by the Commissioner of Insurance. The purpose of the rules is to ensure that case management guidelines and programs do not become a mechanism for avoiding the parity requirement.

(6) A few technical changes were made throughout the bill. All internal references to dates were eliminated. (The effective date alone makes clear that the law would take effect January 1, 1998). In addition, language in the HMO and Blue Cross laws that referred to "insurers" were changed to be consistent with the language typically used to refer to HMOs and medical/hospital service corporations.

S400-SMRN-003

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April 22, 1997

MEMORANDUM

TO: Senator Frank W. Ballance, Jr.

FROM: Stanley Moore SM
Fiscal Research Division

SUBJECT: Actuarial Note (Committee Substitute Senate Bill 538)

Re: Defines a "Professional Firefighter" in the Local Governmental Employees' Retirement System and provides an accrual rate of 2.5% for each year of service as a professional firefighter after July 1, 1987 and provides for unreduced retirement after 25 years of service as a professional firefighter regardless of age or at age 55 with five years of service as a professional firefighter.

In accordance with North Carolina General Statute 120-114 and applicable Rules of the North Carolina Senate and House of Representatives, attached is a certified copy of an original actuarial note on the above subject as prepared by the General Assembly's Consulting Actuary. A certified copy of an original actuarial note on the same subject from the Plan Administrator's Consulting Actuary is also attached for your review.

cc: Chairman, Senate Committee on Pensions & Retirement
Senate Principal Clerk

Attachment(s):
(1) Legislative Actuarial Note
(2) Actuarial Note, Buck Consultants, April 22, 1997
(3) Actuarial Note. Dilts, Umstead & Dunn, April 22, 1997

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

NORTH CAROLINA GENERAL ASSEMBLY

LEGISLATIVE ACTUARIAL NOTE

BILL NUMBER: Committee Substitute for Senate Bill 538

SHORT TITLE: Professional Firefighters' Retirement

SPONSOR(S): Senator Ballance

SYSTEM OR PROGRAM AFFECTED: Local Governmental Employees' Retirement System

FUNDS AFFECTED: Local Government Funds

BILL SUMMARY: Defines a "Professional Firefighter" in the Local Governmental Employees' Retirement System and provides an accrual rate of 2.5% for each year of service as a firemen after July 1, 1987 and provides for unreduced retirement after 25 years of service as a professional firefighter regardless of age or at age 55 with five years of service as a professional firefighter.

EFFECTIVE DATE: July 1, 1997

ESTIMATED IMPACT ON LOCAL GOVERNMENTS:

Local Governmental Employee's Retirement System

Retirement System Actuary: Buck Consultants estimates the normal cost will increase from 4.63% of payroll to 11.26% for a net increase of 6.63% of the payroll of firefighters. Buck Consultants estimates that the annual cost to pay the unfunded accrued liability will be $3,869,000 which is expressed as a percent of the total payroll of all employees within each employer.

	1997-98	1998-99	1999-2000	2000-01	2001-02
Normal Cost Increase	$6.8m	$7.2m	$7.7m	$8.3m	$8.8m
Accrued Liability	$3.8m	$4.2m	$4.4m	$4.7m	$5.0m
Total Local Funds	$10.6m	$11.4m	$12.1m	$13.0m	$13.8m

General Assembly Actuary: Dilts, Umstead & Dunn estimates the normal cost will increase from 4.63% of payroll to 10.98% for a net increase of 6.35% of the payroll of firefighters. They also estimates that the annual cost to pay the unfunded accrued liability will be $6,857,000 which is expressed as 6.71% of the payroll firefighters.

	1997-98	1998-99	1999-2000	2000-01	2001-02
Normal Cost Increase	$6.5m	$6.9m	$7.4m	$7.9m	$8.4m
Accrued Liability	$6.8m	$7.3m	$7.8m	$8.4m	$8.9m
Total Local Funds	$13.3m	$14.2m	$15.2m	$16.3m	$17.3m

ASSUMPTIONS AND METHODOLOGY: **Local Governmental Employees' Retirement System** The cost estimates of the System's Actuary are based on the employee data, actuarial assumptions and actuarial methods used to prepare the December 31, 1995 actuarial valuation of the fund. The data included 101,341 active members with an annual payroll of $2.429 billion and 22,732 retired members in receipt of annual pensions totaling $201.7 million. Significant actuarial assumptions used include (a) an investment return rate of 7.5%, (b) salary increase rate of 6.25%, (c) the 1979 George B. Buck Mortality Tables for deaths in service and after retirement and (d) rates of

separation from active service based on System experience. The actuarial cost method used was the projected benefit method with aggregate level normal cost and frozen accrued liability. Detailed information concerning these assumptions and methods is shown in the actuary's report which is available upon request from Stanley Moore. For the purposes of this bill, some of the cost is based as a percentage of payroll of the firemen's estimated payroll since it deals with about 3,319 firemen with an estimated payroll of $102,183,524 reporting from several different local employers.

SOURCES OF DATA: : Retirement System Actuary - Buck Consultant, Inc.
General Assembly Actuary - Dilts, Umstead & Dunn

FISCAL RESEARCH DIVISION: The above information is provided in accordance with North Carolina General Statute 120-114 and applicable Rules of the North Carolina Senate and House of Representatives. The above cost estimates are bases on the salary base as of July 1, 1997 projected at the average annual increase in compensation base for each system over the last five years.

(919) 733-4910
PREPARED BY: Stanley Moore
APPROVED BY: Tom Covington
DATE: April 22, 1997

BUCK CONSULTANTS
200 Galleria Parkway, N.W. Suite 1200
Atlanta, Georgia 30339-5945

April 22, 1997

Mr. Dennis Ducker
Deputy Treasurer and Director
Retirement Systems Division
Department of State Treasurer
325 North Salisbury Street
Raleigh, North Carolina 27603-1385

Dear Mr. Ducker:

Re: **Proposed Committee Substitute for Senate Bill 538**

We have received your letter of April 16 regarding Proposed Committee Substitute for Senate Bill 538 which affects the Local Governmental Employees' Retirement System.

This legislation appears to create a definition for a "professional firefighter." The legislation further provides that members who are professional firefighters shall be entitled to (i) unreduced service retirement benefits after 25 years of creditable service, at any age, provided that the five years of creditable service prior to retirement are as a professional firefighter and (ii) reduced early retirement benefits at age 50 with 15 years of creditable service as a professional firefighter, calculated by using a reduction of 1/3 of 1% for each month under age 55, or a reduction of 5% times the difference between 25 years and the members' creditable service at retirement, whichever produces the greater benefit. The legislation also appears to provide vested deferred retirement benefits (i) on an unreduced service basis for members attaining age 55 if the member had five years of creditable service as a professional firefighter, and (ii) on a reduced early service basis for a member attaining age 50 if the member had 15 years of creditable service as a professional firefighter.

This legislation further appears to provide retirement benefits for members retiring on and after July 1, 1997 equal to 1.72% of average final compensation multiplied by the number of years of creditable service other than as a professional firefighter and for service as a professional firefighter rendered prior to July 1, 1987 *plus* 2.50% of average final compensation multiplied by the number of years of creditable service as a professional firefighter since July 1, 1987.

Buck Consultants, Inc.
770|955-2488 Fax 770|933-8336

The changes in the Proposed Committee Substitute for Senate Bill 538 appear to provide professional firefighters with the same retirement structure as law enforcement officers with the added provisions for an unreduced service retirement allowance after 25 years of creditable service, and an annual formula accrual rate of 2.50% for service as a professional firefighter since July 1, 1987.

We have determined that the employers' normal contribution rate for firemen members under this legislation would be 11.26% of covered payroll. The increase from the current employer normal rate of 4.63% would be 6.63%, which would require additional annual normal contributions of approximately $6,770,000. The additional unfunded accrued liability created on account of this legislation is $42,125,000, which would require additional normal and accrued liability contributions of approximately $3,869,000. The combined annual additional normal and accrued liability contributions required by the employer is approximately $10,639,000. The attached table shows the estimated annual cost of the additional benefits for employers with firemen and the increase in the accrued liability rate which would be applied to the payroll of all members of each employer.

If we can be of further assistance with regard to this legislation, please do not hesitate to contact us.

Sincerely,

Edward A. Macdonald
Principal and Consulting Actuary

EAM:jq
Enc.
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THIS IS TO CERTIFY THAT THIS IS A TRUE AND EXACT COPY OF AN ORIGINAL ACTUARIAL NOTE.

Dennis Ducker

NORTH CAROLINA LOCAL GOVERNMENTAL EMPLOYEES RETIREMENT SYSTEM
COST TO INDIVIDUAL UNITS OF SENATE BILL 538

Local No.	Name	No. Fire	Fire Payroll	Total Payroll	Incr A.L. Rate (%)	Additional Cost Normal	Additional Cost A.L.	Additional Cost Total
90111	BURLINGTON, CITY OF	53	1,646,216	12,165,599	0.62	109,144	75,427	184,571
90121	GRAHAM, CITY OF	10	306,636	2,278,579	0.72	20,330	16,406	36,736
90131	ELON COLLEGE, TOWN OF	7	176,043	718,761	0.61	11,672	4,384	16,056
90411	WADESBORO, TOWN OF	5	131,223	1,347,396	0.26	8,700	3,503	12,203
90711	WASHINGTON,CITY OF	9	260,125	5,367,249	0.23	17,246	12,345	29,591
90812	WINDSOR, TOWN OF	6	194,022	514,668	1.56	12,864	8,029	20,893
90911	ELIZABETHTOWN, TOWN OF	2	23,865	741,431	0.06	1,582	445	2,027
91120	WEST BUNCOMBE FIRE DEPARTMENT	2	66,222	93,990	2.08	4,391	1,955	6,346
91121	ASHEVILLE, CITY OF	112	3,741,605	23,316,237	0.79	248,068	184,198	432,266
91138	SKYLAND VOLUNTEER FIRE DEPARTMENT	14	332,160	332,160	0.00	22,022	0	22,022
91151	BLACK MOUNTAIN, TOWN OF	10	223,857	1,147,301	0.66	14,842	7,572	22,414
91211	VALDESE, TOWN OF	9	219,707	1,603,595	0.32	14,567	5,132	19,699
91231	MORGANTON, CITY OF	3	84,130	6,851,036	0.05	5,578	3,426	9,004
91311	CONCORD, CITY OF	55	1,622,852	14,400,984	0.45	107,595	64,804	172,399
91331	KANNAPOLIS, TOWN OF	6	168,045	4,060,307	0.22	11,141	8,933	20,074
91411	GRANITE FALLS, TOWN OF	6	152,049	1,070,806	0.51	10,081	5,461	15,542
91451	CITY OF LENIOR	33	841,406	4,281,155	1.20	55,785	51,374	107,159
91611	MOREHEAD CITY, TOWN OF	6	177,841	2,442,205	0.34	11,791	8,303	20,094
91621	NEWPORT, TOWN OF	1	22,486	398,210	0.38	1,491	1,513	3,004
91631	BEAUFORT, TOWN OF	11	264,882	1,089,321	0.66	17,562	7,190	24,752
91651	EMERALD ISLE, TOWN OF	12	330,465	1,143,470	0.43	21,910	4,917	26,827
91811	HICKORY, CITY OF	69	1,958,046	13,587,271	0.60	129,818	81,524	211,342
91851	CONOVER, TOWN OF	4	97,174	1,458,568	0.00	6,443	0	6,443
91871	NEWTON, TOWN OF	9	264,714	3,909,671	0.21	17,551	8,210	25,761
92111	EDENTON, TOWN OF	12	303,866	1,610,326	0.60	20,146	9,662	29,808
92311	SHELBY, CITY OF	36	1,125,153	7,327,224	0.73	74,598	53,489	128,087
92321	KINGS MOUNTAIN, CITY OF	7	172,761	2,455,506	0.32	11,454	7,858	19,312
92411	WHITEVILLE, CITY OF	4	80,348	1,382,114	0.22	5,327	3,041	8,368
92602	WESTAREA VOLUNTEER FIRE DEPARTMENT	2	44,940	108,291	1.16	2,980	1,256	4,236
92611	FAYETTEVILLE, CITY OF	89	2,829,951	25,238,171	0.61	187,626	153,953	341,579
92612	LAFAYETTE VILLAGE FIRE DEPARTMENT	12	281,308	281,309	0.86	18,651	2,419	21,070
92618	BONNIE DOONE FIRE DISTRICT	11	320,140	409,434	2.37	21,225	9,704	30,929
92620	CUMBERLAND ROAD FIRE DEPARTMENT	2	39,631	54,368	0.32	2,628	174	2,802
92631	HOPE MILLS, TOWN OF	4	91,405	1,302,385	0.03	6,060	391	6,451
92811	NAGS HEAD, TOWN OF	13	352,593	2,371,576	0.13	23,377	3,083	26,460

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NORTH CAROLINA LOCAL GOVERNMENTAL EMPLOYEES RETIREMENT SYSTEM
COST TO INDIVIDUAL UNITS OF SENATE BILL 538

Local No.	Name	No. Fire	Fire Payroll	Total Payroll	Incr A.L. Rate (%)	Additional Cost Normal	A.L.	Total
92821	KILL DEVIL HILLS, TOWN OF	17	474,548	2,765,621	0.37	31,463	10,233	41,696
92851	KITTY HAWK, TOWN OF	1	16,995	601,223	0.00	1,127	0	1,127
92911	THOMASVILLE, CITY OF	37	977,184	5,247,321	0.89	64,787	46,701	111,488
92931	LEXINGTON, CITY OF	27	893,784	9,744,770	0.51	59,258	49,698	108,956
93202	PARKWOOD FIRE DEPARTMENT	6	192,839	328,119	0.00	12,785	0	12,785
93208	BETHESDA FIRE DEPARTMENT	3	57,445	98,730	0.00	3,809	0	3,809
93211	DURHAM, CITY OF	204	6,764,654	53,194,589	0.42	448,497	223,417	671,914
93311	TARBORO, TOWN OF	25	699,268	3,997,107	0.56	46,361	22,384	68,745
93321	ROCKY MOUNT, CITY OF	118	3,550,675	18,498,706	0.73	235,410	135,041	370,451
93411	WINSTON-SALEM, CITY OF	167	5,140,686	61,483,135	0.31	340,827	190,598	531,425
93421	KERNERSVILLE, TOWN OF	33	886,225	3,639,894	0.22	58,757	8,008	66,765
93431	RURAL HALL, TOWN OF	4	69,835	208,839	0.31	4,630	647	5,277
93442	CLEMMONS FIRE DEPARTMENT	7	172,374	172,374	1.21	11,428	2,086	13,514
93521	LOUISBURG, TOWN OF	10	285,883	1,147,121	0.62	18,954	7,112	26,066
93611	GASTONIA, CITY OF	98	3,230,753	24,547,428	0.51	214,199	125,192	339,391
93621	BELMONT, CITY OF	6	172,343	1,850,994	0.26	11,426	4,813	16,239
93641	CHERRYVILLE, CITY OF	7	183,031	1,635,429	0.03	12,135	491	12,626
93691	MT HOLLY, CITY OF	1	38,939	1,639,924	0.14	2,582	2,296	4,878
93911	OXFORD, CITY OF	4	90,049	1,978,086	0.08	5,970	1,582	7,552
94102	GUIL-RAND FIRE DEPARTMENT	17	395,243	451,201	1.90	26,205	8,573	34,778
94107	GUILFORD COLLEGE COMMUNITY VOLUNTEER	12	352,900	377,077	2.59	23,397	9,766	33,163
94108	PINECROFT-SEDGEFIELD FIRE DISTRICT	9	234,193	255,037	2.25	15,527	5,759	21,286
94109	ALAMANCE COMMUNITY FIRE DIST,INC	3	87,669	97,965	3.25	5,812	3,184	8,996
94110	DEEP RIVER FIRE DEPARTMENT	1	31,030	31,030	7.66	2,057	2,377	4,434
94111	GREENSBORO, CITY OF	337	11,843,517	75,850,366	0.64	785,225	485,442	1,270,667
94118	GUILFORD FIRE DISTRICT	4	47,863	133,173	0.07	3,173	93	3,266
94121	HIGH POINT, CITY OF	138	4,262,408	33,838,379	0.44	282,598	148,889	431,487
94131	JAMESTOWN, TOWN OF	5	176,103	705,742	1.41	11,676	9,951	21,627
94168	COLFAX VOLUNTEER FIRE DEPARTMENT	5	140,237	151,250	1.74	9,298	2,632	11,930
94172	SUMMERFIELD FIRE DISTRICT	4	107,027	107,027	2.75	7,096	2,943	10,039
94182	MOUNT HOPE FIRE DEPARTMENT	1	21,304	21,304	2.74	1,412	584	1,996
94221	ROANOKE RAPIDS, CITY OF	23	668,094	3,413,688	0.58	44,295	19,799	64,094
94311	DUNN, TOWN OF	9	227,765	2,270,368	0.27	15,101	6,130	21,231
94321	LILLINGTON, TOWN OF	1	21,316	452,844	0.00	1,413	0	1,413
94411	WAYNESVILLE, TOWN OF	20	495,650	2,653,701	0.44	32,862	11,676	44,538

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NORTH CAROLINA LOCAL GOVERNMENTAL EMPLOYEES RETIREMENT SYSTEM
COST TO INDIVIDUAL UNITS OF SENATE BILL 538

Local No.	Name	No. Fire	Fire Payroll	Total Payroll	Incr A.L. Rate (%)	Additional Cost Normal	A.L.	Total
94431	CANTON, TOWN OF	5	66,858	1,544,105	0.25	4,433	3,860	8,293
94511	HENDERSONVILLE, CITY OF	12	377,654	2,703,029	0.87	25,038	23,516	48,554
94532	BLUE RIDGE FIRE DEPARTMENT	6	147,783	164,421	0.00	9,798	0	9,798
94611	AHOSKIE, TOWN OF	5	116,661	1,152,557	0.32	7,735	3,688	11,423
94911	STATESVILLE, CITY OF	44	1,241,892	8,368,915	0.41	82,337	34,313	116,650
94921	MOORESVILLE, CITY OF	16	488,892	3,033,359	0.91	32,414	27,604	60,018
95311	SANFORD, CITY OF	23	706,743	6,921,491	0.53	46,857	36,684	83,541
95411	KINSTON, CITY OF	8	266,736	10,440,714	0.07	17,685	7,308	24,993
95511	LINCOLNTON, CITY OF	16	511,016	3,429,172	0.90	33,880	30,863	64,743
95851	ROBERSONVILLE, TOWN OF	3	77,269	685,901	0.57	5,123	3,910	9,033
95811	WILLIAMSTON, CITY OF	17	348,151	1,452,552	0.73	23,082	10,604	33,686
95908	PLEASANT GARDEN FIRE DEPARTMENT	2	38,810	50,245	3.89	2,573	1,955	4,528
95911	MARION, TOWN OF	4	113,641	1,475,076	0.68	7,534	10,031	17,565
96011	CHARLOTTE, CITY OF	13	520,751	121,421,549	0.03	34,526	36,426	70,952
96311	SOUTHERN PINES, TOWN OF	6	182,043	2,673,335	0.39	12,069	10,426	22,495
96331	ABERDEEN, TOWN OF	6	143,405	1,053,647	0.37	9,508	3,898	13,406
96351	PINEHURST, VILLAGE OF	3	85,945	2,016,804	0.11	5,698	2,218	7,916
96421	NASHVILLE, TOWN OF	1	9,507	881,297	0.00	630	0	630
96511	WRIGHTSVILLE BEACH, TOWN OF	7	240,342	1,946,445	0.45	15,935	8,759	24,694
96531	WILMINGTON, CITY OF	105	2,857,665	17,575,559	0.52	189,463	91,393	280,856
96711	JACKSONVILLE, CITY OF	60	1,720,766	9,116,922	0.76	114,087	69,289	183,376
96751	NORTH TOPSAIL BEACH, TOWN OF	2	64,324	359,299	0.31	4,265	1,114	5,379
96811	CHAPEL HILL, TOWN OF	30	1,087,629	13,876,700	0.27	72,110	37,467	109,577
96821	CARRBORO, TOWN OF	18	496,734	3,025,264	0.29	32,933	8,773	41,706
97011	ELIZABETH CITY	24	738,156	5,145,887	0.50	48,940	25,729	74,669
97111	BURGAW, TOWN OF	3	81,574	490,224	0.41	5,408	2,010	7,418
97311	ROXBORO, CITY OF	12	295,526	2,841,109	0.59	19,593	16,763	36,356
97411	GREENVILLE, CITY OF	94	2,918,743	14,793,644	0.69	193,513	102,076	295,589
97611	ASHEBORO, CITY OF	25	705,009	5,650,543	0.69	46,742	38,989	85,731
97711	ROCKINGHAM, CITY OF	18	422,281	2,785,848	0.45	27,997	12,536	40,533
97721	HAMLET, CITY OF	8	180,287	1,423,937	0.18	11,953	2,563	14,516
97811	LUMBERTON, CITY OF	50	1,310,792	7,773,776	0.55	86,906	42,756	129,662
97821	FAIRMONT, TOWN OF	4	94,533	660,036	0.30	6,268	1,980	8,248
97911	REIDSVILLE, TOWN OF	15	361,304	4,212,303	0.36	23,954	15,164	39,118
97951	EDEN, CITY OF	22	589,844	4,368,874	0.55	39,107	24,029	63,136

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NORTH CAROLINA LOCAL GOVERNMENTAL EMPLOYEES RETIREMENT SYSTEM
COST TO INDIVIDUAL UNITS OF SENATE BILL 538

Local No.	Name	No. Fire	Fire Payroll	Total Payroll	Incr A.L. Rate (%)	Additional Cost Normal	Additional Cost A.L.	Additional Cost Total
98011	SALISBURY, CITY OF	46	1,288,280	9,720,818	0.44	84,087	42,772	126,859
98111	FOREST CITY	8	238,042	2,462,897	0.43	15,782	10,590	26,372
98121	SPINDALE, TOWN OF	4	106,810	870,731	0.53	7,082	4,615	11,697
98141	RUTHERFORDTON, TOWN OF	4	106,323	661,943	0.00	7,049	0	7,049
98211	CLINTON, CITY OF	5	111,412	2,365,836	0.05	7,387	1,183	8,570
98261	ROSEBORO, TOWN OF	1	26,770	191,089	0.52	1,775	994	2,769
98311	LAURINBURG, CITY OF	2	90,076	3,315,894	0.17	5,972	5,637	11,609
98631	MOUNT AIRY, TOWN OF	16	404,921	3,762,346	0.18	26,846	6,772	33,618
98641	ELKIN, TOWN OF	6	136,144	1,178,327	0.38	9,026	4,478	13,504
99011	MONROE, CITY OF	5	147,387	7,857,285	0.06	9,772	4,714	14,486
99101	VANCE COUNTY	18	410,447	5,277,279	0.09	27,213	4,750	31,963
99111	HENDERSON, CITY OF	26	587,061	4,639,795	0.23	38,922	10,672	49,594
99202	HOLLY SPRINGS, TOWN OF	1	17,845	982,622	0.05	1,183	491	1,674
99208	BAYLEAF FIRE DEPARTMENT	4	103,297	114,255	0.80	6,849	914	7,763
99211	RALEIGH, CITY OF	241	9,477,742	78,860,863	0.52	628,374	410,076	1,038,450
99212	DURHAM HIGHWAY FIRE PROTECTION	4	67,940	107,592	0.00	4,504	0	4,504
99218	RALEIGH-DURHAM AIRPORT AUTHORITY	3	103,816	4,869,819	0.08	6,883	3,896	10,779
99221	CARY, TOWN OF	80	2,671,715	16,262,196	0.46	177,135	74,806	251,941
99241	ZEBULON, TOWN OF	3	67,695	1,217,187	0.00	4,488	0	4,488
99252	GARNER FIRE DEPARTMENT	8	248,853	256,284	1.23	16,499	3,152	19,651
99271	APEX, TOWN OF	3	77,710	2,326,941	0.06	5,152	1,396	6,548
99511	BOONE, TOWN OF	9	275,694	2,985,386	0.21	18,279	6,269	24,548
99521	BLOWING ROCK, TOWN OF	7	153,621	761,806	0.61	10,185	4,647	14,832
99611	GOLDSBORO, CITY OF	29	939,309	9,902,917	0.43	62,276	42,583	104,859
99621	MOUNT OLIVE, TOWN OF	4	62,760	841,493	0.17	4,161	1,431	5,592
99711	NORTH WILKESBORO, TOWN OF	5	125,203	1,317,141	0.37	8,301	4,873	13,174
99811	WILSON, CITY OF	75	2,515,718	15,386,911	0.72	166,792	110,786	277,578
Total		3,314	102,109,554	904,463,326		6,769,866	3,869,369	10,639,235

** TOTAL PAGE.07 **

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DILTS, UMSTEAD & DUNN

ACTUARIAL CONSULTING

MARK V. HARTMAN, FSA, MAAA, MCA, EA

Phone: (910) 731-4038
Fax: (910) 731-2583

668 Link Road
Lexington, NC 27295

April 22, 1997

Mr. Stanley Moore
Fiscal Research Division
North Carolina General Assembly
300 N. Salisbury Street
Raleigh, NC 27603-5925

Re: Senate Bill 538: An Act to Define a Professional Firefighters' Benefit Accrual Rate for Members and Beneficiaries of the LGERS

Dear Mr. Moore:

This bill, as amended by the committee substitute, would amend G.S. 128-21 by adding a new subdivision to define a 'professional firefighter' as a full-time, paid employee of a certified fire department who is actively serving to prevent, detect, and suppress fire.

This bill would also amend G.S. 128-24 and G.S. 128-27 to revise the amount of retirement allowance and the service requirements to receive the retirement allowance for professional firefighters. Under this bill, the annual accrual rate would increase from 1.72% to 2.50% for each year of service as a professional firefighter after July 1, 1987. The bill also provides that a member may retire as a professional firefighter with an unreduced allowance after completion of 25 years of creditable service (if the last five years are as a professional firefighter) or upon attainment of age 55 and completion of 5 years of creditable service.

This bill becomes effective July 1, 1997 and applies to members retiring on or after that date. The provisions of this bill will increase both the employer's normal contribution rate and the accrued liability contribution. The estimated cost for the fiscal year beginning July 1, 1997, expressed as a percentage of payroll for professional firemen, is an increase in the normal rate of 6.35% and an increase in the accrued liability rate of 6.71%. This corresponds to a total increase in the unfunded accrued liability of approximately $65,071,000 liquidated over a fifteen year period.

These cost estimates are based on the most recent actuarial valuation as December 31, 1995, including assumed retirement rates, and data provided by you on professional firefighters as of December 31, 1996. This data included 3,319 persons with a total payroll of $102,183,524 and accumulated employee contributions of $71,276,009.

If you have any questions, please let me know.

Sincerely,

Mark Hartman

Mark V. Hartman, FSA, MAAA, MCA, EA
Consulting Actuary

MVH/jj

ACTUARIAL NOTE
True & Exact Copy of Original
Certified By: Stanley Moore Date: 4-22-97
Legislative Fiscal Research

North Carolina General Assembly
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(919) 733-2578

April 23, 1997

MEMORANDUM

TO: Senator Thomas LaFontine Odom, Sr.

FROM: Stanley Moore SM
Fiscal Research Division

SUBJECT: Actuarial Note (Committee Substitute for Senate Bill 673)

Re: : **Changes the definition of a law enforcement officer in the Local Governmental Employees' Retirement System.**

In accordance with North Carolina General Statute 120-114 and applicable Rules of the North Carolina Senate and House of Representatives, attached is a certified copy of an original actuarial note on the above subject as prepared by the General Assembly's Consulting Actuary. A certified copy of an original actuarial note on the same subject from the Plan Administrator's Consulting Actuary is also attached for your review.

cc: Chairman, Senate Committee on Pensions & Retirement
Senate Principal Clerk

Attachment(s):
(1) Legislative Actuarial Note
(2) Actuarial Note, Buck Consultants, April 23, 1997
(3) Actuarial Note. Dilts, Umstead & Dunn, April 23, 1997

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

NORTH CAROLINA GENERAL ASSEMBLY

LEGISLATIVE ACTUARIAL NOTE

BILL NUMBER: Committee Substitute for Senate Bill 673

SHORT TITLE: Amend LEO Retirement Def'n.

SPONSOR(S): Senator Odom

SYSTEM OR PROGRAM AFFECTED: Local Governmental Employees' Retirement System

FUNDS AFFECTED: Local Funds

BILL SUMMARY: : Changes the definition of a law enforcement officer in the Local Governmental Employees' Retirement System by omitting the requirement that the employee is serving in a position with assigned primary duties and responsibilities for prevention and detection of crime and the general enforcement of the criminal laws of the State. The new definition of a law enforcement officer would be any employees who possesses the power of arrest, taken an oath, certified as a law enforcement officer under G. S. 17C or as a deputy sheriff under G. S. 17E. Law enforcement officer also means the sheriff. The bill also provides that the number of law enforcement officers can not exceed the number authorized by the local governing board.

EFFECTIVE DATE: July 1, 1997

ESTIMATED IMPACT ON LOCAL EMPLOYERS: The number of employees who are now being reported as General employees but, with the passage of this bill, will be reported as law enforcement officers is unknown. The employer contribution rate would increase from 4.63%, which is the normal rate for General employees, to 5.10% for law enforcement officers and contributions of 5% of salary to the 401(k) Plan would be required for any employees who would now fit the new definition of a law enforcement officer. The normal rate of 5.10% should be adequate to fund the benefit as a law enforcement officer.

ASSUMPTIONS AND METHODOLOGY: Local Governmental Employees' Retirement System The cost estimates of the System's Actuary are based on the employee data, actuarial assumptions and actuarial methods used to prepare the December 31, 1995 actuarial valuation of the fund. The data included 101,341 active members with an annual payroll of $2.429 billion and 22,732 retired members in receipt of annual pensions totaling $201.7 million. Significant actuarial assumptions used include (a) an investment return rate of 7.5%, (b) salary increase rate of 6.25%, (c) the 1979 George B. Buck Mortality Tables for deaths in service and after retirement and (d) rates of separation from active service based on System experience. The actuarial cost method used was the projected benefit method with aggregate level normal cost and frozen accrued liability. Detailed information concerning these assumptions and methods is shown in the actuary's report which is available upon request from Stanley Moore.

SOURCES OF DATA: : System Actuary - Buck Consultant, Inc.
General Assembly Actuary - Dilts, Umstead & Dunn

FISCAL RESEARCH DIVISION: The above information is provided in accordance with North Carolina General Statute 120-114 and applicable Rules of the North Carolina Senate and House of Representatives.

(919) 733-4910
PREPARED BY: Stanley Moore Stanley Moore
APPROVED BY: Tom Covington
DATE: April 23, 1997

BUCK CONSULTANTS
200 Galleria Parkway, N.W. Suite 1200
Atlanta, Georgia 30339-5945

April 23, 1997

Mr. Dennis Ducker
Deputy Treasurer and Director
Retirement Systems Division
Department of State Treasurer
325 North Salisbury Street
Raleigh, North Carolina 27603-1385

Re: **Proposed Committee Substitute for Senate Bill 673**

Dear Mr. Ducker:

We have received your letter of April 23 regarding the Proposed Committee Substitute for Senate Bill 673 which affects the Local Governmental Employees' Retirement System and the Supplemental Retirement Income Plan.

This legislation appears to change the definition of "Law Enforcement Officer" by repealing the current duty tests of "prevention and detection of crime or for the general enforcement of the criminal laws of the State or for serving civil processes", and substituting therefore the requirements of certification as a law enforcement officer or as a deputy sheriff under Chapters 17C and 17E, respectively, of the General Statutes. This legislation further provides that the number of paid law enforcement officers may not exceed the number of positions approved as "law enforcement positions" by governing boards of the affected local governmental employers.

This legislation further appears to liberalize the eligibility requirements for law enforcement officers in that, on and after July 1, 1997, all full-time, paid employees, including jailers, office assistants, dispatchers, etc., who (i) have the power of arrest; (ii) have taken the prescribed oath; and (iii) are certified under the referenced statutes, may be treated as law enforcement officers for retirement benefit purposes.

Treatment as a law enforcement officer would provide any affected employee with earlier retirement privileges as a member of the Local Governmental Employees' Retirement System, in addition to employer contributions and court-cost receipts being deposited to the account of that employee in the Supplemental Retirement Income Plan [I.R.C. Section 401(k) plan]. The impact on the Retirement System, and the employing units of government, would depend on the number of employees who will in the future be reported

as law enforcement officers in lieu of as general employees. As to the Supplemental Retirement Income Plan, there should be no impact because any additional liabilities would equal additional assets; however the impact on local governments would, once again, depend on the number of employees who will in the future be reported as law enforcement officers in lieu of as general employees. We have no data as to how many employees would be affected.

If we can be of further assistance with regard to this legislation, please do not hesitate to contact us.

Sincerely,

Edward A. Macdonald
Principal and Consulting Actuary

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Enc.
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THIS IS TO CERTIFY THAT THIS IS A TRUE AND EXACT COPY OF AN ORIGINAL ACTUARIAL NOTE

DILTS, UMSTEAD & DUNN

ACTUARIAL CONSULTING

MARK V. HARTMAN, FSA, MAAA, MCA, EA

Phone: (910) 731-4038
Fax: (910) 731-2583

668 Link Road
Lexington, NC 27295

April 23, 1997

Mr. Stanley Moore
Fiscal Research Division
North Carolina General Assembly
300 N. Salisbury Street
Raleigh, NC 27603-5925

Re: Senate Bill 673 - Committee Substitute: An Act to Amend the Definition of Law Enforcement Officer for Purposes of Eligibility for Benefits under the LCERS

Dear Mr. Moore:

The committee substitute to this bill would rewrite the definition of Law Enforcement Officer in G.S. 128-21(11b) and G.S. 143-166.50(a)(3). The revised definition includes as law enforcement officers employees who possess the power of arrest, have taken the law enforcement oath, and are certified as a law enforcement officer or deputy sheriff or county sheriff. This bill removes the requirement that the employee be assigned primary duties for prevention and detection of crime, general enforcement of criminal laws, or serving civil processes. The bill becomes effictive July 1, 1997.

This revised definition would classify additional employees as law enforcement officers which would allow them to retire at an earlier age than general employees. The number of effected members is currently unknown. The financial impact to the retirement plan would be an increase in the normal rate for these employees from 4.63% to 5.10%, an increase of 0.47% of their pay. These employees would also become eligible for a 5% 401(k) contribution.

If you have any questions, please let me know.

Sincerely,

Mark Hartman

Mark V. Hartman, FSA, MAAA, MCA, EA
Consulting Actuary

MVH/jj

ACTUARIAL NOTE
True & Exact Copy of Original
Certified By: Stanley Moore Date: 4-23-97
Legislative Fiscal Research

VISITOR REGISTRATION SHEET

Pen & Red — 4-23-97

Name of Committee — Date

VISITORS: Please sign below and return to Committee Clerk.

NAME	FIRM OR STATE AGENCY AND ADDRESS
Joseph R Norwood	Burlington Fire Department
Frank Hodgin	Burlington F.D. 215 S. Church St.
BRAD BAILEY - Burlington F.D.	Burlington N.C. 215 S. Church St.
Matt Bivins - Burlington Fire	215 S. Church St. Burlington
Danny L. Willets — Burlington Fire	215 S. Church St Burlington
Shawn Cordning - Lenoir Fire	602 Harper Ave. Lenoir
Thorson Tolbert Lenoir Fire	602 Harper Ave Lenoir
Kenny Nelson Lenoir fire	602 Harper Ave Lenoir
Ed Carswell Lenoir Fire	" " " "
Kenneth J. Church Lenoir Fire	1927 Norwood ST SW. Lenoir
Bennie L. Scott Lenoir Fire	1927 Norwood ST SW Lenoir N.C.
Robert Macchia Lenoir Fire	602 Harper Ave Lenoir NC 28645
Clarence E Ritch Lenoir F.D	1927 Norwood ST SW Lenoir
Johnny Wilson Lenoir Fire	602 Harper Ave Lenoir N.C.
BART Severt Lenoir Fire	3330 Lighthouse Lane Hudson NC
Steve E Crisp Lenoir Fire	602 Harper Ave Lenoir N.C 28645
Harold O McCall Lenoir Fire	602 Harper Ave Lenoir NC 28645
Robert L. Phillips Lenoir Fire Dept	602 Harper Ave Lenoir, N.C.
John Borders Lenoir Fire Dept	1927 Norwood ST SW Lenoir NC.
JAMES BRADSHAW LENOIR FIRE DEPT	602 HARPER AV LENOIR N.C.
JACK HOLDEN " " "	" " " " "

VISITOR REGISTRATION SHEET

4-23-97

Name of Committee | Date

VISITORS: Please sign below and return to Committee Clerk.

NAME	FIRM OR STATE AGENCY AND ADDRESS
David Scott Harris	Goldsboro Fire dept PO DRAWER A
Lorraine Bethune	GOLDSBORO FIRE DEPT. P.O. DRAWER A
Evelyn Arrington	NCHA
Tawanda Rivers	DMH/DD/SAS
Bobby Deaton	Goldsboro Fire Dept 204 S Center Street
Harold Richardson	Goldsboro Fire Dept 204 S. Center St
Kenneth R Jernigan	Goldsboro Fire Dept 204 S Center St.

Pensions& Retirement/Insurance Committee
Tuesday, April 29,1997
Room 1124LB
8:00am
Sen. Jenkins, Chairman

AGENDA

SB 843 Insurance Technical Changes
Sen. Jenkins

SB 881 Coverage for Emergency Services
Sen. Winner

SB 1036 Insurance Guaranty Assoc. Amendment
Sen Kerr

SB 778 Fire Marshall Retirement
Sen. Warren

SB 455 Improve HMO Services
Sen. Hoyle

SB 435 Physician-Patient Communications
Sen. Forrester

SB 128 No Ins. Points for Infractions
Sen Odom

SB 420 State Fire and Rescue Commission
Sen. Martin

SB 613 Insurance Company Audits and Exams
SB 611 Insurance Fronting
SB 797 Health & Life Insurance Amendment
SB 1029 Insolvent Insurer Revenue Bonds
Sen. Miller

Pensions & Retirement/ Insurance Committee

MINUTES

The Pensions & Retirement/ Insurance Committee met April 29, 1997 at 8:30 am in room 1124 of the Legislative Building. There were 11 members in attendance, including Sen. Jenkins who presided. The following bills were acted upon:

SB 455 Improve HMO Services. The bill was explained by Sen. Hoyle. Harry Kaplan, Kaiser Permaanente, provided information and spoke in favor of the bill. Adam Searing, NC Advocacy Group, spoke against the bill. Dr. Marsha Ford, President-elect, Emergency Room Physicians Association, provided information. Sen. McDaniel sent forth an amendment which received a favorable vote by the committee. Sen. Weinstein sent forth an amendment which received a favorable vote by the committee. Both amendments were rolled into a committee substitute. Sen. Odom moved for an unfavorable as to original bill, but favorable as to committee substitute. The motion carried.

SB 128 No Ins. Points/15 MPH Over Limit. Sen. Odom explained the proposed committee substitute bill and moved for an unfavorable as to original bill, but favorable as to committee substitute. The motion carried.

SB 843 Insurance Technical Changes. Sen. Jenkins called upon Bill Hale, Dept. of Insurance, to explain the proposed committee substitute. Sen. Kincaid moved for an unfavorable as to the original bill, but favorable as to committee substitute. The motion carried.

The meeting was adjourned.

Sen. Jenkins, Chairman

Katy Haynes, Clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

PENSIONS & RETIREMENT/ INSURANCE COMMITTEE REPORT
Senator Tommy Jenkins, Chairman

Tuesday, April 29, 1997

SENATOR TOMMY JENKINS,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO C.S. BILL

S.B. 128 No Ins. Points for Infractions

Draft Number:	PCS2736
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

S.B. 455 Improve HMO Services.

Draft Number:	PCS6670
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

S.B. 843 Insurance Technical Changes.

Draft Number:	PCS8680
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 3

Committee Clerk Comment: None

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

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SENATE BILL 128
Pensions & Retirement and Insurance Committee Substitute Adopted 4/29/97

Short Title: No Ins. Points/15 MPH Over Limit. (Public)

Sponsors:

Referred to:

February 17, 1997

A BILL TO BE ENTITLED

AN ACT TO PROVIDE THAT THERE IS NO INSURANCE PREMIUM SURCHARGE OR ASSESSMENT OF POINTS FOR A CONVICTION FOR SPEEDING FIFTEEN MILES PER HOUR OR LESS OVER THE SPEED LIMIT.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-36-75(f) reads as rewritten:

"(f) The subclassification plan shall provide that with respect to a conviction for a 'violation of speeding ~~10~~ 15 miles per hour or less over the speed limit' there shall be no premium surcharge nor any assessment of points unless there is a driving record consisting of a conviction or convictions for a moving traffic violation or violations, except for a prayer for judgment continued for any moving traffic violation, during the three years immediately preceding the date of application or the preparation of the renewal. The subclassification plan shall also provide that with respect to a prayer for judgment continued for any moving traffic violation, there shall be no premium surcharge nor any assessment of points unless the vehicle owner, principal operator, or any licensed operator in the owner's household has a driving record consisting of a prayer or prayers for judgment continued for any moving traffic violation or violations during the three years immediately preceding the date of application or the preparation of the renewal. For the purpose of this subsection, a 'prayer for judgment continued' means a determination of guilt by a jury or a court though no sentence has been imposed. For the purpose of this subsection, a 'violation of speeding ~~10~~ 15 miles per hour or less over the speed limit' does not include the offense of speeding in a school zone in excess of the posted school zone speed limit."

Section 2. The North Carolina Rate Bureau shall develop an amendment to the subclassification plan consistent with the provisions of this act. The Bureau shall file the amendment with the Commissioner no later than October 1, 1997, and the amendment shall become effective January 1, 1998.

Section 3. Section 2 of this act is effective when it becomes law. The remainder of this act becomes effective January 1, 1998, and applies to violations occurring on or after January 1, 1998.

GENERAL ASSEMBLY OF NORTH CAROLINA
1997 SESSION

SESSION LAW 1997-474
SENATE BILL 455

AN ACT TO IMPROVE HMO SERVICES BY PROTECTING PHYSICIAN COMMUNICATIONS REGARDING TREATMENT, REQUIRING COVERAGE FOR EMERGENCY CARE, REDUCING THE APPROVAL PERIOD FOR RATE FILINGS, AND PROMOTING COLLABORATION BETWEEN HMOS AND PUBLIC HEALTH DEPARTMENTS.

The General Assembly of North Carolina enacts:

Section 1. Article 3 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-3-176. Treatment discussions not limited.**

(a) An insurer shall not limit either of the following:

(1) The participating plan provider's ability to discuss with an enrollee the clinical treatment options medically available, the risks associated with the treatments, or a recommended course of treatment.

(2) The participating plan provider's professional obligations to patients as specified under the provider's professional license.

(b) Nothing in this section shall be construed to expand or revise the scope of benefits covered by a health benefit plan.

(c) As used in this section:

(1) 'Health benefit plan' means any of the following if written by an insurer: an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; or a plan provided by a multiple employer welfare arrangement. 'Health benefit plan' does not mean any plan implemented or administered through the Department of Human Resources or its representatives. 'Health benefit plan' also does not mean any of the following kinds of insurance:

a. Accident.
b. Credit.
c. Disability income.
d. Long-term or nursing home care.
e. Medicare supplement.
f. Specified disease.
g. Dental or vision.
h. Coverage issued as a supplement to liability insurance.
i. Workers' compensation.
j. Medical payments under automobile or homeowners insurance.

k. Hospital income or indemnity.

l. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance.

(2) 'Insurer' means an entity that writes a health benefit plan and that is an insurance company subject to this Chapter, a service corporation under Article 65 of this Chapter, a health maintenance organization under Article 67 of this Chapter, or a multiple employer welfare arrangement under Article 49 of this Chapter."

Section 2. Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-3-190. Coverage required for emergency care.**

(a) Every insurer shall provide coverage for emergency services to the extent necessary to screen and to stabilize the person covered under the plan and shall not require prior authorization of the services if a prudent layperson acting reasonably would have believed that an emergency medical condition existed. Payment of claims for emergency services shall be based on the retrospective review of the presenting history and symptoms of the covered person.

(b) With respect to emergency services provided by a health care provider who is not under contract with the insurer, the services shall be covered if:

(1) A prudent layperson acting reasonably would have believed that a delay would worsen the emergency, or

(2) The covered person did not seek services from a provider under contract with the insurer because of circumstances beyond the control of the covered person.

(c) An insurer that has given prior authorization for emergency services shall cover the services and shall not retract the authorization after the services have been provided unless the authorization was based on a material misrepresentation about the covered person's health condition made by the provider of the emergency services or the covered person.

(d) Coverage of emergency services shall be subject to coinsurance, co-payments, and deductibles applicable under the health benefit plan. An insurer shall not impose cost-sharing for emergency services provided under this section that differs from the cost-sharing that would have been imposed if the physician or provider furnishing the services were a provider contracting with the insurer.

(e) Both the emergency department and the insurer shall make a good faith effort to communicate with each other in a timely fashion to expedite postevaluation or poststabilization services in order to avoid material deterioration of the covered person's condition within a reasonable clinical confidence, or with respect to a pregnant woman, to avoid material deterioration of the condition of the unborn child within a reasonable clinical confidence.

(f) Insurers shall provide information to their covered persons on all of the following:

(1) Coverage of emergency medical services.

(2) The appropriate use of emergency services, including the use of the '911' system and other telephone access systems utilized to access prehospital emergency services.

(3) Any cost-sharing provisions for emergency medical services.

(4) The process and procedures for obtaining emergency services, so that covered persons are familiar with the location of in-plan emergency departments and with the location and availability of other in-plan settings at which covered persons may receive medical care.

(g) As used in this section, the term:

(1) 'Emergency medical condition' means a medical condition manifesting itself by acute symptoms of sufficient severity, including, but not limited to, severe pain, or by acute symptoms developing from a chronic medical condition that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in any of the following:

a. Placing the health of an individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

b. Serious impairment to bodily functions.

c. Serious dysfunction of any bodily organ or part.

(2) 'Emergency services' means health care items and services furnished or required to screen for or treat an emergency medical condition until the condition is stabilized, including prehospital care and ancillary services routinely available to the emergency department.

(3) 'Health benefit plan' means any of the following if written by an insurer: an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; or a plan provided by a multiple employer welfare arrangement. 'Health benefit plan' does not mean any plan implemented or administered through the Department of Human Resources or its representatives. 'Health benefit plan' also does not mean any of the following kinds of insurance:

a. Accident.

b. Credit.

c. Disability income.

d. Long-term or nursing home care.

e. Medicare supplement.

f. Specified disease.

g. Dental or vision.

h. Coverage issued as a supplement to liability insurance.

i. Workers' compensation.

j. Medical payments under automobile or homeowners insurance.

k. Hospital income or indemnity.

l. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance.

(4) 'Insurer' means an entity that writes a health benefit plan and that is an insurance company subject to this Chapter, a service corporation under Article 65 of this Chapter, a health maintenance organization under Article 67 of this Chapter, or a multiple employer welfare arrangement under Article 49 of this Chapter.

(5) 'To stabilize' means to provide medical care that is appropriate to prevent a material deterioration of the person's condition, within reasonable medical probability, in accordance with the HCFA (Health Care Financing Administration) interpretative guidelines, policies and regulations pertaining to responsibilities of hospitals in emergency cases (as provided under the Emergency Medical

Treatment and Labor Act, section 1867 of the Social Security Act, 42 U.S.C.S. 1395dd), including medically necessary services and supplies to maintain stabilization until the person is transferred."

Section 3. G.S. 58-67-50(c) reads as rewritten:

"(c) The Commissioner shall, within a reasonable period, approve any form if the requirements of subsection (a) of this section are met and any schedule of premiums if the requirements of subsection (b) of this section are met. It shall be unlawful to issue the form or to use the schedule of premiums until approved. If the Commissioner disapproves the filing, the Commissioner shall notify the filer. In the notice, the Commissioner shall specify the reasons for disapproval. A hearing will be granted within 30 days after a request in writing by the person filing. If the Commissioner does not approve or disapprove any form or schedule of premiums within 90 days after the filing for forms and within ~~60~~ 45 days after the filing for premiums, they shall be deemed to be approved."

Section 4. Article 67 of Chapter 58 of the General Statutes is amended by adding the following new section:

"**§ 58-67-66. Collaboration with local health departments.**

A health maintenance organization and a local health department shall collaborate and cooperate within available resources regarding health promotion and disease prevention efforts that are necessary to protect the public health."

Section 5. Section 2 of this act becomes effective January 1, 1998, and applies to health benefit plans issued, renewed, or amended on or after that date. The remainder of this act is effective when it becomes law.

In the General Assembly read three times and ratified this the 22nd day of August, 1997.

s/ Dennis A. Wicker
President of the Senate

s/ Harold J. Brubaker
Speaker of the House of Representatives

s/ James B. Hunt, Jr.
Governor

Approved 10:13 a.m. this 3rd day of September, 1997

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

S 5

SENATE BILL 843
Pensions & Retirement and Insurance Committee Substitute Adopted 4/29/97
House Committee Substitute Favorable 8/18/97
House Committee Substitute #2 Favorable 8/28/97
House Committee Substitute #3 Favorable 8/28/97

Short Title: Insurance Changes. (Public)

Sponsors:

Referred to:

April 15, 1997

A BILL TO BE ENTITLED

AN ACT TO REPEAL OBSOLETE LAWS AND MAKE TECHNICAL AND CLARIFYING AMENDMENTS AND CORRECTIONS IN VARIOUS INSURANCE STATUTES; TO EXTEND THE EXPIRATION DATE OF THE 1986 RISK SHARING PLAN LAW; TO PROVIDE FOR THE LICENSING AND REGULATION OF ENTITIES THAT ADMINISTER WORKERS' COMPENSATION INSURANCE FOR GROUPS OF EMPLOYERS THAT SELF-INSURE; AND TO AMEND THE LAW GOVERNING AGENTS.

The General Assembly of North Carolina enacts:

PART I. REPEALS OF OBSOLETE OR UNNECESSARY PROVISIONS.

Section 1. G.S. 58-3-125, 58-6-10, 58-7-150, 58-41-35, and 58-71-90 are repealed.

Section 2. G.S. 58-2-120 reads as rewritten:

"**§ 58-2-120. Reports of Commissioner to the Governor and General Assembly.**

~~The Commissioner shall biennially submit to the General Assembly, through the Governor, a report of his official acts, including a summary of official rulings and regulations.~~ The Commissioner shall, from time to time, report to the Governor and the General Assembly any change ~~which~~ that in ~~his~~ the Commissioner's opinion should be made in the laws relating to insurance and other subjects pertaining to ~~his department. On or before the first day of February of each year in which the General Assembly is in session he shall make to the Governor the recommendations called for~~

~~in this section, to be transmitted to the General Assembly, with the last annual report of this Department, including receipts and disbursements.~~ the Department."

Section 3. G.S. 58-87-10(e) reads as rewritten:

"(e) Revenue Source. -- Revenue is credited to the Workers' Compensation Fund from appropriations made to the Department of Insurance for this purpose. In addition, every eligible unit that elects to participate shall pay into the Fund an amount set annually by the State Fire and Rescue Commission to ensure that the Fund will be able to meet its payment obligations under this section. The amount shall be set as a per capita fixed dollar amount for each member of the roster of the eligible unit.

The payment shall be made to the State Fire and Rescue Commission on or before July 1 of each year. The Commission shall remit the payments it receives to the State Treasurer, who shall credit the payments to the Fund. ~~If the Commission does not receive an annual payment from an eligible unit by July 1, then that unit shall not receive workers' compensation coverage from the Fund for the fiscal year that begins that July 1.~~"

Section 4. G.S. 120-123(55) and (65) are repealed.

Section 5. G.S. 58-36-15(e) reads as rewritten:

"(e) The Commissioner may require the filing of supporting data including:

(1) The Bureau's interpretation of any statistical data relied upon;
(2) Descriptions of the methods employed in setting the rates;
(3) Analysis of the incurred losses submitted on an accident year or policy year basis into their component parts; to wit, paid losses, reserves for losses and loss expenses, and reserves for losses incurred but not reported;
(4) The total number and dollar amount of paid claims;
(5) The total number and dollar amount of case basis reserve claims;
(6) Earned and written premiums at current rates by rating territory;
(7) Earned premiums and incurred losses according to classification plan categories; and
(8) Income from investment of unearned premiums and loss and loss expense reserves generated by business within this State.

~~Provided, however, that with respect to business written prior to January 1, 1980, the Commissioner shall not require the filing of such supporting data which has not been required to be recorded under statistical plans approved by the Commissioner.~~"

Section 6. G.S. 58-3-115 reads as rewritten:

"**§ 58-3-115. Twisting with respect to insurance policies; penalties.**

No insurer shall make or issue, or cause to be issued, any written or oral statement that willfully misrepresents or willfully makes an incomplete comparison as to the terms, conditions, or benefits contained in any policy of insurance for the purpose of inducing or attempting to induce a policyholder in any way to terminate or surrender, exchange, or convert any insurance policy. Any person who violates this section is subject to the provisions of ~~G.S. 58-2-70, 58-3-90 through 58-3-100, and 58-3-125.~~ G.S. 58-2-70 or G.S. 58-3-100."

Section 7. G.S. 58-30-75(7) reads as rewritten:

"(7) Without first obtaining the written consent of the ~~Commissioner pursuant to G.S. 58-7-150,~~ Commissioner, the insurer has (i) transferred, or attempted to transfer, in a manner contrary to Article 19 of this Chapter, substantially its entire property or business, or (ii) has entered into any transaction, the effect of which is to merge, consolidate, or reinsure substantially its entire property or business in or with the property or business of any other person."

Section 8. G.S. 58-41-40(a) reads as rewritten:

"(a) There is no liability on the part of and no cause of action for defamation or invasion of privacy arises against any insurer or its authorized representatives, agents, or employees, or any licensed insurance agent or broker, for any communication or statement made, unless shown to have been made in bad faith with malice, in any of the following:

(1) A written notice of cancellation under ~~G.S. 58-41-15,~~ G.S. 58-41-15 or of nonrenewal under G.S. 58-41-20, ~~or of cessation of business through an agency under G.S. 58-41-35,~~ specifying the reasons ~~therefor;~~ for cancellation.

(2) Communications providing information pertaining to ~~such cancellation, nonrenewal, or cessation of business through an agency;~~ the cancellation or nonrenewal.

(3) Evidence submitted at any court proceeding, administrative hearing, or informal inquiry in which ~~such cancellation, nonrenewal, or cessation of business through an agency~~ the cancellation or nonrenewal is an issue."

PART II. AMENDMENTS NECESSARY BECAUSE OF 1995 REWRITE OF G.S. 58-2-50.

Section 9. G.S. 58-34-2(j) reads as rewritten:

"(j) The Commissioner shall disapprove any such contract that:

(1) Does not contain the required contract provisions specified in subsection (d) of this section;

(2) Subjects the insurer to excessive charges for expenses or commission;

(3) Vests in the MGA any control over the management of the affairs of the insurer to the exclusion of the board of directors of the insurer;

(4) Is entered into with any person if the person or its officers and directors are of known bad character or have been affiliated directly or indirectly through ownership, control, management, reinsurance transactions, or other insurance or business relationships with any person known to have been involved in the improper manipulation of assets, accounts, or reinsurance; or

(5) Is determined by the Commissioner to contain provisions that are not fair and reasonable to the insurer.

Failure of the Commissioner to disapprove any such contract within 30 days after the contract has been filed with the Commissioner constitutes the Commissioner's approval of the contract. An insurer may continue to accept business from ~~such~~ the person until the Commissioner disapproves the contract. Any disapproval shall be in writing. The Commissioner ~~may, after a hearing held under G.S. 58-2-50,~~ may withdraw approval of any contract the Commissioner has previously approved ~~upon finding~~ if the Commissioner determines that the basis of the original approval no longer exists or that the contract has, in actual operation, shown itself to be subject to disapproval on any of the grounds in this subsection. If the Commissioner withdraws approval of a contract, the Commissioner shall give the insurer notice of, and written reasons for, the withdrawal of approval. The Commissioner shall grant any party to the contract a hearing upon request."

Section 10. G.S. 58-34-15(b) reads as rewritten:

"(b) If the Commissioner disapproves any management contract, ~~notice of such action shall be given to the insurer assigning the reasons therefor in writing.~~ the Commissioner shall give notice of, and written reasons for, the disapproval to the insurer. The Commissioner shall grant any party to the contract a hearing upon ~~request according to G.S. 58-2-50.~~ request."

Section 11. G.S. 58-40-100 reads as rewritten:

"**§ 58-40-100. Request for review of rate, rating plan, rating system or underwriting rule.**

(a) Any person aggrieved by any rate charged, rating plan, rating system, or underwriting rule followed or adopted by an insurer or rating organization may request in writing that the insurer or rating organization ~~to~~ review the manner in which the rate, plan, system, or rule has been applied with respect to ~~insurance afforded him. Such request may be made by his authorized representative, and shall be in writing.~~ the person's insurance. The person's authorized representative may make the request. If the request is not granted within 30 days after it is made, the requestor may treat it as rejected. Any person aggrieved by the action of an insurer or rating organization in refusing the review requested or in failing or refusing to grant all or part of the relief requested, may file a written complaint and request for hearing with the Commissioner, and shall specify the grounds relied upon. If the Commissioner has information concerning a similar ~~complaint he~~ complaint, the Commissioner may deny the hearing. If the Commissioner believes that probable cause for the complaint does not exist or that the complaint is not made in good faith, ~~he~~ the Commissioner shall deny the hearing. If the Commissioner finds that the complaint charges a violation of this Article and that the complainant would be aggrieved if the violation is proven, ~~he~~ the Commissioner shall proceed as provided in G.S. ~~58-2-50 or~~ 58-2-70.

(b) Repealed by Session Laws 1985 (Regular Session, 1986), c. 1027, s. 15."

Section 12. G.S. 58-42-1 reads as rewritten:

"**§ 58-42-1. Establishment of plans.**

If the Commissioner finds, after a ~~hearing held in accordance with G.S. 58-2-50,~~ hearing, that in all or any part of this State, any amount or kind of insurance authorized by G.S. 58-7-15(4) through G.S. 58-7-15(22) is not readily available in the voluntary market and that the public interest requires the availability of that insurance, ~~he~~ the Commissioner may either:

(1) Promulgate plans to provide insurance coverage for any risks in this State that are, based on reasonable underwriting standards, entitled to obtain but are otherwise unable to obtain coverage; or

(2) Call upon insurers to prepare plans for ~~his~~ the Commissioner's approval."

Section 13. G.S. 58-45-50 reads as rewritten:

"**§ 58-45-50. Appeal from acts of Association to Commissioner; appeal from Commissioner to superior court.**

Any person or any insurer who may be aggrieved by an act, ruling or decision of the Association other than an act, ruling or decision relating to the cause or amount of a claimed loss, may, within 30 days after ~~such ruling~~ the ruling, appeal to the Commissioner. Any hearings held by the Commissioner ~~pursuant to such an~~ under the appeal shall be in accordance with ~~the procedure set forth in G.S. 58-2-50.~~ rules adopted by the Commissioner: Provided, however, the Commissioner is authorized to appoint a member of ~~his~~ the Commissioner's staff as deputy commissioner for the purpose of hearing ~~such~~ those appeals and a ruling based upon ~~such~~ the hearing ~~shall have~~ has the same effect as if heard by the Commissioner. All persons or insureds aggrieved by any order or decision of the Commissioner may appeal as ~~is~~ provided ~~by the provisions of~~ in G.S. 58-2-75.

No later than 20 days before each hearing, the appellant shall file with the Commissioner or his designated hearing officer and shall serve on the appellee a written statement of ~~his~~ the appellant's case and any evidence ~~he~~ that the appellant intends to offer at the hearing. No later than five days before ~~such~~ the hearing, the appellee shall file with the Commissioner or ~~his~~ the designated hearing officer and shall serve on the appellant a written statement of ~~his~~ the appellant's case and any evidence ~~he~~ that the appellee intends to offer at the hearing. ~~Each such hearing shall be recorded and transcribed. The cost of such recording and transcribing shall be borne equally by the appellant and appellee; provided that upon any final adjudication the prevailing party shall be reimbursed for his share of such costs by the other party.~~ The procedures governing recordings of hearings and, if necessary, transcripts of recordings, as well as the fees for copies of recordings and transcripts, shall be determined by rules adopted by the Commissioner. Each party shall, on a date determined by the Commissioner or his designated hearing officer, but not sooner than 15 days after delivery of the completed transcript to the party, submit to the Commissioner or his designated hearing officer and serve on the other party, a proposed order. The Commissioner or his designated hearing officer shall then issue an order."

Section 14. G.S. 58-45-70 reads as rewritten:

"**§ 58-45-70. Commissioner may examine affairs of Association.**

The Commissioner may from time to time make an examination into the affairs of the Association when ~~he~~ the Commissioner deems it to be ~~prudent and in undertaking such examination he~~ prudent, and as part of the examination the Commissioner may hold a public ~~hearing pursuant to the provisions of G.S. 58-2-50.~~ hearing. ~~The expenses of such examination shall be borne and paid by the Association.~~ The Association shall pay the expenses of the examination."

Section 15. G.S. 58-46-20(c) reads as rewritten:

"(c) The Commissioner may designate the kinds of property insurance policies on principal residences to be offered by the association, including insurance policies under Article 36 of this Chapter, and the commission rates to be paid to agents or brokers for these policies, if ~~he~~ the Commissioner finds, after a ~~hearing held in accordance with G.S. 58-2-50,~~ hearing, that the public interest requires the designation. The provisions of Chapter 150B of the General Statutes do not apply to any procedure under this subsection, except that G.S. 150B-39 and G.S. 150B-41 shall apply to a hearing under this subsection. Within 30 days after the receipt of notification from the Commissioner of a change in designation ~~pursuant to~~ under this subsection, the association shall submit a revised plan and articles of association for approval in accordance with subsection (b) of this section."

Section 16. G.S. 58-46-30 reads as rewritten:

"**§ 58-46-30. Appeals; judicial review.**

The association shall provide reasonable means, to be approved by the Commissioner, whereby any person or insurer affected by any act or decision of the administrators of the Plan or underwriting association, other than an act or decision relating to the cause or amount of a claimed loss, may be heard in person or by an authorized representative, before the governing board of the association or a designated committee. Any person or insurer aggrieved by any decision of the governing board or designated committee, may be appealed to the Commissioner within 30 days from the date of ~~such~~ the ruling or decision. The Commissioner, after hearing held ~~pursuant to the procedure set forth in G.S. 58-2-50,~~ under rules adopted by the Commissioner, shall issue an order approving or disapproving the act or decision with respect to the matter ~~which~~ that is the subject of appeal. The Commissioner ~~is authorized to~~ may appoint a member of ~~his~~ the Commissioner's staff as deputy commissioner for the purpose of hearing ~~such~~ the appeals and a ruling based on ~~such~~ the hearing ~~shall have~~ has the same effect as if heard by the ~~Commissioner personally.~~ Commissioner. All persons or insurers or their representatives aggrieved by any order or decision of the Commissioner may appeal as provided ~~by the provisions of~~ in G.S. 58-2-75.

No later than 20 days before each hearing, the appellant shall file with the Commissioner or ~~his~~ the designated hearing officer and shall serve on the appellee a written statement of ~~his~~ the appellant's case and any evidence ~~he~~ that the appellant intends to offer at the hearing. No later than five days before ~~such~~ the hearing, the appellee shall file with the Commissioner or ~~his~~ the designated hearing officer and shall serve on the appellant a written statement of ~~his~~ the appellee's case and any evidence ~~he~~ that the appellee intends to offer at the hearing. ~~Each such hearing shall~~

~~be recorded and transcribed. The cost of such recording and transcribing shall be borne equally by the appellant and appellee; provided that upon any final adjudication the prevailing party shall be reimbursed for his share of such costs by the other party.~~ The procedures governing recordings of hearings and, if necessary, transcripts of recordings, as well as the fees for copies of recordings and transcripts, shall be determined by rules adopted by the Commissioner. Each party shall, on a date determined by the Commissioner or ~~his~~ the designated hearing officer, but not sooner than 15 days after delivery of the completed transcript to the party, submit to the Commissioner or ~~his~~ the designated hearing officer and serve on the other party, a proposed order. The Commissioner or ~~his~~ the designated hearing officer shall then issue an order."

PART III. CONTINUING CARE RETIREMENT COMMUNITY NAME CORRECTION AND RECEIVERSHIPS.

Section 17. G.S. 58-30-10(14) reads as rewritten:

"(14) 'Insurer' means any entity licensed under Articles 7, 16, 26, 49, 65, or 67 of this Chapter and any employer that has furnished to the Commissioner satisfactory proof of its financial responsibility under G.S. 97-93(a)(2). For purposes of this Article, 'insurer' also includes continuing care retirement ~~centers~~ communities licensed under Article 64 of this Chapter."

Section 18. The title of Article 64 of Chapter 58 of the General Statutes reads as rewritten:

"ARTICLE 64.

~~"Registration, Disclosure, Contract, and Financial Monitoring Requirements for~~ Continuing Care ~~Facilities.~~ Retirement Communities."

Section 19. G.S. 58-64-1 reads as rewritten:

"§ 58-64-1. Definitions.

As used in this Article, unless otherwise specified:

(1) 'Continuing care' means the furnishing to an individual other than an individual related by blood, marriage, or adoption to the person furnishing the care, of lodging together with nursing services, medical services, or other health related services, ~~pursuant to~~ under an agreement effective for the life of the individual or for a period ~~in excess of~~ longer than one year.

(2) 'Entrance fee' means a payment that assures a resident a place in a facility for a term of years or for life.

(3) 'Facility' means the ~~place or places~~ retirement community or communities in which a provider undertakes to provide continuing care to an individual.

(4) 'Health related services' means, at a minimum, nursing home admission or assistance in the activities of daily living, exclusive of the provision of meals or cleaning services.

(5) 'Living unit' means a room, apartment, cottage, or other area within a facility set aside for the exclusive use or control of one or more identified residents.

(6) 'Provider' means the promoter, developer, or owner of a ~~continuing care~~ facility, whether a natural person, partnership, or other unincorporated association, however organized, trust, or corporation, of an institution, building, residence, or other place, whether operated for profit or not, or any other person, that solicits or undertakes to provide continuing care under a continuing care facility contract, or that represents ~~himself~~ himself, herself, or itself as providing continuing care or 'life care.'

(7) 'Resident' means a purchaser of, a nominee of, or a subscriber to, a continuing care contract.

(8) 'Hazardous financial condition' means a provider is insolvent or in eminent danger of becoming insolvent."

Section 20. G.S. 58-64-40(b) reads as rewritten:

"(b) The board of directors or other governing body of a ~~continuing care~~ facility or its designated representative shall hold annual meetings with the residents of the ~~continuing care~~ facility for free discussions of subjects including, but not limited to, income, expenditures, and financial trends and problems as they apply to the facility and discussions of proposed changes in policies, programs, and services. Residents shall be entitled to at least seven days advance notice of each meeting. An agenda and any materials that will be distributed by the governing body at the meetings shall remain available upon request to residents."

Section 21. G.S. 58-64-80 reads as rewritten:

"**§ 58-64-80. Advisory Committee.**

There shall be a nine member Continuing Care Advisory Committee appointed by the Commissioner. The Committee shall consist of at least two residents of ~~continuing care communities,~~ facilities, two representatives of the North Carolina Association of Nonprofit Homes for the Aging, one individual who is a certified public accountant and is licensed to practice in this State, one individual skilled in the field of architecture or engineering, and one individual who is a health care professional."

Section 21.1. Article 64 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-64-46. Receiverships; exception for facility beds.**

When the Commissioner has been appointed as a receiver under Article 30 of this Chapter for a provider or facility subject to this Article, and if it appears to the court, upon petition of the Commissioner or the provider, or on the court's own motion, that the best interests of the facility or the welfare of persons who have previously contracted with the provider or may contract with the facility may be best served by the addition of adult care home beds, the Department of Human Resources may,

notwithstanding any other provision of law, accept and approve the addition of beds for that facility."

PART IV. WORKERS' COMPENSATION LOSS COSTS CONFORMING CHANGES.

Section 22. G.S. 58-36-1(2) reads as rewritten:

"(2) The Bureau shall provide reasonable means to be approved by the Commissioner whereby any person affected by a rate or loss costs made by it may be heard in person or by ~~his~~ the person's authorized representative before the governing committee or other proper executive of the Bureau."

Section 23. G.S. 58-36-1(5)c. reads as rewritten:

"c. Failure or refusal by any assigned employer risk to make full disclosure to the Bureau, servicing carrier, or insurer writing a policy of information regarding the employer's true ownership, change of ownership, operations, or payroll, or any other failure to disclose fully any records pertaining to workers' compensation insurance shall be sufficient grounds for ~~the Bureau to authorize~~ the termination of the policy of that employer."

Section 24. G.S. 58-36-10 reads as rewritten:

"**§ 58-36-10. Method of rate making; factors considered.**

The following standards ~~shall~~ apply to the making and use of ~~rates:~~ rates or loss costs:

(1) Rates or loss costs shall not be excessive, inadequate or unfairly discriminatory.

(2) Due consideration shall be given to actual loss and expense experience within this State for the most recent three-year period for which ~~such~~ that information is available; to prospective loss and expense experience within this State; to the hazards of conflagration and catastrophe; to a reasonable margin for underwriting profit and to contingencies; to dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers; to investment income earned or realized by insurers from their unearned premium, loss, and loss expense reserve funds generated from business within this State; to past and prospective expenses specially applicable to this State; and to all other relevant factors within this State: Provided, however, that countrywide expense and loss experience and other countrywide data may be considered only where credible North Carolina experience or data is not available.

(3) In the case of fire insurance rates, as are subject to the ratemaking authority of the Bureau, consideration may be given to the experience of such fire insurance business during the most recent five-year period for which ~~such~~ that experience is available. In

the case of fire insurance rates that are subject to the ratemaking authority of the Bureau, consideration shall be given to the insurance public protection classifications of rural fire districts based upon standards established by the Commissioner. To the extent credits are provided for proximity to fire hydrants, the Bureau may also provide appropriate credits in public protection classifications for optional water sources, such as ponds, lakes, or other bodies of water, in accordance with standards and procedures filed with and approved by the Commissioner.

(4) Risks may be grouped by classifications and lines of insurance for establishment of ~~rates~~ rates, loss costs, and base premiums. Classification rates may be modified to produce rates for individual risks in accordance with rating plans ~~which~~ that establish standards for measuring variations in hazards or expense provisions or both. ~~Such~~ Those standards may measure any differences among risks that can be demonstrated to have a probable effect upon losses or expenses. The Bureau ~~is directed to~~ shall establish and implement a comprehensive classification rating plan for motor vehicle insurance under its jurisdiction within 90 days of September 1, 1977. No such classification plans shall base any standard or rating plan for private passenger (nonfleet) motor vehicles, in whole or in part, directly or indirectly, upon the age or sex of the persons insured. The Bureau shall at least once every three years make a complete review of the filed classification rates to determine whether they are proper and supported by statistical evidence, and shall at least once every 10 years make a complete review of the territories for nonfleet private passenger motor vehicle insurance to determine whether they are proper and reasonable.

(5) In the case of workers' compensation insurance and employers' liability insurance written in connection therewith, due consideration shall be given to the past and prospective effects of changes in compensation benefits and in legal and medical fees that are provided for in General Statutes Chapter 97."

Section 25. G.S. 58-36-15(a) reads as rewritten:

"(a) The Bureau shall file with the Commissioner copies of the rates, loss costs, classification plans, rating plans and rating systems used by its members. Each rate or loss costs filing shall become effective on the date specified in the filing, but not earlier than 105 days ~~from~~ after the date the filing is received by the Commissioner: Provided that (1) rate or loss costs filings for workers' compensation insurance and employers' liability insurance written in connection therewith shall not become effective earlier than 120 days from the date the filing is received by the Commissioner or on the date ~~as~~ provided ~~under~~ in G.S. 58-36-100, whichever is

earlier; and (2) any filing may become effective on a date earlier than that specified in this subsection upon agreement between the Commissioner and the Bureau."

Section 26. G.S. 58-36-15(f) reads as rewritten:

"(f) On or before September 1 of each calendar ~~year~~ year, or later with the approval of the Commissioner, the Bureau shall submit to the Commissioner the experience, data, statistics, and information referred to in subsection (c) of this section and required under G.S. 58-36-100 and a residual market rate ~~or~~ and prospective loss costs review based on ~~such~~ those data for workers' compensation insurance and employers' liability insurance written in connection therewith. Any rate or loss costs increase for ~~such~~ that insurance that is implemented ~~pursuant to~~ under this Article shall become effective solely to ~~such insurance as is written having~~ insurance with an inception date on or after the effective date of the rate or loss costs increase."

Section 27. G.S. 58-36-15(g) reads as rewritten:

"(g) The following information must be included in policy form, rule, and rate or loss costs filings under this Article and under Article 37 of this Chapter:

(1) A detailed list of the rates, loss costs, rules, and policy forms filed, accompanied by a list of those superseded; and

(2) A detailed description, properly referenced, of all changes in policy forms, rules, prospective loss costs, and rates, including the effect of each change."

Section 28. G.S. 58-36-30(a) reads as rewritten:

"(a) ~~No insurer, officer, agent or representative thereof~~ Except as permitted by G.S. 58-36-100 for workers' compensation loss costs filings, no insurer and no officer, agent, or representative of an insurer shall knowingly issue or deliver or knowingly permit the issuance or delivery of any policy of insurance in this State ~~which~~ that does not conform to the rates, rating plans, classifications, schedules, rules and standards made and filed by the Bureau. ~~However, an~~ An insurer may deviate from the rates ~~promulgated~~ adopted by the Bureau ~~provided~~ if the insurer has filed the proposed deviation ~~to be applied both~~ with the Bureau and the Commissioner, ~~and provided the deviation is uniform in its application to all risks in the State of the class to which the deviation is to apply; and provided such deviation is approved by the Commissioner.~~ if the proposed deviation is based on sound actuarial principles, and if the proposed deviation is approved by the Commissioner. ~~The Commissioner shall approve proposed deviations if they do not render the rates excessive, inadequate or unfairly discriminatory. If approved, the deviation may thereafter be amended, subject to the provisions of this subsection.~~ Amendments to deviations are subject to the same requirements as initial filings. ~~The deviation may be terminated~~ An insurer may terminate a deviation only if the deviation has been in effect for a period of six months before the effective date of the termination and the insurer notifies the Commissioner of the termination no later than 15 days before the effective date of the termination."

Section 29. G.S. 58-36-30(c) reads as rewritten:

"(c) ~~Any deviation with respect to workers' compensation and employers' liability insurance written in connection therewith as filed under subsection (a) of this section shall apply uniformly to all classifications.~~ Any approved rate under subsection (b) of this section with respect to workers' compensation and employers' liability insurance written in connection therewith shall be furnished to the Bureau."

Section 30. Effective September 1, 1997, G.S. 58-36-100(a) reads as rewritten:

"(a) ~~Nothing in this section requires the Bureau or its member insurers to refile rates previously implemented before two years after the effective date of this section. Any member insurer of the Bureau may continue to use all rates and deviations filed and approved for its use until disapproved, or the insurer makes its own filing to change its rates, either by making an independent filing or by filing a reference filing adoption form adopting the Bureau's prospective loss costs, or modification thereof.~~ Except as provided in ~~subsection~~ subsections (k) and (m) of this section, ~~with the initial prospective loss costs reference filing,~~ the Bureau shall no longer develop or file any minimum premiums, minimum premium formulas, or expense constants. If an insurer wishes to amend minimum premium ~~formulas,~~ formulas or expense constants, it must file the minimum premium rules, formulas, or amounts it proposes to use. A copy of each filing submitted to the Commissioner under subsections (e) and (g) of this section shall also be sent to the Bureau."

Section 31. Effective September 1, 1997, G.S. 58-36-100(b)(1) reads as rewritten:

"(1) 'Expenses'. -- That portion of a rate attributable to acquisition, field supervision, collection expenses, any tax levied by the State or by any political subdivision of the State, licensing costs, fees, and general expenses, as determined by the insurer."

Section 32. Effective September 1, 1997, G.S. 58-36-100(c) reads as rewritten:

"(c) Except as provided in subsection (m) of this section, for workers' compensation and employers' liability insurance written in connection with workers' compensation insurance, the Bureau shall no longer develop or file advisory final rates that contain provisions for expenses (other than loss adjustment expenses) and profit. The Bureau shall instead develop and file for approval with the Commissioner, in accordance with this section, reference filings containing advisory prospective loss costs and the underlying loss data and other supporting statistical and actuarial information for any calculations or assumptions underlying these loss costs. Loss-based ~~assessments, any tax levied by the State or any political subdivision of the State, licensing costs, and fees~~ assessments will be included in prospective loss costs."

Section 32.1. Effective September 1, 1997, G.S. 58-36-100(k) reads as rewritten:

"(k) The Bureau shall file with the Commissioner, for approval, filings containing a revision of rules and supplementary rating information. This includes policy-writing rules, rating plans, classification codes and descriptions, and rules that include factors or relativities, such as ~~employers' liability~~ increased limits ~~factors,~~ factors and related

minimum premiums, classification relativities, or similar ~~factors, but excludes minimum premiums.~~ factors. The Bureau may print and distribute manuals of rules and supplementary rating ~~information, excluding minimum premiums.~~ information."

PART V. INSURANCE COMPANY FINANCIAL OPERATIONS.

Section 33. G.S. 58-5-63(a) reads as rewritten:

"(a) All insurance companies making deposits under this Article are entitled to interest on those ~~deposits, which shall remain in the deposit accounts.~~ deposits. The right to interest is subject to a company paying its insurance policy liabilities. If any company fails to pay those liabilities, interest accruing after the failure is payable to the Commissioner for the payment of those liabilities under subsection (b) of this section."

Section 34. G.S. 58-7-21(a) reads as rewritten:

"(a) As used in this section and in G.S. ~~58-7-26, 58-7-30, and 58-7-31.~~ 58-7-26 and G.S. 58-7-30:

(1) 'Reinsurance' means a transfer of insurance risk from a ceding insurer to an assuming insurer.

(2) 'Insurance risk' means an uncertainty regarding the ultimate amount of any claim payment (underwriting risk) or an uncertainty regarding the timing of the payments (timing risk), or both."

Section 35. G.S. 58-7-31(b)(3) reads as rewritten:

"(3) The ceding insurer is required to reimburse the reinsurer for negative experience under the reinsurance agreement; except that neither offsetting experience refunds against current and prior years' losses under the reinsurance agreement nor payment by the ceding insurer of an amount equal to the current and prior years' losses under the reinsurance agreement upon voluntary termination of in-force reinsurance by the ceding insurer are a reimbursement to the reinsurer for negative experience. Voluntary termination does not include situations where termination occurs because of unreasonable provisions that allow the reinsurer to reduce its risk or increase its risk charge under the reinsurance agreement."

Section 36. G.S. 58-7-31(d)(1) reads as rewritten:

"(1) Reinsurance agreements entered into after October 1, 1993, that involve the reinsurance of business issued ~~prior to~~ before the effective date of the reinsurance agreements, along with any subsequent amendments thereto, shall be filed by the ceding company with the Commissioner within 30 days after its date of execution. Each filing shall include data detailing the ~~final impact~~ financial effect of the transaction. The ceding insurer's actuary who signs the financial statement actuarial opinion with respect to valuation of reserves shall consider this ~~statute~~ section and any applicable actuarial standards of practice when determining the

proper credit in financial statements filed with the Commissioner. The actuary ~~should~~ shall maintain adequate documentation and be prepared upon request to describe the actuarial work performed for inclusion in the financial statements and to demonstrate that ~~such~~ that work conforms to this ~~statute.~~ section."

Section 37. G.S. 58-7-173(12) reads as rewritten:

"(12) Secured obligations of duly constituted churches and of church-holding companies; and the cost of investments made under this subdivision shall not exceed the lesser of one percent (1%) of the insurer's admitted assets ~~of~~ or five percent (5%) of the insurer's capital and surplus."

Section 38. The catchline of G.S. 58-7-177 reads as rewritten:

"**§ 58-7-177. Investments in ~~subsidiaries and affiliated corporations.~~ subsidiaries.**"

Section 39. G.S. 58-8-5(a)(3) reads as rewritten:

"(3) ~~Said officers shall cause said certificate to be published once a week for two consecutive weeks in a newspaper in Raleigh and in the county where the company's principal office is located, or posted at the courthouse door if no newspaper be published within the county. Said printed or posted notices shall be in such form and of such size as the Commissioner may approve, and in addition to setting forth in full the certificate required in subdivision (2) shall state that application for amending the company's charter in the manner specified has been proposed by the board of directors, and shall also state the time set for a meeting of policyholders thereby called to be held at the principal office of the company to take action on the proposed amendment. A true copy of such notice shall be filed with the Commissioner, and also with that official who performs the functions of Commissioner in each state where the company is licensed to do business. Such publication and filing of notices shall be completed at least 30 days prior to the date set therein for the meeting of policyholders and due proof thereof shall be filed with the Commissioner at least 15 days prior to the date of such meeting.~~ If the meeting at which the proposed amendment is to be considered is a special meeting, rather than a regular annual meeting of policyholders, ~~such special~~ that meeting can be called only after the Commissioner has given ~~his~~ approval in ~~writing, and the published notice shall show the fact of such approval;~~ writing;"

Section 40. G.S. 58-8-25 reads as rewritten:

"**§ 58-8-25. Dividends to policyholders.**

(a) Any participating or dividend-paying company, stock or mutual or foreign or domestic, that writes other than life insurance or workers' compensation insurance and employers' liability insurance in connection therewith, may declare and pay a

dividend to policyholders from its ~~surplus,~~ unassigned surplus as reflected in the company's most recent annual or quarterly statement filed with the Commissioner, which shall include only its surplus in excess of any required minimum surplus. No such dividend shall be paid unless it is fair and equitable and for the best interest of the company and its policyholders. In declaring any dividend to its policyholders, any such company may make reasonable classifications of policies expiring during a fixed period, upon the basis of each general kind of insurance covered by ~~such~~ those policies and by territorial divisions of the location of risks by states, except that in fixing the amount of dividends to be paid on each general kind of insurance, ~~which~~ the dividends shall be uniform in rate and applicable to the majority of risks within ~~such~~ that general kind of insurance, and exceptions may be made as to any class or classes of risk and a different rate or amount of dividends paid on ~~such~~ the class or classes if the conditions applicable to ~~such~~ the class or classes differ substantially from the condition applicable to the kind of insurance as a whole. Every such company shall have an equal rate of dividend for the same term on all policies insuring risks in the same classification. The payment of dividends to policyholders shall not be contingent upon the maintenance or renewal of the policy. All dividends shall be paid to the policyholder unless a written assignment ~~thereof be~~ of those dividends is executed. Neither the payment of dividends nor the rate ~~thereof~~ of the dividends may be guaranteed by any company, or its agent, ~~prior to~~ before the declaration of the dividend by the board of directors of ~~such~~ the company. The holders of policies of insurance issued by a company in compliance with the orders of any public official, bureau or committee, in conformity with any statutory requirement or voluntary arrangement, for the issuance of insurance to risks not otherwise acceptable to the company, may be established as a separate class of risks.

(b) Any participating or dividend-paying company, stock or mutual or foreign or domestic, that writes workers' compensation insurance and employers' liability insurance in connection therewith may declare and pay a dividend to policyholders from its ~~surplus,~~ unassigned surplus as reflected in the company's most recent statement filed with the Commissioner under G.S. 58-2-165, which shall include only its surplus in excess of any required minimum surplus. No such dividend shall be paid unless it is fair and equitable and for the best interest of the company and its policyholders. In declaring any dividend to its policyholders, any such company may make reasonable classifications of policies expiring during a fixed period. The payment of dividends to policyholders shall not be contingent upon the maintenance or renewal of the policy. All dividends shall be paid to the policyholder unless a written assignment ~~thereof be~~ of those dividends is executed. Neither the payment of dividends nor the rate ~~thereof~~ of the dividends may be guaranteed by any company, or its agent, ~~prior to~~ before the declaration of the dividend by the board of directors of ~~such~~ the company. The holders of policies of insurance issued by a company in compliance with the orders of any public official, bureau, or committee, in conformity with any statutory requirement or voluntary arrangement, for the issuance of insurance to risks not otherwise acceptable to the company, may be established as a separate class of risks."

Section 41. G.S. 58-9-6(a) reads as rewritten:

"(a) The Commissioner shall issue an intermediary license or an exemption from the license, subject to G.S. 58-9-2(b)(2) or G.S. 58-9-2(c)(3), to any person who has complied with the requirements of this Article. A license issued to a noncorporate entity authorizes all of the members of the entity and any designated employees to act as intermediaries under the license, and those persons shall be named in the application and any supplements. A license issued to a corporation authorizes all of the officers and any designated employees and directors of the corporation to act as intermediaries on behalf of the corporation, and those persons shall be named in the application and any supplements."

Section 42. G.S. 58-9-11(b) reads as rewritten:

"(b) An insurer shall not engage the services of any person to act as a broker on its behalf unless the person is licensed ~~under G.S. 58-9-6.~~ or exempted under this Article. An insurer shall not employ an individual who is employed by a broker with which it transacts business, unless the broker is under common control with the insurer under Article 19 of this Chapter."

Section 43. G.S. 58-9-21(a) reads as rewritten:

"(a) A reinsurer shall not engage the services of any person to act as a manager on its behalf unless the person is licensed ~~under G.S. 58-9-6.~~ or exempted under this Article."

Section 44. G.S. 58-12-2(3) reads as rewritten:

"(3) Domestic insurer. -- Any insurance company organized in this State under ~~Article 7~~ Article 7 or Article 15 of this Chapter."

Section 45. G.S. 58-13-10 reads as rewritten:

"§ 58-13-10. Scope.

(a) This Article applies to all domestic insurers and to all kinds of insurance written by those insurers ~~under Articles 1 through 66~~ of this Chapter. Foreign insurers ~~are to~~ shall comply in substance with the requirements and limitations of this section. ~~This Article does not apply to variable contracts for which separate accounts are required to be maintained nor to statutory deposits that are required to be maintained by insurance regulatory agencies as a requirement for doing business in such jurisdictions.~~

(b) This Article does not apply to:

(1) Variable contracts for which separate accounts are required to be maintained.

(2) Statutory deposits that are required to be maintained by insurance regulatory agencies as a requirement for doing business.

(3) Real estate authorized under G.S. 58-7-187 and encumbered by a mortgage loan with a first lien."

Section 46. G.S. 58-13-15 reads as rewritten:

"§ 58-13-15. Definitions.

As used in this Article:

(1) 'Assets' means all property, real or personal, tangible or intangible, legal or equitable, owned by an insurer.

(2) 'Claimants' means any owners, beneficiaries, assignees, certificate holders, or third-party beneficiaries of any insurance benefit or right arising out of and within the coverage of an insurance policy covered by this Article.

(3) 'Reserve assets' means those assets of an insurer that are authorized investments for policy reserves in accordance with ~~Articles 1 through 64 of this Chapter and G.S. 58-65-95.~~ this Chapter.

(4) 'Policyholder-related liabilities' means those liabilities that are required to be established by an insurer for all of its outstanding insurance policies in accordance with ~~Articles 1 through 64 of this Chapter and G.S. 58-65-95.~~ this Chapter."

Section 47. G.S. 58-13-20(b) reads as rewritten:

"(b) The Commissioner ~~has the right to~~ may examine any of ~~such~~ these assets, reinsurance agreements, or deposit arrangements at any time in accordance with ~~his~~ the Commissioner's authority to make examinations of insurers as conferred by other provisions ~~of Articles 1 through 64~~ of this Chapter."

Section 48. G.S. 58-19-5(5) reads as rewritten:

"(5) 'Person' means an individual, corporation, partnership, limited liability company, association, joint stock company, trust, unincorporated organization, or any similar entity or any combination of the foregoing acting in concert."

Section 49. G.S. 58-19-10(b)(1) reads as rewritten:

"(1) Invest, in common stock, preferred stock, debt obligations, and other securities of one or more subsidiaries, amounts that do not exceed the lesser of ten percent (10%) of ~~such~~ the insurer's admitted assets or fifty percent (50%) of ~~such~~ the insurer's surplus as regards policyholders, provided that after ~~such~~ those investments, the insurer's surplus as regards policyholders will be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs. In calculating the amount of ~~such~~ the investments, investments in domestic or foreign insurance subsidiaries and health maintenance organizations shall be excluded, and there shall be included: (i) total net monies or other consideration expended and obligations assumed in the acquisition or formation of a subsidiary, including all organizational expenses and contributions to capital and surplus of ~~such~~ the subsidiary whether or not represented by the purchase of capital stock or issuance of other securities; and (ii) all amounts expended in acquiring additional common stock, preferred stock, debt obligations, and other securities, and all contributions to the capital or surplus, of a subsidiary subsequent to its acquisition or formation;".

PART VI. HANDICAPPED PERSONS.

Section 50. G.S. 168-10 reads as rewritten:

"**§ 168-10. Eliminate discrimination in treatment of handicapped and disabled.**

Each handicapped person shall have the same consideration as any other person for individual accident and health insurance coverage, and no insurer, service corporation, multiple employer welfare arrangement, or health maintenance organization subject to Chapter 58 of the General Statutes solely on the basis of ~~such~~ the person's handicap, shall deny ~~such~~ coverage or benefits. The availability of ~~such insurance~~ coverage or benefits shall not be denied solely ~~due to~~ because of the ~~handicap, provided, however, that no such insurer shall be prohibited from excluding by waiver or otherwise, any pre-existing conditions from such coverage, and further provided that~~ handicap; however, any such insurer may charge the appropriate premiums or fees for the risk insured on the same basis and conditions as insurance issued to other ~~persons.~~ persons, in accordance with actuarial and underwriting principles prescribed in Chapter 58 of the General Statutes. ~~Nothing contained herein or in any other statute shall restrict or preclude any insurer governed by Chapter 58 of the General Statutes from setting and charging a premium or fee based upon the class or classes of risks and on sound actuarial and underwriting principles as determined by such insurer, or from applying its regular underwriting standards applicable to all classes of risks. The provisions of this section shall apply to both corporations governed by Chapter 58 of the General Statutes.~~"

Section 51. G.S. 168-22(b) reads as rewritten:

"(b) A family care home ~~shall be~~ is deemed a residential use of property for the purposes of determining charges or assessments imposed by political subdivisions or businesses for water, sewer, power, telephone service, cable television, garbage and trash collection, repairs or improvements to roads, streets, and sidewalks, and other services, utilities, and ~~improvements, and for purposes of classification for insurance.~~ improvements."

PART VII. AUTOMOBILE INSURANCE.

Section 52. G.S. 58-36-75(c) is repealed.

Section 53. G.S. 58-36-5(c) reads as rewritten:

"(c) The ~~Bureau, when created,~~ Bureau shall adopt ~~such~~ rules ~~and regulations~~ for its orderly procedure ~~as shall be~~ that are necessary for its maintenance and operation. No ~~such~~ rules ~~and regulations~~ shall discriminate against any type of insurer because of its plan of operation, nor shall any insurer be prevented from returning any unused or unabsorbed premium, deposit, savings or earnings to its policyholders or subscribers. ~~The expense of such Bureau shall be borne by its members by quarterly contributions to be made in advance, such contributions to be made in advance by prorating such expense among the members in accordance with the amount of gross premiums derived from the above lines of insurance in North Carolina during the preceding year and members entering the Bureau since that date to advance an amount to be fixed by the governing committee. After the first fiscal year of operation of the Bureau the~~ The necessary expense of the Bureau shall be advanced by the members in accordance with rules ~~and regulations to be~~ established and adopted by the governing committee. The Bureau ~~shall be empowered to~~ may

subscribe for or purchase any necessary service, ~~and~~ employ and fix the salaries of such personnel and assistants as are ~~necessary.~~ necessary, charge reasonable fees for its products and services, and engage in any lawful activities related to the objects, functions, duties, responsibilities, or authority of the Bureau."

Section 53.1. G.S. 58-37-1(7) reads as rewritten:

"(7) 'Motor vehicle insurance' means direct insurance against liability arising out of the ownership, operation, maintenance or use of a motor vehicle for bodily injury including death and property damage and includes medical payments and uninsured and underinsured motorist coverages.

With respect to motor carriers who are subject to the financial responsibility requirements established under the Motor Carrier Act of 1980, the term, 'motor vehicle insurance' includes coverage with respect to environmental restoration. As used in this subsection the term, 'environmental restoration' means restitution for the loss, damage, or destruction of natural resources arising out of the accidental discharge, dispersal, release, or escape into or upon the land, atmosphere, water course, or body of water of any commodity transported by a motor carrier. Environmental restoration includes the cost of removal and the cost of necessary measures taken to minimize or mitigate damage to human health, the natural environment, fish, shellfish, and wildlife."

Section 53.2. G.S. 58-37-35(b)(2) reads as rewritten:

"(2) Additional ceding privileges for motor vehicle insurance shall be provided by the Board of Governors if there is a substantial public demand for a coverage or coverage limit of any component of motor vehicle insurance up to the following:

Bodily injury liability: one hundred thousand dollars ($100,000) each person, three hundred thousand dollars ($300,000) each accident;

Property damage liability: fifty thousand dollars ($50,000) each accident;

Medical payments: two thousand dollars ($2,000) each person;

Underinsured motorist: one ~~hundred thousand~~ million dollars ~~($100,000)~~ ($1,000,000) each person and ~~three hundred thousand dollars ($300,000)~~ each accident for bodily injury liability;

Uninsured motorist: one ~~hundred thousand~~ million dollars ~~($100,000)~~ ($1,000,000) each person and each accident for bodily injury and ~~fifteen~~ fifty thousand dollars ~~($15,000)~~ ($50,000) for property damage (one hundred dollars ($100.00) deductible)."

Section 53.3. G.S. 58-37-35(e) reads as rewritten:

"(e) The Commissioner and member companies shall provide for a Board of ~~Governors within 30 days after May 24, 1973. If any member seat on the initial Board of Governors is not filled in accordance with this Article within such time,~~

~~then, in that event the Commissioner shall appoint natural persons from any of the classifications specified in subsection (d) of this section to serve the initial term on the Board of Governors. As soon as possible after its selection, the Commissioner shall call for the initial meeting of the Board.~~ Governors. ~~After the~~ The Board of Governors ~~have been selected it~~ shall ~~then~~ elect from its membership a chairman and shall ~~then~~ meet ~~thereafter as often as~~ at the call of the chairman ~~shall require~~ or at the request of ~~three~~ four members of the Board of Governors. The chairman shall retain the right to vote on all issues. ~~Five~~ Seven members of the Board of Governors shall constitute a quorum. The same member may not serve as chairman for more than two consecutive ~~years.~~ years; provided, however, that a member may continue to serve as chairman until a successor chairman is elected and qualified."

Section 53.4. G.S. 58-37-40(e) reads as rewritten:

"(e) Upon approval of the Commissioner of the plan so submitted or promulgation of a plan deemed approved by the Commissioner, all insurance companies licensed to write motor vehicle insurance in this State or any component thereof as a prerequisite to further engaging in writing the insurance shall formally subscribe to and participate in the plan so approved.

The plan of operation shall provide for, among other matters, (i) the establishment of necessary facilities; (ii) the management of the Facility; (iii) the preliminary assessment of all members for initial expenses necessary to commence operations; (iv) the assessment of members if necessary to defray losses and expenses; (v) the distribution of gains to defray losses incurred since September 1, 1977; (vi) the distribution of gains by credit or reduction of recoupment ~~or allocation~~ surcharges to policies subject to recoupment ~~or allocation~~ surcharges pursuant to this Article (the Facility may apportion the distribution of gains among the coverages eligible for cession pursuant to this Article); (vii) the recoupment ~~or allocation~~ of losses sustained by the Facility since September 1, 1977, pursuant to this Article, which losses may be recouped by equitable pro rata assessment of member ~~companies;~~ companies or by way of a surcharge on motor vehicle policies issued by member companies or through the Facility; (viii) the standard amount (one hundred percent (100%) or any equitable lesser amount) of coverage afforded on eligible risks which a member company may cede to the Facility; and (ix) the procedure by which reinsurance shall be accepted by the Facility. The plan shall further provide that:

(1) Members of the Board of Governors shall receive reimbursement from the Facility for their actual and necessary expenses incurred on Facility business, en route to perform Facility business, and while returning from Facility business plus a per diem allowance of twenty-five dollars ($25.00) a day which may be waived.

(2) In order to obtain a transfer of business to the Facility effective when the binder or policy or renewal thereof first becomes effective, the company must within 30 days of the binding or policy effective date notify the Facility of the identification of the insured, the coverage and limits afforded, classification data, and premium. The Facility shall accept risks at other times on receipt of

necessary information, but acceptance shall not be retroactive. The Facility shall accept renewal business after the member on underwriting review elects to again cede the business."

Section 54. G.S. 58-37-40(f) reads as rewritten:

"(f) The plan of operation shall provide that every member shall, following payment of any pro rata assessment, ~~commence~~ begin recoupment of that assessment by way of a surcharge on motor vehicle insurance policies issued by the member or through the Facility until the assessment has been recouped. ~~Such~~ Any surcharge under this subsection or under subsection (e) of this section shall be a percentage of premium adopted by the Board of Governors of the Facility; and the charges determined on the basis of the surcharge shall be combined with and displayed as a part of the applicable premium charges. ~~Provided, however, that recoupment~~ Recoupment of losses sustained by the Facility ~~since September 1, 1977,~~ with respect to nonfleet private passenger motor vehicles may be ~~recouped~~ made only by surcharging nonfleet private passenger motor vehicle insurance policies. ~~policies (i) that are subject to the classification plan promulgated pursuant to G.S. 58-36-65 and (ii) to which one or more driving record points have been assigned pursuant to said plan, subject to the provisions of G.S. 58-36-75.~~ If the amount collected during the period of surcharge exceeds assessments paid by the member to the Facility, the member shall pay over the excess to the Facility on a date specified by the Board of Governors. If the amount collected during the period of surcharge is less than the assessments paid by the member to the Facility, the Facility shall pay the difference to the member. Except as ~~hereinafter provided,~~ otherwise provided in this Article, the amount of recoupment shall not be considered or treated as a rate or premium for any purpose. The Board of Governors shall adopt and implement a plan for compensation of agents of Facility members when recoupment surcharges are imposed; ~~such~~ that compensation shall not exceed the compensation or commission rate normally paid to the agent for the issuance or renewal of the automobile liability policy issued through the North Carolina Reinsurance Facility affected by ~~such surcharge; provided, however, that~~ the surcharge. However, the surcharge ~~provided for in this section~~ shall include an amount necessary to recover the amount of the assessment to member companies and the compensation paid by each member, ~~pursuant to~~ under this section, to agents."

Section 55. G.S. 58-37-35(g)(8) reads as rewritten:

"(8) To establish fair and reasonable procedures for the sharing among members of any loss on Facility business ~~which~~ that cannot be recouped ~~pursuant to~~ under G.S. 58-37-40~~(f)~~ (e) ~~or which cannot be recouped or allocated under G.S. 58-37-75,~~ and other costs, charges, expenses, liabilities, income, property and other assets of the Facility and for assessing or distributing to members their appropriate shares. ~~Such~~ The shares may be based on the member's premiums for voluntary business for the appropriate category of motor vehicle insurance or by any other fair and reasonable method."

Section 56. G.S. 58-37-35(l) reads as rewritten:

"(l) The classifications, rules, rates, rating plans and policy forms used on motor vehicle insurance policies reinsured by the Facility may be made by the Facility or by any licensed or statutory rating organization or bureau on its behalf and shall be filed with the Commissioner. The Board of Governors shall establish a separate subclassification within the Facility for 'clean ~~risks' as herein defined.~~ risks'. For the purpose of this Article, a 'clean risk' ~~shall be~~ is any owner of a nonfleet private passenger motor vehicle as defined in G.S. 58-40-10, if the owner, principal operator, and each licensed operator in the owner's household have two years' driving experience as licensed drivers and if none of the persons has been assigned any Safe Driver Incentive Plan points under Article 36 of this Chapter during the three-year period immediately preceding either (i) the date of application for a motor vehicle insurance policy or (ii) the date of preparation of a renewal of a motor vehicle insurance policy. ~~Such~~ The filings may incorporate by reference any other material on file with the Commissioner. Rates shall be neither excessive, inadequate nor unfairly discriminatory. If the Commissioner finds, after a hearing, that a rate is either excessive, inadequate or unfairly discriminatory, ~~he~~ the Commissioner shall issue an order specifying in what respect it is deficient and stating when, within a reasonable period thereafter, ~~such rate shall be deemed~~ the rate is no longer effective. ~~Said~~ The order is subject to judicial review as set out in Article 2 of this Chapter. Pending judicial review of ~~said~~ the order, the filed classification plan and the filed rates may be used, charged and collected in the same manner as set out in G.S. 58-40-45 of this Chapter. ~~Said~~ The order shall not affect any contract or policy made or issued ~~prior to~~ before the expiration of the period set forth in the order. All rates shall be on an actuarially sound basis and shall be calculated, insofar as is possible, to produce neither a profit nor a loss. However, the rates made by or on behalf of the Facility with respect to 'clean ~~risks', as defined above,~~ risks' shall not exceed the rates charged 'clean risks' who are not reinsured in the Facility. The difference between the actual rate charged and the actuarially sound and self-supporting rates for 'clean risks' reinsured in the Facility may be recouped in similar manner as assessments ~~pursuant to G.S. 58-37-40(f) or allocated pursuant to G.S. 58-37-75.~~ under G.S. 58-37-40(f). Rates shall not include any factor for underwriting profit on Facility business, but shall provide an allowance for contingencies. There shall be a strong presumption that the rates and premiums for the business of the Facility are neither unreasonable nor excessive."

Section 57. G.S. 58-37-75 is repealed.

PART VIII. WORKERS' COMPENSATION SELF-INSURANCE.

Section 58. G.S. 58-50-60 reads as rewritten:

"§ 58-50-60. Rules for precertification practices.

(a) This section applies to all accident and health insurers under Articles 1 through 64 of this Chapter, all third-party administrators and preferred provider arrangements, all entities subject to Articles 65 through 67 of this Chapter, and all self-funded ~~health benefit~~ workers' compensation insurance plans.

(b) The Commissioner shall adopt reasonable rules governing ~~precertification practices and forms~~ utilization review and utilization review organizations ~~affiliated~~ that do business with the entities subject to this section."

Section 59. G.S. 58-50-65(a) reads as rewritten:

"(a) ~~Nothing~~ Except as provided in this subsection, nothing in Articles 50 through 55 of this Chapter ~~shall apply~~ applies to ~~or affect~~ any ~~policy of~~ liability or workers' compensation ~~insurance, except that~~ insurance policy. Except for G.S. 58-50-55(a), the provisions of ~~G.S. 58-50-50 and subsections (b) and (c) of G.S. 58-50-55 shall~~ this Article and Articles 65 and 67 of this Chapter and any administrative rules adopted under those Articles relating to preferred providers and utilization review apply to ~~policies of~~ workers' compensation ~~insurance.~~ insurance policies and to individual and group self-funded workers' compensation insurance plans. If there is any conflict between managed care rules adopted by the Commissioner under this Chapter and managed care rules adopted by the Industrial Commission under G.S. 97-25.2, the Industrial Commission's rules govern. If there is any conflict between managed care provisions in this Chapter and in Chapter 97 of the General Statutes with respect to workers' compensation, the provisions in Chapter 97 govern."

PART IX. CERTIFICATE OF AUTHORITY CONFORMING NAME CHANGE.

Section 60. The phrase "certificate of authority" is deleted and replaced by the word "license" wherever it occurs in each of the following sections of the General Statutes:

G.S. 58-4-15.	Revocation of certificate of authority.
G.S. 58-7-55.	Exceptions to requirements of G.S. 58-7-50.
G.S. 58-7-70.	Effects of redomestication.
G.S. 58-15-5.	Definitions.
G.S. 58-16-35.	Unauthorized Insurers Process Act.
G.S. 58-24-45.	Organization.
G.S. 58-24-145.	Injunction -- Liquidation -- Receivership of domestic society.
G.S. 58-28-5.	Transacting business without certificate of authority prohibited; exceptions.
G.S. 58-28-15.	Validity of acts or contracts of unauthorized company shall not impair obligation of contract as to the company; maintenance of suits; right to defend.
G.S. 58-28-45.	Uniform Unauthorized Insurers Act.
G.S. 58-30-10.	Definitions.
G.S. 58-30-55.	Condition on release from delinquency proceedings.
G.S. 58-30-260.	Conservation of property of foreign or alien insurers found in this State.
G.S. 58-33-132.	Qualifications of instructors.
G.S. 58-41-55.	Penalties; restitution.
G.S. 58-48-35.	Powers and duties of the Association.
G.S. 58-48-45.	Duties and powers of the Commissioner.
G.S. 58-57-80.	Penalties.

PART X. RISK SHARING PLAN SUNSET EXTENSION.

Section 61. G.S. 58-42-55 reads as rewritten:

"**§ 58-42-55. Expiration.**

This Article ~~shall expire~~ expires on July 1, ~~1997.~~ 1999."

PART XI. HEALTH INSURANCE CLARIFYING CHANGES.

Section 62. G.S. 58-50-130(a), as amended by S.L. 1997-259, is amended by adding the following new subdivision:

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

Section 63.1. G.S. 58-51-55(d), as amended by S.L. 1997-259, reads as rewritten:

"(d) Applicability. -- Subsection (b1) of this section applies only to group health insurance ~~contracts~~ contracts, other than excepted benefits as defined in G.S. 58-68-25, covering more than 50 employees. The remainder of this section applies only to group health insurance contracts covering 20 or more employees. For purposes of this section, 'group health insurance contracts' include MEWAs, as defined in G.S. 58-49-30(a)."

Section 63.2. G.S. 58-65-90(d), as amended by S.L. 1997-259, reads as rewritten:

"(d) Applicability. -- Subsection (b1) of this section applies only to subscriber ~~contracts~~ contracts, other than excepted benefits as defined in G.S. 58-68-25, covering more than 50 employees. The remainder of this section applies only to group contracts covering 20 or more employees."

Section 63.3. G.S. 58-67-75(d), as amended by S.L. 1997-259, reads as rewritten:

"(d) Applicability. -- Subsection (b1) of this section applies only to group ~~contracts~~ contracts, other than excepted benefits as defined in G.S. 58-68-25, covering more than 50 employees. The remainder of this section applies only to group contracts covering 20 or more employees."

Section 63.4. G.S. 58-51-15(h), as enacted by S.L. 1997-259, reads as rewritten:

"(h) Preexisting Condition Exclusion Clarification. -- Sub-subdivision (a)(2)b. of this section does not apply to:

(1) Policies issued to eligible individuals under G.S. 58-68-60.

(2) Excepted benefits as described in ~~G.S. 58-68-25(b).~~ G.S. 58-68-25(b)(1)."

Section 63.5. G.S. 58-68-40(e), as enacted by S.L. 1997-259, reads as rewritten:

"(e) Exception for ~~Coverage Offered Only to Bona Fide Association Members.~~ Coverage. -- Subsection (a) of this section does not apply to:

(1) Health insurance coverage offered by a health insurer if the coverage is made available in the small group market only through one or more bona fide associations.

(2) A self-employed individual as defined in ~~G.S. 58-50-110(21a).~~ G.S. 58-50-110(21a), except as otherwise provided for the basic and standard health care plans under the North Carolina Small Employer Group Health Coverage Reform Act."

Section 63.6. G.S. 58-68-60(b)(2), as enacted by S.L. 1997-259, reads as rewritten:

"(2) Who is not eligible for coverage under (i) ~~an ERISA~~ a group health plan, (ii) part A or part B of title XVIII of the Social Security Act, or (iii) a State plan under title XIX of the Act (or any successor program), and does not have other health insurance coverage;".

Section 63.7. G.S. 58-50-65(d) reads as rewritten:

"(d) The provisions of G.S. ~~58-51-5(5)~~ 58-51-5(a)(5) and G.S. 58-51-15(a)(1), (4), and (10) may be omitted from railroad ticket policies sold only at railroad stations or at railroad ticket offices by railroad employees."

Section 63.8. G.S. 58-67-74(a), as enacted by S.L. 1997-225, reads as rewritten:

"(a) Every health care plan written by a health maintenance organization ~~and in force,~~ that is issued, renewed, or amended on or after October 1, 1997, and that is subject to this Article, shall provide coverage for medically appropriate and necessary services, including diabetes outpatient self-management training and educational services, and equipment, supplies, medications, and laboratory procedures used to treat diabetes. Diabetes outpatient self-management training and educational services shall be provided by a physician or a health care professional designated by the physician. The health maintenance organization shall determine who shall provide and be reimbursed for the diabetes outpatient self-management training and educational services. The same deductibles, coinsurance, and other limitations ~~as~~ that apply to similar services covered under the ~~policy, contract, or~~ plan shall apply to the diabetes coverage required under this section."

Section 63.9. G.S. 58-67-79(a), as enacted by S.L. 1997-312, reads as rewritten:

"(a) Every health care plan written by a health maintenance organization ~~and in force,~~ that is issued, renewed, or amended on or after January 1, 1998, that is subject to this ~~Article~~ Article, and that provides coverage for mastectomy shall provide coverage for reconstructive breast surgery resulting from a mastectomy. The coverage shall include coverage for all stages and revisions of reconstructive breast surgery performed on a nondiseased breast to establish symmetry when reconstructive surgery on a diseased breast is performed. The same deductibles, coinsurance, and other limitations ~~as~~ that apply to similar services covered under the ~~policy, contract, or~~ plan

shall apply to coverage for reconstructive breast surgery. Reconstruction of the nipple/areolar complex following a mastectomy is covered without regard to the lapse of time between the mastectomy and the reconstruction, subject to the approval of the treating physician."

PART XII. COMMERCIAL INSURANCE FORM DOCUMENT RETENTION.

Section 64. G.S. 58-41-50(g) reads as rewritten:

"(g) An insurer subject to this Article may develop and use an individual form or rate as a result of the uniqueness of a particular risk. The form or rate shall be developed, filed, and used in accordance with rules adopted by the Commissioner. Rules adopted by the Commissioner under this section may provide for retention of certain documents and data by insurers instead of insurers filing those records with the Commissioner."

PART XIII. BAIL BONDS.

Section 65. G.S. 58-71-82 reads as rewritten:

"**§ 58-71-82. Dual license holding.**

If an individual holds a professional bondsman's license or a runner's license and a surety bondsman's license simultaneously, they are considered one license for the purpose of disciplinary actions involving suspension, revocation, or ~~renewal~~ nonrenewal under this Article. Separate renewal fees must be paid for each license, however."

PART XIV. WORKERS' COMPENSATION TPA.

Section 65.1. Article 47 of Chapter 58 of the General Statutes is amended by adding the following new Part:

"Part 3. Third-Party Administrators for Groups.

"**§ 58-47-210. Definitions.**

As used in this Part:

(1) 'Board' means the board of trustees or other governing body of a group.

(2) 'Control' means 'control' as defined in G.S. 58-19-5(2).

(3) 'GAAP financial statement' means a financial statement as defined by generally accepted accounting principles.

(4) 'Group' means a group of employers that is licensed under Part 1 of this Article.

(5) 'Hazardous financial condition' means that, based on its present or reasonably anticipated financial condition, a person is insolvent or, although not yet financially impaired or insolvent, is unlikely to be able to meet obligations with respect to known and reasonably anticipated obligations in the normal course of business.

(6) 'Member' means an employer that participates in a group.

(7) 'Third-party administrator' or 'TPA' means a person engaged by a board to execute the policies established by the board and to provide day-to-day management of the group. 'Third-Party Administrator' and 'TPA' does not mean:

a. An employer acting on behalf of its employees or the employees of one or more of its affiliates.
b. An insurer that is licensed under this Chapter or that is acting as an insurer with respect to a policy lawfully issued and delivered by it and under the laws of a state in which the insurer is licensed to write insurance.
c. An agent or broker who is licensed by the Commissioner under Article 33 of this Chapter whose activities are limited exclusively to the sale of insurance.
d. An adjuster licensed by the Commissioner under Article 33 of this Chapter whose activities are limited to adjustment of claims.
e. An individual who is an officer, a member, or an employee of a board.

"**§ 58-47-215. TPA authority; license, qualification for approval.**

(a) No person shall act as, offer to act as, or hold himself or herself out as a TPA with respect to risks located in this State for a group unless that person is licensed by the Commissioner under this Part.

(b) An applicant for a license shall file with the Commissioner the information required by subsection (c) of this section on a form prescribed by the Commissioner at least 90 days before the proposed licensing date. No application is complete until the Commissioner has received all required information.

(c) The following information shall be included in the license application:

(1) All organizational documents of the TPA, including articles of incorporation, articles of association, a partnership agreement, a trade name certificate, or a trust agreement, any other applicable documents, and all amendments to these documents;
(2) The bylaws, rules, regulations, or similar documents regulating the internal affairs of the TPA;
(3) The names, addresses, official positions, and professional qualifications of the individuals who are responsible for the conduct of affairs of the TPA, including (i) all members of the board of directors, executive committee, or other governing board or committee, (ii) the principal officers in the case of a corporation or the partners or members in the case of a partnership or association, (iii) all shareholders holding directly or indirectly ten percent (10%) or more of the voting securities of the TPA, and (iv) any other person who exercises control or influence over the affairs of the TPA;
(4) The annual audited GAAP financial statements for the two most recent years that demonstrate the applicant is solvent and an ongoing concern and any other information the Commissioner may require in order to review the current financial condition of the applicant;

(5) A general description of the business operations, including information on staffing levels and activities proposed in this State and nationwide. The description shall provide details setting forth the TPA's capability for providing a sufficient number of experienced and qualified personnel in the areas of claims processing, record keeping, and underwriting;

(6) The annual report of the manner and amount of all charges, fees, and direct and indirect compensation received from the group as specified in the service agreement;

(7) All written agreements or contracts with groups; and

(8) Any other pertinent information, including evidence of compliance with other provisions of this Article, as required by the Commissioner.

(d) The information required by subsection (c) of this section, including any trade secrets, shall be kept confidential; provided that the Commissioner may use that information in any judicial or administrative proceeding instituted against the TPA.

(e) TPA licenses shall be renewed annually and applications for renewals of licenses shall include or be accompanied by any changes in the information required by subsection (c) of this section.

(f) A TPA shall notify the Commissioner of any material change in its ownership, control, or other fact or circumstance affecting its qualification for a license in this State, 30 business days before the change. Failure of the Commissioner to disapprove any material changes within 30 days after the changes have been filed with the Commissioner constitutes the Commissioner's approval of the filed changes.

(g) After initial licensing, a TPA shall file with the Commissioner all contracts with a group 60 days before the effective date of the contract.

"§ 58-47-220. TPA license; termination; revocation; restrictions.

(a) The Commissioner may refuse to issue a license if the Commissioner determines that any of the provisions of this section apply to the TPA, or to any individual responsible for the conduct of affairs of the TPA.

(b) The Commissioner shall suspend or revoke automatically the license of a TPA and a request for a hearing shall not stay the effect of the revocation, suspension, or nonrenewal if the Commissioner finds that any of the following apply to the TPA:

(1) The TPA is using methods or practices in the conduct of its business that render its further transaction of business in this State hazardous or injurious to insured persons or the public;

(2) The TPA has failed to pay any judgment rendered against it in this State within 60 days after the judgment has become final;

(3) The TPA has refused to be examined or to produce its accounts, records, and files for examination, or any of its officers have refused to give information with respect to its affairs or have refused to perform any other legal obligation as to that examination, when required by the Commissioner;

(4) The TPA has, without just cause, refused to pay proper claims or perform services arising under its contract, has caused covered members to accept less than the amount due them, or has caused covered members to employ attorneys or bring suit against the TPA to secure full payment or settlement of the claims;

(5) The TPA is an affiliate of or under the same general management, interlocking directorate, or ownership as another TPA or group that unlawfully transacts business in this State;

(6) The TPA, or any principal or affiliate of the TPA, has been convicted of or has entered a plea of guilty or nolo contendere to a felony without regard to whether judgment was withheld;

(7) The TPA or an affiliate is under revocation, suspension, or nonrenewal in another state;

(8) The TPA is in hazardous financial condition;

(9) The TPA has filed for protection under the United States Bankruptcy Code or any state receivership law;

(10) The financial condition or business practices of the TPA otherwise pose an imminent threat to the public health, safety, or welfare of the residents of this State; or

(11) The TPA is found to be in violation of Article 63 of this Chapter.

(c) The Commissioner may, after notice and opportunity for hearing, suspend or revoke the license of a TPA if the Commissioner finds that any of the following apply to the TPA:

(1) The TPA has violated a rule or an order of the Commissioner or any provision of this Chapter or Chapter 97 of the General Statutes; or

(2) The TPA at any time fails to meet any qualification for which issuance of the license could have been refused had the failure then existed and been known to the Commissioner at the time of the application.

(d) If the Commissioner determines that a TPA or any other person has not materially complied with this Article or with any rule adopted or order issued under this Article, after notice and opportunity to be heard, the Commissioner may order:

(1) For each separate violation, a civil penalty pursuant to G.S. 58-2-70(d); or

(2) Revocation, suspension, or nonrenewal of the person's license.

(e) If the Commissioner finds that because of a material noncompliance a group has suffered any loss or damage, the Commissioner may maintain a civil action brought by or on behalf of the group and its policyholders and creditors for recovery of compensatory damages for the benefit of the group and its policyholders and creditors or for other appropriate relief.

(f) Nothing in this Article affects the Commissioner's right to impose any other penalties provided for in this Chapter. Nothing in this Article limits or restricts the rights of policyholders, claimants, and creditors.

(g) If an order of rehabilitation or liquidation of the group has been entered under Article 30 of this Chapter, and the receiver appointed under that order determines that the TPA or any other person has not materially complied with this section, or any order or rule adopted thereunder, and the group suffered any loss or damage therefrom, the receiver may maintain a civil action for recovery of damages or other appropriate sanctions for the benefit of the group."

PART XV. AGENTS.

Section 65.2. Article 33 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-33-41. Agent or broker of record; managed care contracts.**

Notwithstanding G.S. 58-33-25(g), an insurer or service corporation offering managed care products and an HMO shall recognize a licensed agent or broker that has been designated by an employer to inquire about or secure group health coverage for the employer. If coverage is placed, the agent or broker shall receive the same commission as brokers or appointed agents for the same coverage."

Section 65.3. G.S. 58-33-25(o) reads as rewritten:

"(o) No license as an agent, broker, or limited representative is required of the following:

(1) Any regular salaried officer or employee of an insurance company, of a licensed agent, of a broker, or of a limited representative, if such officer's or employee's duties and responsibilities do not include the negotiation or solicitation of insurance.

(2) Persons who secure and furnish information on behalf of an employer, where no commission is paid for such service, for the purpose of group or wholesale life insurance, annuities, or group, blanket or franchise health insurance; or for enrolling individuals under such plans or issuing certificates thereunder; or otherwise assisting in administering such plans.

(3) Employers or their officers or employees, or the trustees of any employee trust plan, to the extent that such employers, officers, employees, or trustees are engaged in the administration or operation of any program of employee benefits for their own employees or the employees of their subsidiaries or affiliates involving the use of insurance issued by a licensed insurance company; provided that such employers, officers, employees, or trustees are not in any manner compensated, directly or indirectly, by the insurance company issuing such insurance.

(4) Agency office employees acting within the confines of the agent's office, under the direction and personal supervision of the duly licensed agent and within the scope of the agent's license, in the acceptance of applications, personally underwritten by the agent, payment of premiums, and the performance of clerical, stenographic, and similar office duties; provided that the activity does not amount to the interpretation of insurance policies,

provisions or coverage, to sales or negotiation of insurance policies, to any underwriting function, or to the signing or verification of applications for insurance.

(5) Licensed insurers authorized to write the kinds of insurance described in G.S. 58-7-15(1) through G.S. 58-7-15(3) that do business without the involvement of a licensed agent.

(6) The Commissioner may adopt rules to carry out the provisions of this subsection."

PART XVI. EFFECT OF HEADINGS.

Section 66. The headings to the parts of this act are a convenience to the reader and are for reference only. The headings do not expand, limit, or define the text of this act.

PART XVII. EFFECTIVE DATE.

Section 67. Sections 30 through 32.1 of this act become effective September 1, 1997. Section 61 of this act is effective retroactively to June 30, 1997. Sections 62, 63.4, 63.5, and 63.6 of this act are effective retroactively July 1, 1997. Section 63.8 is effective retroactively to June 26, 1997. Section 63.9 is effective retroactively to July 17, 1997. Sections 63.1, 63.2, and 63.3 become effective January 1, 1998. Section 65.1 of this act becomes effective July 1, 1998. The remainder of this act is effective when it becomes law.

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April 23, 1997

MEMORANDUM

To: Senate Committee on Pensions & Retirement and Insurance

From: M. Lynn Marshbanks, Committee Counsel

Re: Senate Bill 843: Technical Amendments

Senate Bill 843 would make numerous technical changes to the insurance laws. It would repeal obsolete provisions; remove references in statutes to hearings under G.S. 58-2-50 because the hearings provisions were removed in 1995; change references to "continuing care retirement centers [or facilities]" to "continuing care retirement communities"; make changes conforming to the new law on workers' compensation loss costs; and make other technical changes. It also would extend the sunset on mandatory and voluntary risk sharing plans from July 1, 1997, to July 1, 1999.

Effective date: For most of act, when it becomes law. For three of the provisions involving loss costs workers' compensation changes, September 1, 1997.

S843-SMRS-001

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

VISITOR REGISTRATION SHEET

Pen. & Ref. — 4-29-97

Name of Committee — Date

VISITORS: Please sign below and return to Committee Clerk.

NAME	FIRM OR STATE AGENCY AND ADDRESS
Tommy Watts	CHS
[illegible]	[illegible] Corp
V. L. Williams	Bd. Corr & Trng
Richard E. Cline	NCALU
Bruce Watts	Senator Reeves
Stan Williams	State Hwy Patrol
Dan [illegible]	Smith Anderson
Ann Anderson	Hunton & Williams
Haskell Thomas	NC DOL
Sara H. McNeill	NC DOT
Susan McDaniel	citizen
Alan Miles	Bailey & Dixon, LLP
[illegible]	Mast & Van Hoy
[illegible]	National
[illegible]	NC Pediatric Society
[illegible]	Bode Call & Stroupe
[illegible]	Columbia
[illegible]	ABC NC Bd. Cos.
[illegible]	[illegible]
Rob Paschal	Venus Moore

Pensions& Retirement/Insurance Committee
Tuesday, April 29,1997
Room 1124LB

Sen. Jenkins, Chairman

AGENDA

SB 843 Insurance Technical Changes
Sen. Jenkins

SB 881 Coverage for Emergency Services
Sen. Winner

SB 1036 Insurance Guaranty Assoc. Amendment
Sen Kerr

SB 778 Fire Marshall Retirement
Sen. Warren

SB 455 Improve HMO Services
Sen. Hoyle

SB 435 Physician-Patient Communications
Sen. Forrester

SB 128 No Ins. Points for Infractions
Sen Odom

SB 420 State Fire and Rescue Commission
Sen. Martin

SB 613 Insurance Company Audits and Exams
SB 611 Insurance Fronting
SB 797 Health & Life Insurance Amendment
SB 1029 Insolvent Insurer Revenue Bonds
Sen. Miller

Pension & Retirement Meeting

Minutes

The Pensions & Retirement Committee met Tuesday, April 29, 1997,at 3:45 pm in room 1124 of the Legislative Building. There were 12 members in attendance including Sen. Jenkins who presided. Action was taken on the following bills:

SB 613 Insurance Company Audit and Exam. Sen. Miller explained the bill. Sen. Kincaid sent forth an amendment which received a favorable vote from the committee. Sen. Weinstein moved for an unfavorable as to original bill, but favorable as to committee substitute. The motion carried .

SB 611 Insurance Fronting Sen. Miller explained the committee substitute bill. Allen Miles, American Insurance Assn. spoke against the bill. Sen. Odom moved for an unfavorable as to the original bill, but favorable as to committee substitute. The motion carried.

SB797 Health & Life Insurance Amendments Sen. Miller explained the bill. Sen. Wellons moved for a favorable report. The motion carried.

SB 420 State Fire and Rescue Commission. Sen. Jenkins presented the bill. Sen. Wellons moved for a favorable report. The motion carried.

The meeting was adjourned.

Sen. Tommy Jenkins, Chairman

Katy Haynes, Clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

PENSIONS & RETIREMENT/ INSURANCE COMMITTEE REPORT
Senator Tommy Jenkins, Chairman

Wednesday, April 30, 1997

SENATOR TOMMY JENKINS,
submits the following with recommendations as to passage:

FAVORABLE

S.B. 797 Health and Life Insurance Amendments.
Sequential Referral: None
Recommended Referral: None

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO C.S. BILL

S.B. 611 Insurance Fronting
Draft Number: PCS6666
Sequential Referral: None
Recommended Referral: None
Long Title Amended: No

S.B. 613 Insurance Company Audits and Exams.
Draft Number: PSCA750
Sequential Referral: None
Recommended Referral: None
Long Title Amended: No

TOTAL REPORTED: 3

Committee Clerk Comment: None

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

S 3

SENATE BILL 613
Pensions & Retirement and Insurance Committee Substitute Adopted 4/30/97
Third Edition Engrossed 5/7/97

Short Title: Insurance Company Audits and Exams. (Public)

Sponsors:

Referred to:

April 1, 1997

A BILL TO BE ENTITLED

AN ACT TO AMEND PROVISIONS IN THE INSURANCE LAWS DEALING WITH EXAMINATIONS OF INSURANCE COMPANIES AND AUDITS OF THEIR FINANCIAL STATEMENTS.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-2-131(d) reads as rewritten:

"(d) The Commissioner may conduct an examination of any insurer whenever the Commissioner deems it to be prudent for the protection of policyholders but shall at a minimum conduct ~~an~~ a regular examination of every domestic insurer not less frequently than once every ~~three~~ five years. In scheduling and determining the nature, scope, and frequency of examinations, the Commissioner shall consider such matters as the results of financial statement analyses and ratios, changes in management or ownership, actuarial opinions, reports of independent certified public accountants, and other criteria as set forth in the NAIC Examiners' Handbook."

Section 2. G.S. 58-2-205 reads as rewritten:

"**§ 58-2-205. CPA audits of financial statements.**

~~The Commissioner is authorized to adopt rules to provide for audits and opinions of insurers' financial statements by certified public accountants. Such rules shall be in accordance with the NAIC model rule that requires audited financial reports, as amended.~~ (a) The NAIC model rule requiring annual audited financial reports as provided for in the annual statement instructions is incorporated into this section by reference, except as specified in subsections (b) through (g) of this section.

(b) The annual audited financial report shall be filed with the Commissioner on or before May 10 for the previous calendar year. Two copies of this report shall be filed with the Chief Examiner in the Field Audit Section of the Department. An extension of the May 10 filing date may be granted by the Commissioner for a period of up to 45 days. The request for extension must be submitted in writing no sooner than 15 days before the due date.

(c) This requirement applies to all insurers; provided that insurers having direct premiums written in North Carolina of less than two hundred fifty thousand dollars ($250,000) in any year and having fewer than 500 policyholders in North Carolina at the end of any year are exempt from this requirement for that year unless the Commissioner makes a specific finding that compliance is necessary for the Commissioner to carry out his or her statutory responsibilities.

(d) Certified public accountants that intend to practice pursuant to the provisions of the annual statement instructions shall file a notice to that effect with the Commissioner by October 1 of each year. The Commissioner may reject the filing if the certified public accountant does not meet the requirements. The filing shall contain a statement from the certified public accountant affirming that the certified public accountant is aware of and will comply with the provisions of the annual statement instructions related to the definition, availability, and maintenance of certified public accountant workpapers and evidence of the certified public accountant's expertise in the areas of insurance auditing and insurance accounting. This evidence shall also demonstrate experience in the areas of insurance auditing and insurance accounting for the certified public accountant's staff members who are assigned to the audit.

(e) The certified public accountant may be deemed to be experienced in the areas of insurance auditing and accounting if the office filing with the Department pursuant to this section has existing audit clients in the insurance industry.

(f) The staff assigned to an audit under this section may be considered by the Commissioner to be experienced in the areas of insurance auditing and accounting if they meet the following criteria:

(1) Managerial staff that has been assigned or has had responsibility for audit engagements in the insurance industry in an amount averaging at least thirty percent (30%) of its chargeable time during the last three years.

(2) Nonmanagerial staff that has been assigned or has had responsibility for audit engagements in the insurance industry in an amount averaging at least fifteen percent (15%) of its chargeable time during the last three years or during the staff members' periods of employment if employed fewer than three years.

(g) An audit performed by a certified public accountant under this section shall be staffed by managerial staff experienced in the areas of insurance auditing and accounting and by a majority or an equal number of nonmanagerial staff experienced in the areas of insurance auditing and accounting.

(h) As used in this section, 'insurance' includes financial services."

Section 3. G.S. 58-2-131(k) reads as rewritten:

"(k) ~~When making an examination,~~ For any regular examination of an insurer, if the Commissioner determines that appropriated resources within the Department are insufficient to properly conduct or complete the examination, the Commissioner may retain attorneys, appraisers, ~~independent~~ actuaries, ~~independent~~ certified public accountants, or other professionals and specialists ~~as examiners.~~ to assist the Commissioner in the examination. The insurer that is examined shall pay the persons retained for their services under this subsection. The payments by an insurer under this subsection for any regular examination shall not exceed fifty thousand dollars ($50,000). If any examination is requested by an insurer and not initiated by the Commissioner, the Commissioner may retain the types of professionals and specialists named in this subsection and in accordance with this subsection; and there shall be no limit on the payments by the insurer under this subsection."

Section 4. This act becomes effective October 1, 1997, and applies to audits or examinations conducted on or after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

S 2

SENATE BILL 611
Pensions & Retirement and Insurance Committee Substitute Adopted 4/30/97

Short Title: Insurance Fronting. (Public)

Sponsors:

Referred to:

April 1, 1997

A BILL TO BE ENTITLED

AN ACT TO PROTECT INSURANCE POLICYHOLDERS BY SETTING STANDARDS FOR THE FRONTING OF INSURANCE BUSINESS.

The General Assembly of North Carolina enacts:

Section 1. Article 10 of Chapter 58 of the General Statutes is amended by adding a new Part to read:

"Part 4. Disclosure and Regulation of Fronting.

"**§ 58-10-70. Purpose.**

(a) The purposes of this Part are to ensure proper:

(1) Disclosure and regulation of reinsurance transactions in which a domestic insurer delegates to an unauthorized reinsurer underwriting or claim settlement authority on business written directly by the licensed insurer or assumed from another licensed insurer.

(2) Disclosure of reinsurance transactions in which, if the transaction covers risks resident in this State, a foreign insurer licensed in this State delegates to an unauthorized reinsurer underwriting or claim settlement authority on business written directly by the licensed insurer or assumed from another licensed insurer.

(b) This Part applies to every domestic insurer that delegates underwriting or claim settlement authority to an unauthorized reinsurer on business written directly by the insurer or assumed from another licensed insurer.

"**§ 58-10-75. Definitions.**

As used in this Part:

(1) 'Affiliate' or 'affiliated with' has the meaning ascribed to it in G.S. 58-19-5(1).

(2) 'Claim settlement authority' means the investigation, negotiation, and settlement of claims arising under original policies subject to a reinsurance agreement.

(3) 'Single-parent captive insurer' means an insurance company owned by one or more affiliated persons, provided that the captive insurer directly writes or reinsures only one or more of the following:

a. Risks of the owners of the insurance company and affiliates of the owners.

b. Risks related to or arising out of the business or operations of the owners and affiliates.

c. Risks derived from a pool, or other similar arrangement, whether or not organized as an insurance company or a reinsurance company, formed solely as a mechanism to cede, distribute, or allocate among other qualifying single-parent captive insurers whose parents are in the same industry, risks described in sub-subdivision a. or b. of this subdivision, as long as all risks placed in the pool are similar, the kinds of insurance covered are the same, and each captive participating in the pool retains more than fifty percent (50%) of its risks net of all other reinsurance cessions.

(4) 'Unauthorized reinsurer' means an individual assuming reinsurer or a group of assuming reinsurers or its affiliate or agent for which credit for reinsurance is not allowed under G.S. 58-7-21 or a substantially similar law in the insurer's state of domicile.

(5) 'Underwriting authority' means the acceptance or declination of risks under original policies; and may include the determination of pricing and of the terms and conditions of coverage under the original policies.

"**§ 58-10-80. Reporting requirements.**

(a) If the transaction covers risks resident in this State, this section also applies to any foreign insurer licensed in this State that delegates underwriting or claim settlement authority to an unauthorized reinsurer on business written directly by the insurer or assumed from another licensed insurer.

(b) If an insurer does business with an unauthorized reinsurer, the insurer shall report with its annual financial statement, in a form acceptable to the Commissioner, the following information about the unauthorized reinsurer:

(1) The total gross original written premium.

(2) The total ceded written premium.

(3) The lines and classes of business involved.

(4) The identity, domicile, and NAIC number, if applicable, of the reinsurer; and the name, address, and telephone number of the reinsurer's senior operating officer.

(5) The total ceded losses incurred, including incurred but not reported losses, and allocated loss adjustment expenses.

(6) The amount and type of collateral retained by the insurer for liabilities for unearned premiums, unpaid losses, and allocated loss adjustment expenses, including estimated incurred but not reported losses.

(7) The identity of any third party to which underwriting or claim settlement authority has been delegated by the reinsurer.

(8) Any other information the Commissioner considers necessary.

"**§ 58-10-85. Prior approval of certain reinsurance transactions.**

(a) Before entering into a reinsurance transaction covering direct business written or business assumed from a licensed insurer under which underwriting or claim settlement authority will be delegated to an unauthorized reinsurer, a domestic insurer, including a United States branch of an alien insurer entered through this State, shall obtain prior approval of the Commissioner if:

(1) The annual gross written premium, as estimated by the insurer, for business subject to the proposed reinsurance transaction, before deduction of ceding commission or any other allowances, exceeds five percent (5%) of the insurer's statutory policyholder surplus as reported in its most recent annual financial statement; or

(2) The annual gross written premium, as estimated by the insurer, for business subject to the proposed reinsurance transaction, before deduction of ceding commission or any other allowances, when added to the estimated annual gross written premium for all other business in force that is subject to a similar reinsurance arrangement in which underwriting or claim settlement authority has been delegated to an unauthorized reinsurer, amounts in total to more than ten percent (10%) of the insurer's statutory policyholder surplus as reported in its most recent annual financial statement.

(b) Along with each application in subsection (a) of this section, the insurer shall submit for the Commissioner's review and consideration the following information:

(1) The identity, domicile, and NAIC number, if applicable, of the reinsurer and, if applicable, the reinsurer's representative to whom underwriting or claim settlement authority will be delegated.

(2) A detailed description of the proposed transaction, setting forth the rights and duties of the parties, the scope of underwriting or claim settlement authority to be delegated, and the monitoring and control procedures to be implemented by the insurer.

(3) The amounts and nature of any collateral to be held by the insurer for the reinsurer's liabilities arising out of the proposed transaction.

(4) The annual gross written premium, as estimated by the insurer, before deduction of ceding commission or any other allowances, for business subject to the proposed reinsurance transaction, and for all business in force that is subject to a similar reinsurance arrangement in which underwriting or claim settlement authority has been delegated to an unauthorized reinsurer. The premium data shall be broken down for each state in which risks subject to the transactions reside or are located.

(c) The Commissioner shall be deemed to have approved the proposed reinsurance transaction if approval is not denied within 45 days after receipt of the complete information required under subsection (b) of this section.

"**§ 58-10-90. Exceptions.**

This Part does not apply to any reinsurance transaction:

(1) Involving only life insurance, annuities, or credit accident and health insurance.

(2) Involving only an affiliate of the insurer or any pooling arrangement within the same insurance holding company system.

(3) Involving any group, association, pool, or organization of insurers that engages in joint underwriting activities and that is subject to examination by any state regulatory authority or that operates under any state, federal statutory, or federal administrative authorization.

(4) With a single-parent captive insurer.

(5) That is nonobligatory and facultative and in which the annual gross written premium, before deduction of ceding commission or any other allowances, does not exceed one percent (1%) of the insurer's statutory policyholder surplus as reported in its most recent annual financial statement.

"**§ 58-10-95. Responsibilities of the insurer.**

(a) Before the inception of any reinsurance transaction subject to G.S. 58-10-80 or G.S. 58-10-85, the insurer shall:

(1) Make a determination that the reinsurer or its designated representative possesses sufficient technical expertise and administrative capabilities to perform satisfactorily the functions delegated to it.

(2) Obtain an opinion from a qualified actuary independent of the insurer and the reinsurer or its designated representative that the premium rates applicable to all policies subject to the reinsurance transaction make reasonable provision for expected losses and loss adjustment expenses.

(3) Obtain a written commitment from the reinsurer and its designated representative, if any, to abide by all provisions, stipulations, and guidelines established by the insurer about:

a. Maximum annual gross written premium.

b. Maximum policy limits of liability.
c. Lines and classes of business to be written.
d. Policy rates and rating basis.
e. Maximum policy period.
f. Required policy wording and exclusions.
g. Territorial limitations.
h. Maximum claim settlement authority.
i. Authorized independent claim adjusters and defense counsel.

(4) Obtain written acknowledgment from the reinsurer that all files and records for claims arising out of business subject to the reinsurance agreement shall be the property of both parties to the agreement, that the insurer shall be given unrestricted access to the files and records upon request, and that the files and records shall not be deleted or destroyed without the insurer's and the Commissioner's prior consent.

(b) The insurer shall perform, or have a qualified independent party perform, a compliance audit to verify the reinsurer's strict adherence to all of the established underwriting and claim settlement provisions, stipulations, and guidelines set forth in subdivision (a)(3) of this section. The audit shall be performed at least once a year, and records evidencing proper and timely performance of the audit shall be maintained in accordance with G.S. 58-10-100.

(c) If there is a disagreement or dispute between the insurer or reinsurer about the performance of any delegated underwriting or claim settlement functions, or upon the discovery of any failure on the part of the reinsurer to comply with all established underwriting or claim settlement provisions, stipulations, and guidelines, the insurer shall immediately suspend the reinsurer's authority to perform the functions until the disagreement, dispute, or noncompliance has been satisfactorily resolved.

(d) An insurer shall obtain written documentation from each captive with which it has entered into a reinsurance transaction and for which an exemption is claimed under G.S. 58-10-90(4), verifying that the captive is in fact a single-parent captive insurer.

"**§ 58-10-100. Records to be maintained by domestic insurers.**

(a) A domestic insurer shall maintain the following records for each reinsurance transaction subject to this Part:

(1) A copy of the complete reinsurance agreement properly executed by the parties, and any amendments.

(2) A copy of all accounting records detailing written and earned premiums, commission, paid losses, and loss adjustment expenses, reserves for outstanding losses, including incurred but not reported losses, and collateral held by the insurer with respect to the liabilities of the reinsurer.

(3) A copy of the reinsurer's latest audited financial statement.

(4) A copy of the document detailing the guidelines, procedures, and controls applicable to any underwriting, loss reserving, or claim settlement functions delegated to the reinsurer or its affiliate.

(5) A copy of the report of a compliance audit, to be conducted at least once a year by the insurer or a qualified independent party, with respect to any delegated functions.

(b) All of the records required by this section shall be made available for review at any time by the Commissioner and shall be retained for at least three years after the end of the reinsurance agreement, or until the completion of an examination conducted under G.S. 58-2-131 covering the period during which the reinsurance agreement was in effect, whichever is later. Records on claims arising under policies subject to the reinsurance agreement shall be retained until the claims are finally settled and closed.

"**§ 58-10-105. Required reinsurance agreement provisions for domestic insurers.**

A reinsurance transaction between a domestic insurer and an unauthorized reinsurer shall be documented properly in a reinsurance agreement to be executed by the parties within 120 days after its inception, which, in addition to any other requirements of this Chapter, shall include the following provisions:

(1) A funding clause obligating the unauthorized reinsurer to provide collateral in a form prescribed by G.S. 58-7-26 and in an amount equal to no less than one hundred percent (100%) of its liabilities for unearned premiums, unpaid losses, and allocated loss adjustment expenses, including estimated incurred but not reported losses.

(2) A reports and remittances clause obligating the reinsurer to remit payment in full of all balances due and payable and not in dispute within 30 days after the receipt of satisfactory proof of loss. Any balance in dispute shall be deposited in an interest-bearing escrow account pending resolution of the dispute, to be remitted with interest to the appropriate party as determined by the arbitration panel within 30 days after the resolution of the dispute.

(3) An insolvency clause obligating the reinsurer to pay all balances due under the terms of the reinsurance agreement on the basis of the insurer's liability, without diminution because of the insolvency of the insurer, to the liquidator, receiver, conservator, or statutory successor of the insurer.

(4) A service of suit clause obligating any unauthorized reinsurer to submit to the jurisdiction of a court of competent jurisdiction within this State and to designate the Commissioner as its lawful agent for receipt of service in any suit or proceeding arising out of the reinsurance agreement.

(5) An arbitration clause obligating the parties to the agreement to submit disagreements or disputes to arbitration and to promptly comply with the decision rendered by the arbitration panel.

(6) A cancellation clause allowing the insurer to cancel the agreement at any time with 30-days' written notice to the reinsurer and at the insurer's option:

a. Obligating the reinsurer to remain liable for all losses on policies in force as of the cancellation date of the reinsurance agreement; or

b. Relieving the reinsurer of liability for all losses occurring after the cancellation date of the reinsurance agreement and obligating the reinsurer to refund to the insurer the applicable unearned reinsurance premium, unless the Commissioner has authorized an alternative disposition.

(7) If the services of a reinsurance intermediary have been used in effecting the reinsurance transaction, an intermediary clause stipulating that balances payable to the insurer, exclusive of any payments made by the reinsurer directly to the policyholder or claimant on the insurer's behalf, shall be deemed to have been paid only to the extent that the balances have been received by the insurer, and that balances payable to the reinsurer shall be deemed to have been paid if those balances have been remitted to the intermediary.

"**§ 58-10-110. Commissioner's authority.**

In addition to other remedies or penalties under this Chapter, the Commissioner may, after notice and opportunity to be heard, order a domestic insurer found to be in violation of this Part to do any or all of the following:

(1) Issue no new or renewal policies subject to this Part.

(2) Make no cessions under the reinsurance agreement.

(3) Immediately draw upon all letters of credit or other collateral to the extent of the reinsurer's overdue liabilities under the reinsurance agreement.

"**§ 58-10-115. Effective date and scope.**

This Part applies to all reinsurance agreements entered into or renewed on and after January 1, 1998. A reinsurance agreement is deemed to be renewed on each anniversary of its inception date."

Section 2. This act becomes effective January 1, 1998.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

S 1

SENATE BILL 797

Short Title: Health and Life Insurance Amendments. (Public)

Sponsors: Senator Miller.

Referred to: Pensions & Retirement and Insurance.

April 10, 1997

A BILL TO BE ENTITLED

AN ACT TO MAKE VARIOUS SUBSTANTIVE AMENDMENTS TO LAWS RELATING TO SMALL EMPLOYER GROUP HEALTH INSURANCE, GROUP HEALTH INSURANCE CONTINUATION, MEDICARE SUPPLEMENT INSURANCE, GROUP LIFE INSURANCE POLICIES, LIFE INSURANCE SALES, AND UNFAIR TRADE PRACTICES.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-3-150(b) reads as rewritten:

"(b) With respect to group and blanket accident and health insurance, group life insurance, and group annuity policies issued and delivered to a trust or to an association outside of this State and covering persons resident in this State, the group certificates to be delivered or issued for delivery in this State and the application or enrollment form used to solicit the group insurance or annuity certificate to each insured person in this State shall be filed with and approved by the Commissioner pursuant to subsection (a) of this section. Group certificates, applications, or enrollment forms shall conform with all applicable provisions of this Chapter."

Section 2. G.S. 58-50-110(14) reads as rewritten:

"(14) 'Late enrollee' means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer after the end of the initial enrollment period provided under the terms of the health benefit plan in effect at the time the employee first became eligible; provided that the initial enrollment period shall be a period of at least 30 consecutive calendar days. However,

an eligible employee or dependent shall not be considered a late enrollee if:

a. The individual was covered under a public or private health benefit plan that provided, at the time the individual was eligible to enroll, ~~the same required level of~~ benefits ~~in~~ that were similar to or that exceeded the basic and standard health care plans adopted pursuant to G.S. 58-50-120 and either the individual:

1. Lost coverage under another health plan as a result of termination of employment, termination of a spouse's health plan coverage, or the death of a spouse or divorce and requests enrollment in ~~a basic or standard~~ the individual's employer's health care plan within 30 days after termination of coverage provided under another health plan; or

2. Stated, in writing, during the enrollment period that coverage under another employer health benefit plan was the reason for declining coverage;

3,4. Repealed by Session Laws 1993, c. 529, s. 3.3.

b. The individual elects a different health plan offered through the Alliance during an open enrollment period;

c. An eligible employee requests enrollment within 30 days of becoming an employee of a member small employer;

d. A court has ordered coverage be provided for a spouse ~~or minor child~~ under a covered employee's health benefit plan and the request for enrollment for the spouse is made within 30 days after issuance of the court order; ~~or~~

d1. A court has ordered coverage be provided for a minor child under a covered employee's health benefit plan and the minor child is enrolled under G.S. 58-51-120; or

e. The individual or employee enrollee makes a request for enrollment of the spouse or child within 30 days of the individual or employee's marriage or the ~~birth~~ birth, foster placement, or adoption of a child."

Section 3. G.S. 58-50-110(21a) reads as rewritten:

"(21a) 'Self-employed individual' means an individual or sole proprietor who derives a majority of ~~his or her~~ the individual's income from a trade or business ~~carried on by the individual or sole proprietor which results in taxable income as indicated on~~ through which the individual or sole proprietor has attempted to earn taxable income and for which the individual has filed IRS form 1040, Schedule C or F ~~and which generated taxable income in one of the two previous years.~~ for the previous taxable year. For a newly established trade or business, the individual or sole proprietor shall

certify the intention to file the appropriate Internal Revenue Service Form 1040, Schedule C or F, for the current taxable year."

Section 4. G.S. 58-50-125(a) reads as rewritten:

"(a) To improve the availability and affordability of health benefits coverage for small employers, the Committee shall recommend to the Commissioner two plans of coverage, one of which shall be a basic health care plan and the second of which shall be a standard health care plan. Each plan of coverage shall be in two forms, one of which shall be in the form of insurance and the second of which shall be consistent with the basic method of operation and benefit plans of HMOs, including federally qualified HMOs. ~~On or before January 1, 1992, the Committee shall file a progress report with the Commissioner. The Committee shall submit the recommended plans to the Commissioner for approval within 180 days after the appointment of the Committee under G.S. 58-50-120.~~ The Committee may also recommend a preferred provider version of the standard health care plan that incorporates reasonable benefit differentials applicable to participating and nonparticipating health care providers. The Committee shall take into consideration the levels of health benefit plans provided in North Carolina, and appropriate medical and economic factors, and shall establish benefit levels, cost sharing, exclusions, and limitations. Notwithstanding subsection (c) of this section, in developing and approving the plans, the Committee and the Commissioner shall give due consideration to cost-effective and life-saving health care services and to cost-effective health care providers. The Committee shall file with the Commissioner its findings and recommendations, and reasons for the findings and recommendations, if it does not provide for coverage by any type of health care provider specified in G.S. 58-50-30. The recommended plans may include cost containment features such as, but not limited to: preferred provider provisions; utilization review of medical necessity of hospital and physician services; case management benefit alternatives; or other managed care provisions."

Section 5. G.S. 58-50-125(d) reads as rewritten:

"(d) Within 180 days after the Commissioner's approval under subsection (b) of this section, every small employer carrier shall, as a condition of transacting business in this State, offer small employers at least one basic and one standard health care plan. This offer shall include the preferred provider version of the standard health care plan if the small employer is located in an area serviced by a provider network of the carrier, and the carrier provides a preferred provider benefit plan to small employers in that area. Every small employer that elects to be covered under such a plan and agrees to make the required premium payments and to satisfy the other provisions of the plan shall be issued such a plan by the small employer carrier. The premium payment requirements used in connection with basic and standard health care plans may address the potential credit risk of small employers that elect coverage in accordance with this subsection by means of payment security provisions that are reasonably related to the risk and are uniformly applied.

If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all eligible employees of a small employer and their

dependents. A small employer carrier shall not offer coverage to only certain individuals in a small employer group except in the case of late enrollees as provided in G.S. 58-50-130(a)(4). A small employer carrier shall not modify any health benefit plan with respect to a small employer, any eligible employee, or dependent through riders, endorsements, or otherwise, in order to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan. In the case of an eligible employee or dependent of an eligible employee who, before the effective date of the plan, was excluded from coverage or denied coverage by a small employer carrier in the process of providing a health benefit plan to an eligible small employer, the small employer carrier shall provide an opportunity for the eligible employee or dependent of an eligible employee to enroll in the health benefit plan currently held by the small employer."

Section 6. G.S. 58-50-130(b)(1) reads as rewritten:

"(1) Small employer carriers shall use an adjusted-community rating methodology in which the premium for each small employer can vary only on the basis of the eligible employee's or dependent's age as determined in accordance with subdivision (6) of this subsection, the gender of the eligible employee or dependent, number of family members covered, or geographic area as determined under subdivision (7) of this subsection. Premium rates charged during a rating period to small employers with similar case characteristics for same coverage shall not vary from the adjusted community rate by more than twenty percent (20%) for any reason, including differences in administrative costs and claims experience. A small employer carrier shall use its entire book of North Carolina small employer health insurance business when developing the community rate and adjustment factors used in this section. The adjusted community rating methodology, the rating factors, and any amendments to the methodology or factors shall be filed with the Commissioner before they are used in this State."

Section 7. G.S. 58-50-130(b)(3) reads as rewritten:

"(3) Small employer carriers shall not modify the rate for a small employer for 12 months from the initial issue date or renewal date, unless the group is composite rated and composition of the group changed by twenty percent (20%) or more or benefits are changed. The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

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

b. Any adjustment, not to exceed fifteen percent (15%) annually, due to claim ~~experience, health status, or duration~~

~~of coverage~~ experience or health status of the employees or dependents of the small employer, and

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

Section 8. G.S. 58-50-130(g) reads as rewritten:

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

Section 9. G.S. 58-50-135(a) reads as rewritten:

"(a) Every small employer carrier shall elect either to become a risk-assuming carrier and comply with the provisions of G.S. 58-50-140 or become a reinsuring carrier and comply with the provisions of G.S. 58-50-145. The election shall be binding for a five-year period except that ~~the~~ a newly licensed carrier's initial election ~~shall be made within 60 days after January 1, 1992, and~~ shall be made for two years. The Commissioner may, for good cause, permit a carrier to modify its election during the five-year period. All carriers under common ownership or control must make the same election in this State; provided, however, that the Commissioner may, for good cause, permit an affiliated carrier to make a separate election."

Section 10. G.S. 58-53-25 reads as rewritten:

"**§ 58-53-25. Notification to employee.**

In addition to the notification requirement set forth in G.S. 58-53-40, notification may be included on insurance identification cards or may be given by the employer, orally or in writing as a part of the exit process from the employment. The employer shall notify the employee or member when the employee or member loses eligibility for continuation under this Part."

Section 11. Article 54 of Chapter 58 of the General Statutes is amended by adding two new sections to read:

"**§ 58-54-45. By reason of disability.**

In addition to any rule adopted under this Article that is directly or indirectly related to open enrollment, an insurer shall at least make standardized Medicare Supplement Plan A available to persons eligible for Medicare by reason of disability before age 65. This action shall be taken without regard to medical condition, claims experience, or health status. To be eligible, a person must submit an application during the six-month period beginning with the first month the person first enrolls in Medicare Part B.

"**§ 58-54-50. Rules for compliance with federal law and regulations.**

The Commissioner may adopt rules necessary to conform Medicare supplement policies and certificates to the requirements of federal law and regulations, including:

(1) Requiring refunds or credits if the policies or certificates do not meet loss ratio requirements.
(2) Establishing a uniform methodology for calculating and reporting loss ratios.
(3) Assuring public access to policies, premiums, and loss ratio information of issuers of Medicare supplement insurance.
(4) Establishing standards for Medicare Select policies and certificates."

Section 12. Article 58 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-58-136. Additional group life insurance policies.**

(a) A licensed life insurance company may issue a policy to an association or to a trust or to the trustee or trustees of a fund established, created, or maintained for the benefit of members of one or more associations, other than an association specified in G.S. 58-58-135. The association shall:

(1) Have at the outset a minimum of 500 persons;
(2) Have been organized and maintained in good faith for purposes other than that of obtaining insurance;
(3) Have been in active existence for at least five years;
(4) Not condition membership in the association on any health status-related factor of any individual, including an employee of a member employer or a dependent of an employee;
(5) Not make insurance coverage through the association available other than in connection with membership in the association; and
(6) Have a constitution and bylaws that provide that:
a. The association holds regular meetings not less often than annually to further purposes of the members.
b. Except for credit unions, the association collects dues or solicits contributions from members.
c. The members have voting privileges and representation on the association's governing board and committees.

(b) The policy described in subsection (a) of this section is subject to the following requirements:

(1) The policy may insure (i) members of the association or a class of members, (ii) employees of the association or a class of employees, (iii) employees of association members or a class of employees, or (iv) any combination of those persons listed in (i) through (iii) of this subdivision, for the benefit of persons other than the employees of the employer.
(2) The premium for the policy shall be paid from funds contributed by (i) the association, (ii) employer members, (iii) both the association and employer members, (iv) the covered persons, or (v) both the covered persons and the association or employer members.

(3) A policy on which no part of the premium is to be derived from funds contributed by the covered persons specifically for their insurance must insure all eligible persons, except those who reject the coverage, in writing.

(c) A licensed life insurance company may issue a policy to a credit union or to a trustee or trustees or an agent designated by two or more credit unions. The credit union, trustee, or agent shall be deemed the policyholder, to insure members of the credit union for the benefit of persons other than the credit union, trustee, or agent or any of the officials, subject to the following requirements:

(1) The members eligible for insurance shall be all of the members of the credit union, or all of any class thereof.

(2) The premium for the policy shall be paid by the policyholder from the credit union's funds and, except as provided in subdivision (3) of this subsection, shall insure all eligible members.

(3) An insurer may exclude or limit the coverage on any member as to whom evidence of individual insurability is not satisfactory to the insurer."

Section 13. G.S. 58-60-5 reads as rewritten:

"**§ 58-60-5. Scope of Article; exemptions.**

(a) Except as ~~hereafter exempted,~~ otherwise provided in this Article, this Article ~~shall apply~~ applies to any solicitation, negotiation or procurement of life insurance occurring within this State. This Article ~~shall apply~~ applies to any issuer of a life insurance ~~contract~~ contract, including fraternal benefit societies.

(b) Unless otherwise specifically included, this Article ~~shall~~ does not apply to:

(1) Annuities,

(2) Credit life insurance,

(3) Group life insurance,

(4) Life insurance policies issued in connection with pension and welfare plans as defined by and ~~which~~ that are subject to the federal Employee Retirement Income Security Act of 1974 (ERISA),

(5) Variable life insurance under which the death benefits and cash values vary in accordance with unit values of investments held in a separate account.

(c) The policy summary in this Article is not required for policies that are sold subject to rules adopted by the Commissioner for life insurance illustrations."

Section 14. G.S. 58-63-5 reads as rewritten:

"**§ 58-63-5. Definitions.**

When used in this Article:

(1) Repealed by Session Laws 1991, c. 720, s. 6.

(2) 'Person' ~~shall mean~~ means any individual, corporation, association, partnership, reciprocal exchange, interinsurer, Lloyds insurer, fraternal benefit society, and any other legal entity engaged in the business of ~~insurance, including agents,~~ insurance under Articles 1

through 63, 65, and 67 of this Chapter; and includes brokers, limited representatives, and adjusters."

Section 15. Sections 1, 4 through 7, 10 through 12, and 14 of this act become effective October 1, 1997. The remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

S 1

SENATE BILL 420*

Short Title: State Fire and Rescue Commission. (Public)

Sponsors: Senators Martin of Guilford and Winner.

Referred to: Pensions & Retirement and Insurance.

March 18, 1997

A BILL TO BE ENTITLED

AN ACT TO AMEND THE MEMBERSHIP OF THE STATE FIRE AND RESCUE COMMISSION.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-78-1 reads as rewritten:

"**§ 58-78-1. State Fire and Rescue Commission created; membership.**

(a) There is created the State Fire and Rescue Commission of the Department, which shall be composed of ~~14~~ 15 voting members to be appointed as follows:

(1) The Commissioner shall appoint ~~eleven~~ 12 members, two from nominations submitted by the North Carolina State Firemen's Association, one from nominations submitted by the North Carolina Association of Fire Chiefs, one from nominations submitted by the Professional Firefighters of North Carolina Association, one from nominations submitted by the North Carolina Society of Fire Service Instructors, one from nominations submitted by the North Carolina Association of County Fire Marshals, one from nominations submitted by the North Carolina Fire Marshal's Association, two from nominations submitted by the North Carolina Association of Rescue and Emergency Medical Services, Inc., one mayor or other elected city official nominated by the President of the League of Municipalities, one county commissioner nominated by the President of the Association of County Commissioners, and one from the public at large;

(2) The Governor shall appoint one member from the public at large; and

(3) The General Assembly shall appoint two members from the public at large, one upon the recommendation of the Speaker of the House of Representatives pursuant to G.S. 120-121, and one upon the recommendation of the President Pro Tempore of the Senate pursuant to G.S. 120-121.

Public members may not be employed in State government and may not be directly involved in fire fighting or rescue services.

(b) Of the members initially appointed by the Commissioner, the nominees of the North Carolina State Firemen's Association and the nominees of the North Carolina Association of Fire Chiefs and the nominees of the Professional Firefighters of North Carolina Association and of the North Carolina Association of Rescue and Emergency Medical Services, Inc., shall serve three-year terms; the nominees from the North Carolina Society of Fire Service Instructors, the North Carolina Association of County Fire Marshals, and the North Carolina Fire Marshal's Association shall serve two-year terms; and the mayor or other elected city official, the county commissioner, and the member from the public at large shall serve one-year terms. The Governor's initial appointee shall serve a three-year term. The General Assembly's initial appointees shall serve two-year terms. Thereafter all terms shall be for three years.

(c) Vacancies shall be filled by the original appointer in the same manner as the original appointment was made, except that vacancies in the appointments made by the General Assembly shall be filled in accordance with G.S. 120-122.

(d) Appointed members shall serve until their successors are appointed and qualified.

(e) The following State officials, or their designees, shall serve by virtue of their offices as nonvoting members of the Commission: the Commissioner of Insurance, the Commissioner of Labor, the Attorney General, the Secretary of Crime Control and Public Safety, the Secretary of Environment, Health, and Natural Resources, and the President of the Department of Community Colleges.

(f) Members of the Commission shall receive per diem and necessary travel and subsistence allowances in accordance with the provisions of G.S. 138-5 or G.S. 138-6, as appropriate."

Section 2. This act is effective when it becomes law.

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April 16, 1997

MEMORANDUM

To: Senate Committee on Pensions & Retirement and Insurance

From: M. Lynn Marshbanks, Committee Counsel

Re: Senate Bill 613: Insurance Company Audits and Exams

Senate Bill 613 amends insurance laws concerning examinations and audits of insurance companies. It provides that the Commissioner examine every domestic company at least once every five (currently, three) years. It also incorporates the NAIC model rule requiring annual audited financial statements by reference, except for the following provisions:

1. The annual audited financial report is to be filed on or before May 10; the filing date may be extended by the Commissioner for up to 45 days.

2. Insurer with direct premiums written in North Carolina of less than $250,000 and less than 500 policyholders in North Carolina are exempt unless the Commissioner finds that compliance is necessary for the Commissioner to carry out statutory responsibilities.

3. CPAs who intend to practice under the provisions of the annual statement instructions must file notice with the Commissioner by October 1 of each year, stating that the CPA will comply with those instructions related to CPA work papers and giving evidence of expertise in insurance auditing and accounting.

4. An audit performed by a CPA must be staffed by managerial staff experienced in insurance auditing and accounting and by a majority or an equal number of nonmanagerial staff experienced in insurance auditing and accounting.

The bill also amends the Examination Law by requiring that the Commissioner may retain attorneys, appraisers, and other professionals to conduct an examination only if the Commissioner determines that there are insufficient resources in the Department. Also, the insurer must pay the persons retained, and the payments may not exceed $100,000.

Effective date: October 1, 1997, applying to audits or examinations conducted on or after that date.

S613-SMRS-001

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

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April 9, 1997

MEMORANDUM

To: Senate Committee on Pensions & Retirement and Insurance

From: M. Lynn Marshbanks, Committee Counsel

Re: Senate Bill 611: Insurance Fronting

Senate Bill 611 would add a new Part to Article 10 of Chapter 58 to regulate the "fronting" of insurance business by reinsurance transactions where either (i) a domestic insurer or (ii) a foreign insurer licensed in North Carolina and covering risks in this state, delegates to an unauthorized reinsurer underwriting or claim settlement authority. An "unauthorized reinsurer" is a reinsurer or group of reinsurers or any affiliate or agent that is not allowed credit for reinsurance under G.S. 58-7-21 or a similar law in the insurer's state of domicile.

The bill would do the following:

1. Require that the delegating insurer report certain information regarding the unauthorized insurer to the Commissioner – including gross and ceded premium; the lines and classes of business involved; the name and NAIC number of the reinsurer; the total ceded losses incurred; the amount and type of collateral retained; and the identity of any third party to which underwriting or claim settlement authority has been delegated by the reinsurer.

2. Require that before entering into reinsurance transactions that cover (i) direct business written or business assumed from a licensed insurer under which underwriting or claim settlement authority will be delegated to an unauthorized reinsurer, or (ii) risks resident or located in this State under which there will be a delegation of underwriting or claim settlement authority to an unauthorized reinsurer, the delegating insurer must get the Commissioner's prior approval if the annual gross premium would exceed certain stated amounts. The delegating insurer must submit such information as the name and NAIC number of the reinsurer; a detailed description of the proposed transactions; the amounts and nature of collateral to be held by the insurer with respect to the reinsurer's liabilities; and the annual gross written premium.

3. Require that the delegating insurer do the following: determine that the reinsurer has sufficient technical and administrative expertise to perform the delegated functions satisfactorily; get an opinion from a qualified independent actuary that the premium rates make reasonable provision for expected losses; and get a written commitment from the reinsurer to abide by all provisions established by the insurer and that all files and records

regarding the transaction are the property of both parties. The insurer must have an annual audit done to ensure the reinsurer's compliance with all the requirements and maintain certain records for each transaction.

4. Requires the transaction to be documented in a reinsurance agreement with certain stated provisions.

5. Allow the Commissioner to order, upon finding that the delegating insurer is in violation of this Part, that the insurer issue no new or renewal policies subject to this Part, make no cessions under the reinsurance agreement, and pay a civil penalty for each violation.

The above provisions would not apply to a reinsurance transaction that (i) involves only life insurance or annuities, or credit accident and health insurance; (ii) involves only an affiliate of the insurer or any pooling arrangement with the same insurance holding company system; (iii) involves any group or organization of insurers that engages in joint underwriting activities subject to examination by any state regulatory authority or operates under any state, federal statutory, or federal administrative authorization; (iv) has a single-parent captive insurer (owned by one or more affiliated persons and domiciled in a jurisdiction that is accredited under NAIC's financial standards, provided that it writes only certain stated risks), or (v) is a nonobligatory facultative reinsurance transaction below a certain stated premium amount.

Effective date: January 1, 1998, applying to all reinsurance agreements entered into or renewed on and after that date.

S611-SMRS-001

VISITOR REGISTRATION SHEET

Pension & Retirement / DNS — 4-29-97

Name of Committee — Date

VISITORS: Please sign below and return to Committee Clerk.

NAME	FIRM OR STATE AGENCY AND ADDRESS
D Stan Hunter	NCIUA
Janet Pittard	OSBM
Kirsten Mitchell	NCFRNG
Roger Langley	NC DOI
Sarah W. McKenney	NC DOI
Jim Long	NC DOI
Bill Owens	N.C. House
Eddie Caldwell	CAPIA
Lowe Wrenn	Both Carr & Strong
Alan Miles	Banks & DIXON LLP
[illegible]	Coleman
[illegible]	ABC NC Bdcst. Cos.
RD	[illegible]
Rob Paschal	Vance Rogers
Fran Taylor	WRAL-TV

Pensions & Retirement/ Insurance Committee

May 14,1997
1124 LB
Sen. Jenkins, Chairman

AGENDA

HB 312 Update Mortality Tables
Rep. Goodwin

HB 391 High Point Firemen's Pension
Rep. Jarrell

HB 522 State Fire and Rescue Commission
Rep. Buchanan

HB 1115 Church Insurance Coverage
Rep. Boyd-McIntyre

Pensions & Retirement/ Insurance Committee

MINUTES

The Pensions Retirement/ Insurance Committee met Wednesday, May 14, 1997 at 10:00 in room 1124 of the Legislative Building. Thirteen senators were in attendance, including Sen. Jenkins who presided.

HB 312 Update Mortality Tables was explained by Rep. Goodwin. Sen. Reeves sent forth an amendment which was rolled into a committee substitute, Sen. Odom moved for an unfavorable as to the original bill, but favorable to committee substitute. The motion carried.

HB 391 High Point Fireman's Pension was explained by Rep. Jarrell. Sen. Kincaid moved for a favorable report of the bill. The motion carried.

HB 522 State Fire and Rescue Commission was explained by Rep. Buchanan. Sen. Odom moved for a favorable report of the bill. The motion carried.

The meeting was adjourned.

Sen. Jenkins, Chairman

Katy Haynes, Clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

PENSIONS & RETIREMENT/ INSURANCE COMMITTEE REPORT
Senator Tommy Jenkins, Chairman

Thursday, May 15, 1997

SENATOR TOMMY JENKINS,
submits the following with recommendations as to passage:

FAVORABLE

H.B. **522** State Fire and Rescue Commission
Sequential Referral: None
Recommended Referral: None

H.B. **391** High Point Firemen's Pension
Sequential Referral: None
Recommended Referral: None

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO SENATE C.S. BILL

H.B. **312** Update Mortality Tables
Draft Number: PCS1374
Sequential Referral: None
Recommended Referral: None
Long Title Amended: No

TOTAL REPORTED: 3

Committee Clerk Comment: None

GENERAL ASSEMBLY OF NORTH CAROLINA
1997 SESSION

S.L. 1997-133
HOUSE BILL 312

AN ACT UPDATING THE STATUTORY MORTALITY TABLES USED AS EVIDENCE TO ESTABLISH THE EXPECTANCY OF CONTINUED LIFE.

The General Assembly of North Carolina enacts:

Section 1. G.S. 8-46 reads as rewritten:

"**§ 8-46. ~~Mortuary~~ Mortality tables as evidence.**

Whenever it is necessary to establish the expectancy of continued life of any person from any period of ~~such~~ the person's life, whether ~~he be~~ the person is living at the time or not, the table hereto appended shall be received in all courts and by all persons having power to determine litigation, as evidence, with other evidence as to the health, constitution and habits of ~~such~~ the person, of such expectancy represented by the figures in the columns headed by the words 'completed age' and 'expectation' respectively:

Completed Age	Expectation
0	~~68.40~~ 75.8
1	~~69.64~~ 75.4
2	~~68.78~~ 74.5
3	~~67.86~~ 73.5
4	~~66.92~~ 72.5
5	~~65.98~~ 71.6
6	~~65.02~~ 70.6
7	~~64.06~~ 69.6
8	~~63.09~~ 68.6
9	~~62.12~~ 67.6
10	~~61.15~~ 66.6
11	~~60.18~~ 65.6
12	~~59.20~~ 64.6
13	~~58.22~~ 63.7
14	~~57.25~~ 62.7
15	~~56.29~~ 61.7
16	~~55.34~~ 60.7
17	~~54.39~~ 59.8
18	~~53.45~~ 58.8
19	~~52.52~~ 57.9
20	~~51.58~~ 56.9
21	~~50.65~~ 56.0
22	~~49.72~~ 55.1
23	~~48.80~~ 54.1
24	~~47.87~~ 53.2
25	~~46.94~~ 52.2

26	~~46.02~~	51.3
27	~~45.09~~	50.4
28	~~44.17~~	49.4
29	~~43.25~~	48.5
30	~~42.33~~	47.5
31	~~41.41~~	46.6
32	~~40.49~~	45.7
33	~~39.58~~	44.7
34	~~38.67~~	43.8
35	~~37.76~~	42.9
36	~~36.85~~	42.0
37	~~35.95~~	41.0
38	~~35.06~~	40.1
39	~~34.17~~	39.2
40	~~33.29~~	38.3
41	~~32.42~~	37.4
42	~~31.57~~	36.5
43	~~30.72~~	35.6
44	~~29.87~~	34.7
45	~~29.04~~	33.8
46	~~28.21~~	32.9
47	~~27.38~~	32.0
48	~~26.56~~	31.1
49	~~25.76~~	30.2
50	~~24.96~~	29.3
51	~~24.18~~	28.5
52	~~23.40~~	27.6
53	~~22.64~~	26.8
54	~~21.89~~	25.9
55	~~21.15~~	25.1
56	~~20.42~~	24.3
57	~~19.70~~	23.5
58	~~18.99~~	22.7
59	~~18.29~~	21.9
60	~~17.61~~	21.1
61	~~16.94~~	20.4
62	~~16.29~~	19.7
63	~~15.65~~	18.9
64	~~15.02~~	18.2
65	~~14.40~~	17.5
66	~~13.79~~	16.8
67	~~13.20~~	16.1
68	~~12.61~~	15.5
69	~~12.04~~	14.8
70	~~11.48~~	14.2
71	~~10.93~~	13.5
72	~~10.39~~	12.9
73	~~9.86~~	12.3
74	~~9.35~~	11.7
75	~~8.84~~	11.2
76	~~8.35~~	10.6
77	~~7.87~~	10.0
78	~~7.40~~	9.5

79		~~6.96~~ 9.0
80		~~6.53~~ 8.5
81		~~6.12~~ 8.0
82		~~5.75~~ 7.5
83		~~5.39~~ 7.1
84		~~5.05~~ 6.6
85	and over	~~4.70~~ 6.6
~~86~~		~~4.38~~
~~87~~		~~4.08~~
~~88~~		~~3.79~~
~~89~~		~~3.54~~
~~90~~		~~3.30~~
~~91~~		~~3.08~~
~~92~~		~~2.89~~
~~93~~		~~2.72~~
~~94~~		~~2.56~~
~~95~~		~~2.43~~
~~96~~		~~2.32~~
~~97~~		~~2.21~~
~~98~~		~~2.10~~
~~99~~		~~2.01~~
~~100~~		~~1.91~~
~~101~~		~~1.83~~
~~102~~		~~1.75~~
~~103~~		~~1.67~~
~~104~~		~~1.60~~
~~105~~		~~1.53~~
~~106~~		~~1.46~~
~~107~~		~~1.40~~
~~108~~		~~1.35~~
~~109~~		~~1.29~~".

Section 2. G.S. 8-47 reads as rewritten:

"**§ 8-47. Present worth of annuities.**

Whenever it is necessary to establish the present worth or cash value of an annuity to a person, payable annually during ~~his~~ the person's life, such present worth or cash value may be ascertained by the use of the following table in connection with the ~~mortuary~~ mortality tables established by law, the first column representing the number of years the annuity is to run and the second column representing the present cash value of an annuity of one dollar for such number of years, respectively:

No. of Years Annuity is to Run	Cash Value of the Annuity of $1
1	$ 0.943
2	1.833
3	2.673
4	3.465
5	4.212
6	4.917
7	5.582
8	6.210
9	6.802
10	7.360
11	7.887
12	8.384

13	8.853
14	9.295
15	9.712
16	10.106
17	10.477
18	10.828
19	11.158
20	11.470
21	11.764
22	12.042
23	12.303
24	12.550
25	12.783
26	13.003
27	13.211
28	13.406
29	13.591
30	13.765
31	13.929
32	14.084
33	14.230
34	14.368
35	14.498
36	14.621
37	14.737
38	14.846
39	14.949
40	15.046
41	15.138
42	15.225
43	15.306
44	15.383
45	15.456
46	15.524
47	15.589
48	15.650
49	15.708
50	15.762
51	15.813
52	15.861
53	15.907
54	15.950
55	15.991
56	16.029
57	16.065
58	16.099
59	16.131
60	16.161
61	16.190
62	16.217
63	16.242
64	16.266
65	16.289

66 .....16.310
67 .....16.331

The present cash value of the annuity for a fraction of a year may be ascertained as follows: Multiply the difference between the cash value of the annuities for the preceding and succeeding full years by the fraction of the year in decimals and add the sum to the present cash value for the preceding full year. When a person is entitled to the use of a sum of money for life, or for a given time, the interest thereon for one year, computed at four and one half percent (4 1/2%), may be considered as an annuity and the present cash value be ascertained as herein provided: Provided, the interest rate in computing the present cash value of a life interest in land shall be six percent (6%).

Whenever the ~~mortuary~~ mortality tables set out in G.S. 8-46 are admissible in evidence in any action or proceeding to establish the expectancy of continued life of any person from any period of ~~such~~ the person's life, whether ~~he be~~ the person is living at the time or not, the annuity tables herein set forth shall be evidence, but not conclusive, of the loss of income during the period of life expectancy of ~~such~~ the person."

Section 3. G.S. 46-25 reads as rewritten:

"§ 46-25. Sale of standing timber on partition; valuation of life estate.

When two or more persons own, as tenants in common, joint tenants or copartners, a tract of land, either in possession, or in remainder or reversion, subject to a life estate, or where one or more persons own a remainder or reversionary interest in a tract of land, subject to a life estate, then in any such case in which there is standing timber upon any such land, a sale of said timber trees, separate from the land, may be had upon the petition of one or more of said owners, or the life tenant, for partition among the owners thereof, including the life tenant, upon such terms as the court may order, and under like proceedings as are now prescribed by law for the sale of land for partition: Provided, that when the land is subject to a life estate, the life tenant shall be made a party to the proceedings, and shall be entitled to receive his or her portion of the net proceeds of sales, to be ascertained under the ~~mortuary~~ mortality tables established by law: Provided further, that prior to a judgment allowing a life tenant to sell the timber there must be a finding that the cutting is in keeping with good husbandry and that no substantial injury will be done to the remainder interest."

Section 4. This act is effective when it becomes law.

In the General Assembly read three times and ratified this the 27th day of May, 1997.

s/ Dennis A. Wicker
President of the Senate

s/ Harold J. Brubaker
Speaker of the House of Representatives

s/ James B. Hunt, Jr.
Governor

Approved 9:50 a.m. this 4th day of June, 1997

GENERAL ASSEMBLY OF NORTH CAROLINA
1997 SESSION

S.L. 1997-67
HOUSE BILL 391

AN ACT TO ALLOW ALL RETIRED HIGH POINT FIREMEN TO RECEIVE PENSION BENEFITS.

The General Assembly of North Carolina enacts:

Section 1. The first sentence of Section 3 of Chapter 877 of the 1957 Session Laws is rewritten to read:

"Any former full time member of the City of High Point Fire Department who receives retirement benefits pursuant to the provisions of the Local Governmental Employees' Retirement System is entitled to receive benefits under this Act."

Section 2. This act applies only to the City of High Point.

Section 3. This act is effective when it becomes law.

In the General Assembly read three times and ratified this the 20th day of May, 1997.

s/ Dennis A. Wicker
President of the Senate

s/ Harold J. Brubaker
Speaker of the House of Representatives

GENERAL ASSEMBLY OF NORTH CAROLINA
1997 SESSION

S.L. 1997-116
HOUSE BILL 522

AN ACT TO AMEND THE MEMBERSHIP OF THE STATE FIRE AND RESCUE COMMISSION.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-78-1 reads as rewritten:

"**§ 58-78-1. State Fire and Rescue Commission created; membership.**

(a) There is created the State Fire and Rescue Commission of the Department, which shall be composed of ~~14~~ 15 voting members to be appointed as follows:

(1) The Commissioner shall appoint ~~eleven~~ 12 members, two from nominations submitted by the North Carolina State Firemen's Association, one from nominations submitted by the North Carolina Association of Fire Chiefs, one from nominations submitted by the Professional Firefighters of North Carolina Association, one from nominations submitted by the North Carolina Society of Fire Service Instructors, one from nominations submitted by the North Carolina Association of County Fire Marshals, one from nominations submitted by the North Carolina Fire Marshal's Association, two from nominations submitted by the North Carolina Association of Rescue and Emergency Medical Services, Inc., one mayor or other elected city official nominated by the President of the League of Municipalities, one county commissioner nominated by the President of the Association of County Commissioners, and one from the public at large;

(2) The Governor shall appoint one member from the public at large; and

(3) The General Assembly shall appoint two members from the public at large, one upon the recommendation of the Speaker of the House of Representatives pursuant to G.S. 120-121, and one upon the recommendation of the President Pro Tempore of the Senate pursuant to G.S. 120-121.

Public members may not be employed in State government and may not be directly involved in fire fighting or rescue services.

(b) Of the members initially appointed by the Commissioner, the nominees of the North Carolina State Firemen's Association and the nominees of the North Carolina Association of Fire Chiefs and the nominees of the Professional Firefighters of North Carolina Association and of the North Carolina Association of Rescue and Emergency Medical Services, Inc., shall serve three-year terms; the nominees from the North Carolina Society of Fire Service Instructors, the North Carolina Association of County Fire Marshals, and the North Carolina Fire Marshal's Association shall serve two-year terms; and the mayor or other elected city official,

the county commissioner, and the member from the public at large shall serve one-year terms. The Governor's initial appointee shall serve a three-year term. The General Assembly's initial appointees shall serve two-year terms. Thereafter all terms shall be for three years.

(c) Vacancies shall be filled by the original appointer in the same manner as the original appointment was made, except that vacancies in the appointments made by the General Assembly shall be filled in accordance with G.S. 120-122.

(d) Appointed members shall serve until their successors are appointed and qualified.

(e) The following State officials, or their designees, shall serve by virtue of their offices as nonvoting members of the Commission: the Commissioner of Insurance, the Commissioner of Labor, the Attorney General, the Secretary of Crime Control and Public Safety, the Secretary of Environment, Health, and Natural Resources, and the President of the Department of Community Colleges.

(f) Members of the Commission shall receive per diem and necessary travel and subsistence allowances in accordance with the provisions of G.S. 138-5 or G.S. 138-6, as appropriate."

Section 2. This act is effective when it becomes law.

In the General Assembly read three times and ratified this the 20th day of May, 1997.

s/ Dennis A. Wicker
President of the Senate

s/ Harold J. Brubaker
Speaker of the House of Representatives

s/ James B. Hunt, Jr.
Governor

Approved 4:35 p.m. this 29th day of May, 1997

To: Members of the Insurance Commitee

From: M. Lynn Marshbanks, Committee Counsel

Re: Effect of House Bill 312 on Annuities or Life Insurance Contracts

Walter James, a life actuary at the Department of Insurance, sent the following information:

"NCGS 8-46 exhibits the life expectancy for a given individual, e.g., an individual who is age 60 has a life expectancy of 21.1 years.
NCGS 8-47 exhibits the present value of $1 paid at the end of a given number of years discounted at 6%.

Neither of these tables would be used by insurance companies to price annuities or to establish reserves for annuities.

The two tables work together to establish a single sum that is paid now. For example, an individual currently age 36 has a life expectancy of 42 years. If this individual had been accidently killed, then this person's annual income is lost. Also, the individual's defined benefit pension benefits would also most likely be lost or the surviving spouse may receive the individual's accrued benefit. The surviving spouse would be actuarially entitled to the individual's lost income, say $10,000, for the person's life expectancy of 42 years. Instead of paying the surviving spouse $10,000 per year for 42 years, a commuted value of $152,250 could be paid now ($10,000 x 15.225) - see NCGS 8-47. $152,250 is the actuarial equivalent of $10,000 paid per year at the end of each year and discounted at 6%.

Again, these tables would not be used by insurers to price annuities. Insurers would most likely use the 1983 "a" annuity mortality table or a more recent annuity mortality table released by the Society of Actuaries or the NAIC, and then modify these tables to reflect their own experience or at least to factor out the conservatism within the aforementioned tables. The aforementioned tables are mortality tables used to establish reserves and as such contain an element of conservatism.

I am an Associate of the Society of Actuaries, a Member of the American Academy of Actuaries and a Fellow of the Conference of Consulting Actuaries."

H312-SMRS-002

North Carolina General Assembly
Legislative Services Office

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(919) 733-7044

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16 W. Jones Street
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(919) 733-2578

May 14, 1997

MEMORANDUM

To: Senate Committee on Pensions & Retirement and Insurance

From: M. Lynn Marshbanks, Committee Counsel

Re: House Bill 312: Update Mortality Tables

House Bill 312 would update the mortality tables (currently called "mortuary tables") in G.S. 8-46, which list life expectancies for persons of any age from birth to 109. Courts may use the information in the mortality tables, along with the health and habits of a person, to determine a person's life expectancy. The mortality tables are only evidence of life expectancy; they are not conclusive. The bill increases the life expectancy for each age, and sets the last entry at "85 and over", rather than listing each age up to 109. The tables were last updated in 1971, and before that, in 1955.

There are other technical changes, including changing the designation "mortuary tables" to "mortality tables" in two other statutes that refer to the tables in G.S. 8-46: (1) G.S. 8-47, (establishing the present worth or cash value of an annuity payable annually during the annuitant's life), and (2) G.S. 46-25, (establishing the value of the life estate portion of a sale of timber on land subject to a life estate).

Effective date: When it becomes law.

H312-SMRS-002

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

North Carolina General Assembly
Legislative Services Office

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March 31, 1997

V

The Honorable Mary Jarrell and Joanne Bowie
North Carolina House of Representatives
Legislative Building
Raleigh, North Carolina 27601-1096

Re: Actuarial/Fiscal Note (House Bill 391)
City of High Point Firemen's Pension and Disability Fund

Dear Representatives Jarrell and Bowie:

In accordance with North Carolina General Statute 120-114 and applicable Rules of the North Carolina Senate and House of Representatives, we hereby submit an Actuarial/Fiscal Note on the following: The present law provides that any full time paid member of the City of High Point Fire Department must have reached the age of 60 in order to receive a monthly benefit from the City of High Point Firemen's Pension and Disability Fund. This change would allow any member of the City of High Point Fire Department to receive a monthly benefit from the City of High Point Firemen's Pension and Disability Fund, regardless of age, if they are retired from the Local Governmental Employees' Retirement System.

A reliable estimate of the financial and actuarial effects of the foregoing proposal is as follows: The City of High Point Firemen's Pension and Disability Fund is financed by the transfer of funds including investment income in excess of $15,000 from the Firemen's Local Relief Fund on a annual money-purchase basis. Since the total amount of benefits payable from the Fund each year is limited to the amount of its assets, the Fund is supported on a pay-as-you-go basis,.

Actuarial Endorsement:

Charles W. Dunn
Consulting Actuary
Dilts, Umstead & Dunn
Durham, North Carolina

Sincerely,

Stanley Moore
Fiscal Analyst
Fiscal Research Division

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

ACTUARIAL NOTE
True & Exact Copy of Original
Certified By: Stanley Moore **Date:** 3-31-97
Legislative Fiscal Research

North Carolina General Assembly
Legislative Services Office

George R. Hall, Legislative Services Officer
(919) 733-7044

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March 31, 1997

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North Carolina House of Representatives
Legislative Building
Raleigh, North Carolina 27601-1096

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Actuarial Endorsement:

Charles W. Dunn
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Durham, North Carolina

Sincerely,

Stanley Moore
Fiscal Analyst
Fiscal Research Division

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

ACTUARIAL NOTE
True & Exact Copy of Original
Certified By: Stanley Moore **Date:** 3-31-97
Legislative Fiscal Research

VISITOR REGISTRATION SHEET

Pensions & Retirement — 5-14-97

Name of Committee — Date

VISITORS: Please sign below and return to Committee Clerk.

NAME	FIRM OR STATE AGENCY AND ADDRESS
LANE Wharton	Bode, Call & Stroup
Monroe Buchanan	Repl. 46 Dist.
Susan Valauri	Nationwide
Alan Wilson	Barley & Downer
Stan Wilson	Wells Fargo
David Andrews	PTFA
Robert PASchal	Young, Moore & Henderson
Bill Scoggin	NCBA
Harry Kaplan	
[illegible]	
Jill Miller	NCATL
Naomi Long	PCC Student LCC-97
Jackson Elliott	Piedmont Community College LCC-97
Sandra Warren	PCC LCC-97
Jane Dustin	PCC LCC-97
[illegible] Ford	LCC 97
Mary Jo Henderson	PCC-LCC 96
Deloris M Rose	PCC - LCC 97
Debra Sanders	Piedmont Community College LCC-97
Robert Rose	Jordan Price Wall
Eugene Hafer	CAPIA

5/14

VISITOR REGISTRATION SHEET

Name of Committee | Date

VISITORS: Please sign below and return to Committee Clerk.

NAME	FIRM OR STATE AGENCY AND ADDRESS
JOHN CAHILL	GREENSBORO NEWS & RECORD
Andy Ellen	NC Farm Bureau
John Burdick	206 Alley PA
Larry Pearrell Jr.	N.C. Retired School Personnel
H.C. Dawson	" " " "
Marcia Smith	NCSEPS

Pensions & Retirement/ Insurance Committee Meeting
Sen. Jenkins, Chairman
May 21,1997
10:00

Agenda

HB 1024
Rep. Hurley

SB 1029
Sen. Miller

HB 1115
Rep. Boyd-McIntyre

Pension & Retirement/ Insurance Committee Meeting

MINUTE

The Pensions & Retirement/ Insurance Committee met May 21, 1997 at 10:00 in room 1124 of the Legislative Building. There were eleven members in attendance, including Sen. Jenkins who presided. Action was taken on the following bills:

HB 1024 **Foreign Insurer Licensing.** The bill was explained Rep. Hurley. Ruffin Bailey, Bailey & Dixon, gave further explanation. Sen. Reeves sent forth an amendment which was accepted and rolled into a committee substitute. Sen. Larry Shaw moved for an unfavorable as to original bill, but favorable as to committee substitute. The motion carried.

SB 1029 **Insolvent Insurer Revenue Bonds**. The bill was explained by Sen. Miller. Sen. Soles sent forth an amendment that was approved and rolled into a committee substitute. George Teague, NC Insurance Guaranty Association spoke regarding the bill. Sen. Kincaid moved for an unfavorable as to the original bill, but favorable as to committee substitute. The motion carried.

The meeting was adjourned.

Sen. Jenkins, Chairman

Katy Haynes, Clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

PENSIONS & RETIREMENT/ INSURANCE COMMITTEE REPORT
Senator Tommy Jenkins, Chairman

Thursday, May 22, 1997

SENATOR TOMMY JENKINS,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO C.S. BILL

H.B. **1024** Foreign Insurer Licensing

Draft Number:	PCS2332
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

S.B. **1029** Insolvent Insurer Revenue Bonds

Draft Number:	PCS6683
Sequential Referral:	Finance
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 2

Committee Clerk Comment: None

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

S 2

SENATE BILL 1029
Pensions & Retirement and Insurance Committee Substitute Adopted 5/22/97

Short Title: Insolvent Insurer Revenue Bonds. (Public)

Sponsors:

Referred to: Finance.

April 21, 1997

A BILL TO BE ENTITLED

AN ACT TO PROVIDE REVENUE BOND FUNDING FOR THE PAYMENT OF NATURAL DISASTER CLAIMS UNDER POLICIES OF INSOLVENT INSURERS.

The General Assembly of North Carolina enacts:

Section 1. The General Statutes are amended by adding a new Chapter to read:

"Chapter 159J.

"Insurance Guaranty Association Bond Act.

"**§ 159J-1. Short title.**

This Chapter shall be known and cited as the North Carolina Insurance Guaranty Association Bond Act.

"**§ 159J-2. Definitions.**

The following definitions apply in this Chapter.

(1) Association. -- The North Carolina Insurance Guaranty Association created under G.S. 58-48-25, or any successor of that association.

(2) Bonds. -- Bonds, notes, or other obligations issued by the State under this Chapter.

(3) Covered claim. -- A covered claim, as defined in G.S. 58-48-20, to be paid from the issuance of bonds under this Chapter in the event of insolvencies as described in G.S. 58-48-35(c).

(4) 'Natural disaster' means any hurricane, tornado, storm, flood, high water, wind-driven water, tidal wave, tsunami, earthquake, volcanic

eruption, landslide, mudslide, snowstorm, ice storm, drought, fire, explosion, civil disturbance, or other catastrophe which causes or may cause substantial damage or injury to property.

"§ 159J-3. Authorization of bonds.

The State may issue bonds in an amount not to exceed the ability of the Association to repay the bond indebtedness from assessments assessed pursuant to G.S. 58-48-35(a)(3) and G.S. 58-48-35(c) to fund with the proceeds of the bonds a loan to the Association in accordance with the provisions of the bond documents under which the bonds are issued. The Association shall expend the loan funds for the purpose of paying to claimants or policyholders covered claims arising through an insolvency that results in whole or in part from a natural disaster. Any bonds issued by the State under this Chapter may all be payable from and secured by moneys received by or on behalf of the State from assessments levied under G.S. 58-48-35(c), and assigned and pledged under G.S. 58-48-35(c), to or on behalf of the State for the benefit of the holders of the bonds. The funds, credit, property, and taxing power of the State shall not be pledged for the payment of the bonds.

"§ 159J-4. Review by Commissioner of Insurance.

Before bonds may be issued under this Chapter to pay covered claims, the Commissioner of Insurance must recommend the amount of unpaid covered claims to be paid from the bond issuance. In making this recommendation, the Commissioner shall review whether the amount of assessments proposed by the Association could service repayment of the bond indebtedness and whether the insurers have the ability to pay the assessments to be levied.

"§ 159J-5. Conditions for issuance of bonds and notes.

For the purpose of providing money to fund loans authorized by this Chapter, the State may issue from time to time negotiable bonds and notes in accordance with the following terms:

(1) The State shall establish a repayment schedule to be made under a loan agreement. The repayments shall be in such amounts as will be at least sufficient, together with other funds available therefor, to pay the principal of, and interest on, bonds and notes issued under this Chapter and as may be necessary for the State to maintain a reserve for debt service. The State may collect a reasonable administrative fee in addition to the repayment schedule in an amount as may be set forth in the loan agreement.

(2) The annual repayment schedule for each loan shall be:

a. In cases prior to the funding of the loans or in which the loans have been financed on a interim basis other than by bonds, an estimated annual repayment schedule showing debt service requirements under the loan agreement as if the bonds to be issued to fund the loans will bear interest at a rate per annum and mature in the manner the State establishes at the time of the approval of each loan.

b. In cases in which bonds have been issued to fund the loans, the actual debt service requirements on the bonds.

(3) The State shall not authorize the issuance of bonds under this Chapter for loans until it has determined that the Association has the ability to repay the amount loaned.

"§ 159J-6. Administration of loans; rules.

The Department of Administration shall administer loans made under this Chapter. The Department of Administration shall establish prerequisites that must be fulfilled by the Association in order to be eligible for a loan, procedures to be followed in making loan applications to the State, procedures to be followed in the disbursement of loan funds, and procedures for enforcing loan agreements entered into by the Association with the State. The Department of Administration may adopt rules to implement this Chapter.

"§ 159J-7. Loan agreements.

A loan agreement may include any provisions agreed upon by the State and the Association and shall include, in substance, the following:

(1) The amount of the loan as determined by the State.

(2) An agreement by the Association to:

a. Proceed expeditiously with the complete payment of the covered claims in accordance with the loan agreement.

b. Pledge any assessments and make payments according to the repayment schedule established by the State.

c. Establish and maintain adequate financial records for the payment of covered claims, have an annual audit made of the financial records and transactions covering each fiscal year in accordance with generally accepted accounting principles, and furnish a copy of the audits to the State Treasurer.

"§ 159J-8. Approval of agreements; audits.

All loan agreements entered into pursuant to this Chapter must be approved by the State Treasurer. The form of all loan agreements entered into pursuant to this Chapter must be approved by the Attorney General. The funding of all payments made pursuant to loan agreements entered into pursuant to this Chapter must be approved by the Department of Administration and the Council of State in amounts consistent with the loan amount; these payments may be audited at any time.

"§ 159J-9. Requirements and procedure.

(a) Nature of Bonds. -- The bonds authorized under this Chapter are revenue bonds as if issued pursuant to Article 5 of Chapter 159 of the General Statutes; the procedures, power, and conditions described in Article 5 apply to bonds under this Chapter, except where inconsistent with this Chapter. The bonds and notes for covered claims payment shall be authorized by resolution issued by the Department of Administration, may be in one or more series, shall bear such date or dates, and shall mature at such time or times, in the case of any note or any renewals thereof, not exceeding eight years after the date of issue of the original note, and in the case

of any bond, not exceeding 30 years after the date of issue, as the resolution may provide.

The bonds and notes shall bear interest at such rate or rates, be in such denominations, be in such form, either coupon or registered, carry such registration privileges, be executed in such manner, be payable in such medium of payment at such place or places, and be subject to such terms of redemption as the resolution may provide.

The bonds and notes may be sold at public or private sale, at any price or prices the State may provide.

(b) Resolution. -- A resolution authorizing any bonds or notes, or any series thereof, may contain the following provisions, which shall be part of the contract with the holders thereof:

(1) Pledging all or any part of the moneys which the State is permitted by law to pledge, and securing the payment of the bonds or notes or of any series thereof, subject to any agreements with bondholders or noteholders that then exist.

(2) Creating and establishing any funds and accounts considered necessary or advisable, setting aside reserves or sinking funds, and agreeing as to the maintenance, regulation, and disposition thereof.

(3) Limiting the issuance of additional bonds or notes, the terms upon which additional bonds or notes may be issued and secured, and the refunding of outstanding or other bonds or notes.

(4) Prescribing the procedure, if any, by which the terms of any contract with bondholders or noteholders may be amended or abrogated, the amount of bonds or notes the holders of which must consent thereto, and the manner in which the consent may be given.

(5) Investing in a trustee or trustees any property, rights, powers, and duties in trust as the State may determine, which may include any or all of the rights, powers, and duties of the trustee appointed by bondholders, and limiting or abrogating the right of the bondholders to appoint a trustee or limiting the rights, powers, and duties of the trustee.

(6) Setting forth any other matters that in any way affect the security or protection of the bonds or notes.

(c) Purchase. -- The State, subject to any agreements with bondholders or noteholders as may then exist, shall have power to purchase bonds or notes out of any moneys available therefor at a price not exceeding the redemption price then applicable, plus accrued interest to the next interest payment date thereon, if the bonds or notes are then redeemable. All bonds and notes so purchased shall be canceled.

(d) Personal Liability. -- Neither the State nor any person executing the bonds or notes shall be liable personally on the bonds or notes or be subject to any personal liability or accountability by reason of the issuance thereof.

(e) Pledge. -- Any pledge made by the State pursuant to this Chapter shall be valid and binding from the time when the pledge is made. The moneys or property so pledged and thereafter received by the State shall immediately be subject to the lien of the pledge without any physical delivery thereof or further act and the lien of the pledge shall be valid and binding as against all parties having claims of any kind in tort, contract, or otherwise, against the State, irrespective of whether the parties have notice thereof. Neither the resolution nor any other instrument of which a pledge is created must be recorded.

Bonds and notes of the State shall not constitute a debt or a pledge of the faith and credit of the State or a local governmental unit, and the holders or owners of the bonds and notes shall have no right to have taxes levied by the General Assembly or any local governmental unit or any other taxing authority within the State for the payment of the principal of, premium, if any, and interest on, any bonds and notes; the bonds and notes shall be payable solely from the assessments pledged for their payment. Except as may otherwise be expressly provided by the State, each issue of its bonds or notes issued pursuant to this Chapter shall be limited special obligations of the State, payable solely from and secured solely by moneys derived by the State from all or a portion of payments made pursuant to the loan agreement with the Association as provided in the resolution authorizing such bonds and notes.

All bonds and notes shall contain on their face a statement to the effect that the bonds or notes, as the case may be, are not a debt of the State, any local governmental unit, or any other taxing authority, but are payable solely from the assessments pledged for their payment.

(f) Validity. -- The bonds and notes shall not be invalid for any irregularity or defect in the proceedings for their issuance or sale. The bonds and notes shall contain a recital that they have been authorized and issued pursuant to the laws of the State, including particularly this Chapter, which recital shall be conclusive evidence of their validity and the regularity of their issuance.

(g) Refunding Bonds. -- The refunding bonds shall be sold and the proceeds applied to the purchase, redemption, or payment of the bonds to be refunded.

(h) Default. -- If the State defaults in the payment of principal of or interest and premium, if any, on the bonds or notes, the determination of the default and the remedies therefor shall be governed by this Chapter.

"§ 159J-10. North Carolina Insurance Guaranty Association Fund.

(a) The Department of Administration shall establish a special trust fund of the State to be known as the 'North Carolina Insurance Guaranty Association Fund'.

(b) The State covenants and agrees that after the issuance of any bonds or notes under this Chapter, moneys derived by the State from payments made pursuant to loan agreements with the Association as permitted under the terms of the loan agreements which are pledged to the payment of the bonds or notes shall be paid into the particular fund established for the issuance of bonds or notes to which the moneys are pledged.

These moneys shall be accounted for separately from all other moneys in the treasury and shall be applied by the State solely for the purpose of paying principal

of and interest and premium, if any, on the bonds and notes issued pursuant to this Chapter, refunding moneys due to the Association where appropriate, and paying all other costs incidental to the administration of the State in connection with the loan agreements and the issuance of the bonds and notes.

"§ 159J-11. Powers of the State.

The State has the right, in addition to all other rights, by mandamus or other suit, action, or proceeding in any court of competent jurisdiction, to require the Association and the board of directors and any proper officer, agent, or employee of the Association to carry out any agreements and to perform its and their duties under this Chapter or any rule adopted pursuant to this Chapter.

"§ 159J-12. Relationship with other laws.

This Chapter is supplemental to any other law providing for financing by the Association and does not amend or repeal any other law. Notwithstanding any other provision of law, no proceedings by the Association are required for loan agreements under this Chapter, except as provided by this Chapter. Any requirements or restrictions applicable to borrowing by the Association contained in any other law do not apply to loans under this Chapter."

Section 2. G.S. 58-48-35 is amended by adding a new subsection to read:

"(c) In the event of an insolvency caused in whole or in part by a natural disaster, as defined in Chapter 159J of the General Statutes, resulting in covered claims payable by the Association in excess of its capacity to pay from assessments under subdivision (a)(3) of this section, the Association, in its sole discretion, may by resolution request the State to issue bonds, notes, or both pursuant to Chapter 159J of the General Statutes, in amounts the Association considers necessary to provide funds for the payment of covered claims and expenses related to the claims. The amount of the bond issuance may be limited by Chapter 159J of the General Statutes, and the State has the final authority to determine the total amount of the bond issuance including issuance costs. When the Association and the State agree that bonds or notes shall be issued to pay covered claims in the event of an insolvency caused in whole or in part by a natural disaster, the Association may annually assess member insurers for amounts necessary to secure and provide for the repayment of the indebtedness, including, without limitation, the principal, redemption premium, if any, and interest on, and related costs of, issuance of the indebtedness, including bond investors insurance. Necessary assessments collected pursuant to this subsection shall be collected under the same procedures provided in subdivision (a)(3) of this section. Assessments collected under this section may be assigned and pledged to or on behalf of the State for the benefit of the holders of the indebtedness, in order to provide for the payment of the principal of, redemption premium, if any, and interest on the indebtedness, the costs of issuance, and funding of any reserves and any other payments under the documents under which the indebtedness was incurred. In addition to the assessments provided for in this subsection, the Association in its sole discretion may utilize assessments made under subdivision (a)(3) of this section to service the indebtedness, if necessary. The Association is not obligated to pay covered claims solely from the proceeds of bonds or notes issued under Chapter 159J,

except that if the Association makes assessments under this section for the covered claims, and assigns and pledges the assessments to or on behalf of the State as issuer of the indebtedness for the benefit of the holders of bonds or notes, the Association may administer the covered claims and present valid covered claims for payment."

Section 3. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
1997 SESSION

S.L. 1997-179
HOUSE BILL 1024

AN ACT TO ALLOW FOR THE LICENSING OF CERTAIN SUBSIDIARIES OF INSURERS OWNED OR CONTROLLED BY FOREIGN GOVERNMENTS.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-16-20 reads as rewritten:

"**§ 58-16-20. Company owned or controlled by ~~alien~~ foreign government prohibited from doing business.**

(a) Any insurance company or other insurance entity ~~which~~ that is ~~financially~~ owned or ~~financially~~ controlled by any ~~alien or~~ foreign government outside the continental limits of the United States or the territories of the United States is ~~hereby~~ prohibited from doing any kind of insurance business in the State of North Carolina. For the purposes of this section, ~~the term 'alien or foreign~~ 'foreign government' ~~is defined to mean~~ means any foreign government or any state, province, municipality, or political subdivision of any foreign government, and shall not be construed to apply to any insurance company organized under the laws of a foreign nation ~~which~~ that is ~~financially~~ owned or ~~financially~~ controlled by the private citizens or private business interest of ~~such~~ that foreign nation.

(b) The Commissioner ~~is hereby forbidden to grant a~~ shall not license ~~to~~ any insurance company or other insurance entity ~~which~~ that is ~~financially~~ owned or ~~financially~~ controlled by any ~~alien or~~ foreign government outside the continental limits of the United States or the territories of the United States, ~~or to~~ nor shall the Commissioner authorize any such company or entity to transact any kind of insurance business in the State of North Carolina.

(c) Any insurance company or other insurance entity ~~which~~ that is ~~financially~~ owned or ~~financially~~ controlled by any ~~alien or~~ foreign government outside the continental limits of the United States or the territories of the United States, or any representative or agent of any such company or entity ~~which~~ that violates the provisions of this section, ~~shall be~~ is guilty of a Class 3 misdemeanor.

(d) This section does not apply to the operating subsidiary of any insurance company or other insurance entity, where the company or entity is owned or controlled by any foreign government outside the continental limits of the United States or the territories of the United States, as long as the operating subsidiary is domesticated in and licensed by another state of the United States as an insurer or reinsurer and as a separate subsidiary."

Section 2. This act becomes effective October 1, 1997, and applies to acts committed and applications for licensure submitted on or after that date.

In the General Assembly read three times and ratified this the 2nd day of June, 1997.

s/ Dennis A. Wicker
President of the Senate

s/ Harold J. Brubaker
Speaker of the House of Representatives

s/ James B. Hunt, Jr.
Governor

Approved 3:39 p.m. this 12th day of June, 1997

North Carolina General Assembly
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May 21, 1997

MEMORANDUM

To: Senate Committee on Pensions & Retirement and Insurance

From: M. Lynn Marshbanks, Committee Counsel

Re: Senate Bill 1029: Insolvent Insurer Revenue Bonds

Senate Bill 1029 would provide for the State to issue revenue bonds for the payment of covered claims against insurers who are rendered insolvent because of a natural disaster, where the claims exceed the capacity of the N.C. Insurance Guaranty Association. The bond proceeds and assessments of member insurers would fund a loan to the Association, to pay the covered claims. Before bonds could be issued, the Commissioner would have to recommend the amount of uncovered claims to be paid from the bond issuance. The Department of Administration would administer loans, including establishment of prerequisites to be fulfilled by the Association to be eligible for a loan. The State Treasurer would have to approve all loan agreements, and the Attorney General would have to approve the form of all loan agreements. The Department of Administration and the Council of State would have to approve the funding of payments made under loan agreements. The bonds would not constitute a debt or a pledge of the faith and credit of the State or a local governmental unit, and the holders or owners of the bonds would have no right to have taxes levied by the General Assembly or any local governmental unit for payment of bond principal or interest.

The bill would establish a special trust fund known as the "North Carolina Insurance Guaranty Association Fund". The money in that fund would be used solely to pay principal and interest on the bonds issued.

Effective date: When bill becomes law.

S1029-SMRS-001

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

North Carolina General Assembly
Legislative Services Office

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May 21, 1997

MEMORANDUM

To: Senate Committee on Pensions & Retirement and Insurance

From: M. Lynn Marshbanks, Committee Counsel

Re: House 1024: Foreign Insurer Licensing

House 1024 would allow some subsidiaries of foreign insurance companies to be licensed in North Carolina. Currently, no insurance entity that is financially owned or controlled by a foreign government may do business in this state. This bill would allow an operating subsidiary of such an insurance company to be licensed in North Carolina if the subsidiary is domesticated in and licensed by another state as an insurer or reinsurer and as a separate subsidiary.

Effective date: October 1, 1997, applying to acts committed and applications for licensure submitted on or after that date.

H1024-SMRS-001

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

VISITOR REGISTRATION SHEET

Pen & Pat. Committee — 5-21-97

Name of Committee — Date

VISITORS: Please sign below and return to Committee Clerk.

NAME	FIRM OR STATE AGENCY AND ADDRESS
John J. Justice	Intergen Corp
Amy Hunkin	Hunton & Williams
Bob Hall	Dept. State Treas.
Mark Edens	Morris & Van Allen
Rachel Payne	NC DOI
Susan Valenti	Nationwide
Robert Pascal	Young Moore
Robert Pinson	Jordan Price Wall
Benny Gupta	NSPFRA
Alan Miller	Bailey & Dixon LLP
Griffin Bailey	Brooks & Pierce LLP
John Jordan	Jordan, Price
Paul Morgan	NFIB
John Bowdish	Zeke Alley P.A.
Mark Gale	NCDOI
Sheila M. McKenney	NC DOI
Darrell Propst	NC DOI
Amy Jo Bain	Smith Anderson
Evelyn Hutchinson	NCHA
Dan Hudson	NCPA
Susan Hagan	CAFIA

VISITOR REGISTRATION SHEET

Name of Committee

Date

VISITORS: Please sign below and return to Committee Clerk.

NAME	FIRM OR STATE AGENCY AND ADDRESS
David Anders	AFENC
Paul Smith	PFENC
Archibald E. Claud	YCALY

Pensions & Retirement Committee Meeting
June 4,1997
10:00
1124 LB
Sen. Tommy Jenkins, chairman

AGENDA

HB 5 Health Coverage/Diabetes
Rep. Aldridge

HB 1052 Permit Exclusion of Excess Coverage
Rep. Miller

HB 115 Church Insurance Coverage
Rep. Boyd-Intyre

Pensions & Retirement/ Insurance Committee Meeting

MINUTES

The Pensions & Retirement/ Insurance committee met June 4,1997 at 10:00 in room 1124 of the Legislative Building. There were sixteen members in attendance including Sen. Jenkins, who presided.

HB 5 **Health Coverage/ Diabetes.** Rep. Alldridge explained the bill. John Bowdish, Diabetes Association, spoke for the bill. Sen. Kincaid sent forth an amendment . He later withdrew the proposed amendment. Some technical changes were needed as pointed out by staff person, Linwood Jones. Sen. Weinstein sent forth an amendment to address the changes which were rolled into a committee substitute. Sen. Weinstein moved for a favorable report. The motion carried.

Sen. Jenkins, Chairman

Katy Haynes, Clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

PENSIONS & RETIREMENT/ INSURANCE COMMITTEE REPORT
Senator Tommy Jenkins, Chairman

Thursday, June 05, 1997

SENATOR TOMMY JENKINS,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 1,
BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

H.B.(CS #1)5 Health Coverage/Diabetes

Draft Number:	PCS7324
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 1

Committee Clerk Comment: None

GENERAL ASSEMBLY OF NORTH CAROLINA
1997 SESSION

S.L. 1997-225
HOUSE BILL 5

AN ACT TO REQUIRE CERTAIN COVERAGE FOR DIABETES IN HEALTH AND ACCIDENT INSURANCE POLICIES, IN HOSPITAL OR MEDICAL SERVICES PLANS, AND IN HMO PLANS.

The General Assembly of North Carolina enacts:

Section 1. Article 51 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-51-61. Coverage for certain treatment for diabetes.**

(a) Every policy or contract of accident or health insurance, and every preferred provider contract, policy, or plan as defined and regulated under G.S. 58-50-50 and G.S. 58-50-55, that is issued, renewed, or amended on or after October 1, 1997, shall provide coverage for medically appropriate and necessary services, including diabetes outpatient self-management training and educational services, and equipment, supplies, medications, and laboratory procedures used to treat diabetes. Diabetes outpatient self-management training and educational services shall be provided by a physician or a health care professional designated by the physician. The insurer shall determine who shall provide and be reimbursed for the diabetes outpatient self-management training and educational services. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the policy, contract, or plan shall apply to the diabetes coverage required under this section.

(b) For the purposes of this section, 'physician' is a person licensed to practice in this State under Article 1 or Article 7 of Chapter 90 of the General Statutes."

Section 2. Article 65 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-65-91. Coverage for certain treatment of diabetes.**

(a) Every insurance certificate or subscriber contract under any hospital service plan or medical service plan governed by this Article and Article 66 of this Chapter, and every preferred provider contract, policy, or plan as defined and regulated under G.S. 58-50-50 and G.S. 58-50-55, that is issued, renewed, or amended on or after October 1, 1997, shall provide coverage for medically appropriate and necessary services, including diabetes outpatient self-management training and educational services, and equipment, supplies, medications, and laboratory procedures used to treat diabetes. Diabetes outpatient self-management training and educational services shall be provided by a physician or a health care professional designated by the physician. The hospital or medical service plan shall determine who shall provide and be reimbursed for the diabetes outpatient self-management training and educational services. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the policy, contract, or plan shall apply to the diabetes coverage required under this section.

(b) For the purposes of this section, 'physician' is a person licensed to practice in this State under Article 1 or Article 7 of Chapter 90 of the General Statutes."

Section 3. Article 67 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-67-74. Coverage for certain treatment of diabetes.**

(a) Every health care plan written by a health maintenance organization and in force, issued, renewed, or amended on or after October 1, 1997, that is subject to this Article, shall provide coverage for medically appropriate and necessary services, including diabetes outpatient self-management training and educational services, and equipment, supplies, medications, and laboratory procedures used to treat diabetes. Diabetes outpatient self-management training and educational services shall be provided by a physician or a health care professional designated by the physician. The health maintenance organization shall determine who shall provide and be reimbursed for the diabetes outpatient self-management training and educational services. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the policy, contract, or plan shall apply to the diabetes coverage required under this section.

(b) For the purposes of this section, 'physician' is a person licensed to practice in this State under Article 1 or Article 7 of Chapter 90 of the General Statutes."

Section 4. Nothing in this act shall apply to specified accident, specified disease, hospital indemnity, or long-term care health insurance policies.

Section 5. The North Carolina Commission for Health Services shall develop voluntary standards or guidelines for diabetes outpatient self-management training and educational services based on clinical practice recommendations and guidelines established by the Center for Disease Control and the American Diabetes Association. These standards or guidelines are not subject to Article 2A of Chapter 150B of the General Statues.

Section 6. This act is effective when it becomes law.

In the General Assembly read three times and ratified this the 16th day of June, 1997.

s/ Dennis A. Wicker
President of the Senate

s/ Harold J. Brubaker
Speaker of the House of Representatives

s/ James B. Hunt, Jr.
Governor

Approved 4:00 p.m. this 26th day of June, 1997

North Carolina General Assembly
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June 4, 1997

MEMORANDUM

TO: Senate Pensions and Retirement and Insurance Committee

FROM: Linwood Jones, Staff Counsel

RE: House Bill 5 (Diabetes Coverage)

House Bill 5 requires insurers, Blue Cross, and HMOs to provide coverage for medically necessary and appropriate services for the treatment of diabetes, including outpatient self-management training for diabetics and educational services, equipment, supplies, medications, and lab procedures that are medically necessary and appropriate for the treatment of diabetes. The outpatient training and educational services must be provided by a physician or other health care professional designated by the physician. The insurer determines who is reimbursed for this training. The bill also requires that the same deductibles, copayments, and limitations appliable to other benefits under the policy apply to the required diabetes coverage.

The bill also requires the Commission for Health Services to develop voluntary standards for diabetes outpatient self-management training and educational services, based on the CDC and ADA (American Diabetes Association) guidelines. These guidelines will not be considered rules under the Administrative Procedures Act.

This bill takes effect when it becomes law and applies to policies issued or renewed on or after October 1, 1997. Policies that do not provide general health care benefits, such as specified disease and hospital indemnity policies, are excluded from the requirement.

H5-SMRN-001

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. _____

H. B. No. 5 DATE _____

S. B. No. _____ Amendment No. _____
(to be filled in by Principal Clerk)

COMMITTEE SUBSTITUTE _____

Rep.)
) _____
Sen.)

moves to amend the bill on page 1, line 8 - p. 2, line 4

( ) WHICH CHANGES THE TITLE

by deleting "and educational services wherever it appears in the bill.

Withdrawn

SIGNED _____

ADOPTED _____ FAILED _____ TABLED _____

GA-33-A

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. _____

H. B. No. 5 DATE _____

S. B. No. _____ Amendment No. _____
(to be filled in by Principal Clerk)

COMMITTEE SUBSTITUTE _____

Rep.)
) _____
Sen.)

moves to amend the bill on page 1, line 8 - p. 2, line 14

( ) WHICH CHANGES THE TITLE

by deleting "and educational services whenever it appears in the bill.

Withdrawn

SIGNED _____

ADOPTED _____ FAILED _____ TABLED _____

GA-33-A

PRINCIPAL CLERK'S OFFICE

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. _____

H. B. No. 5 DATE _____

S. B. No. _____ Amendment No. _____
(to be filled in by Principal Clerk)

COMMITTEE SUBSTITUTE _____

Rep.)
) _____
Sen.)

1 moves to amend the bill on page 1, line 2-7, 11-14
2 ( ) WHICH CHANGES THE TITLE
3 by deleting and adding the following
4
5 to read as appears in the bill
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Withdrawn

SIGNED _____

ADOPTED _____ FAILED _____ TABLED _____

GA-33-A

PRINCIPAL CLERK'S OFFICE

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. _____

H. B. No. _____ DATE _____

S. B. No. _____ Amendment No. _____
(to be filled in by Principal Clerk)

COMMITTEE SUBSTITUTE _____

Rep.)
) _____
Sen.)

1 moves to amend the bill on page _____, line _____
2 ( ) WHICH CHANGES THE TITLE
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SIGNED _____

ADOPTED _____ FAILED _____ TABLED _____

INSTITUTE OF GOV'T.

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. _____

H. B. No. _____ DATE _____

S. B. No. _____ Amendment No. _____
(to be filled in by
Principal Clerk)

COMMITTEE SUBSTITUTE _____

Rep.)
) _____
Sen.)

1 moves to amend the bill on page _____, line _____

2 ( ) WHICH CHANGES THE TITLE

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16 _____

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18 _____

19 _____

SIGNED _____

ADOPTED _____ FAILED _____ TABLED _____

GA-33-A

COMMITTEE CLERK

VISITOR REGISTRATION SHEET

Pen & Ret. — 6-4-97

Name of Committee — Date

VISITORS: Please sign below and return to Committee Clerk.

NAME	FIRM OR STATE AGENCY AND ADDRESS
Zeb Alley	ZDA PA
John Jackson	Blue Cross Corp
Debbie Moore	Diabetes Treatment Center
Tommy Worth	CHS
Anthony Ayers	Raleigh Endocrinology
John Bowdish	Zeb Alley P.A.
Ed Owens	American Diabetes Association
Robert Davis	Assn NC Hse Mgt. Cos
Anna Henderson	Hunton & Williams
Ken Wright	BCBSNC
Bill Wade	DOI
Starla H. McKenney	DOI
John McMillan	Manning Fulton & Skinner PA
Mari Auer	BMS
Alan Miles	Barley & Dixon LLP
Robt Pasichal	Young, Moore
Peter Anderson	DEHNR/DHP
Lucia Peel	NC Medical Society
Emily Hawthorne	NCHA
Tony Rapp	
Margaret Hoffa	CAPIA

VISITOR REGISTRATION SHEET

Name of Committee

Date

VISITORS: Please sign below and return to Committee Clerk.

NAME	FIRM OR STATE AGENCY AND ADDRESS
Otis Carter	Carter & Assoc
PAUL MAHONEY	NC HMO ASSOCIATION
DAVID Anders	PFPAC
Jon Carr	Jordan Price
David Simmons	ZDA, PA
LEIGHTON Cooper	"

PENSION & RETIREMENT/INSURANCE COMMITTEE

June 11,1997
10:00
Sen. Tommy Jenkins, Chairman

AGENDA

HB 434
Federal Health Insurance Changes/AB
Rep. Dockham

HB 1115
Church Insurance Coverage
Rep. Boyd-Intyre

Pensions & Retirement/Insurance Committee Meeting

MINUTES

The Pensions & Retirement/ Insurance committee met June 11,1997 at 10:00 in room 1124 of the Legislative Building. There were fourteen members attendance including Sen. Jenkins, who presided. Action was taken on the following bills:

HB 434 **Federal Health Insurance Changes/ AB.** Rep. Dockman explained the committee substitute bill and called upon Bill Hale, Dept. of Insurance and Linwood Jones, legal counsel to give further explanation. Sen. Wellons moved for an unfavorable as to original bill, but favorable as to committee substitute. The motion carried.

HB 1115 **Church Insurance Coverage.** Rep. Boyd-Intyre explained the bill. Sen Webster sent forth an amendment which was approved. Sen. Soles sent forth an amendment which was approved. Sen. Kincaid sent forth an amendment which was approved. The amendments were rolled into a committee substitute. Sen. Larry Shaw moved for an unfavorable as to original bill, but favorable to committee substitute. The motion carried.

The meeting was adjourned.

Sr. Jenkins, Chairman

Katy Haynes Clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

PENSIONS & RETIREMENT/ INSURANCE COMMITTEE REPORT
Senator Tommy Jenkins, Chairman

Thursday, June 12, 1997

SENATOR TOMMY JENKINS,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 1,
BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

H.B.(CS #1)**434** Federal Health Insurance Changes/AB

Draft Number:	PCS1397
Sequential Referral:	NONE
Recommended Referral:	NONE
Long Title Amended:	No

TOTAL REPORTED: 1

Committee Clerk Comment: None

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

PENSIONS & RETIREMENT/ INSURANCE COMMITTEE REPORT
Senator Tommy Jenkins, Chairman

Wednesday, July 30, 1997

SENATOR TOMMY JENKINS,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO SENATE C.S. BILL

H.B. **1115** Church Insurance Coverage

Draft Number:	PCS8253
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 1

Committee Clerk Comment: None

GENERAL ASSEMBLY OF NORTH CAROLINA
1997 SESSION

S.L. 1997-259
HOUSE BILL 434

AN ACT TO CONFORM NORTH CAROLINA HEALTH INSURANCE LAWS TO RECENTLY ENACTED FEDERAL LAWS CONCERNING HEALTH INSURANCE UNDERWRITING AND PORTABILITY, MATERNITY COVERAGE, AND COVERAGE FOR MENTAL ILLNESS.

The General Assembly of North Carolina enacts:

Section 1. Article 68 of Chapter 58 of the General Statutes is amended as follows:

(a) By repealing G.S. 58-68-1, 58-68-5, 58-68-10, 58-68-15, and 58-68-20.

(b) By rewriting the Article heading to read:

"~~North Carolina Health Insurance Trust Commission.~~
Health Insurance Portability and Accountability."

(c) By adding the following Part A and Part B:

"Part A. Group Market Reforms.

"Subpart 1. Portability, Access, and Renewability Requirements.

"**§ 58-68-25. Definitions; excepted benefits; employer size rule.**

(a) Definitions. -- In addition to other definitions throughout this Article, the following definitions and their cognates apply in this Article:

(1) 'Bona fide association'. -- With respect to health insurance coverage offered in this State, an association that:

a. Has been actively in existence for at least five years.

b. Has been formed and maintained in good faith for purposes other than obtaining insurance.

c. Does not condition membership in the association on any health status-related factor relating to an individual (including an employee of an employer or a dependent of an employee).

d. Makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to the members (or individuals eligible for coverage through a member).

e. Does not make health insurance coverage offered through the association available other than in connection with a member of the association.

f. Meets the additional requirements as may be imposed under State law.

(2) 'COBRA continuation provision'. -- Any of the following:

a. Section 4980B of the Internal Revenue Code of 1986, other than subdivision (f)(1) of the section insofar as it relates to pediatric vaccines.

items and services paid for as medical care) are provided, in whole or in part, through a defined set of health care providers under contract with the health insurer.

(14) 'Participant'. -- The meaning given the term under section 3(7) of the Employee Retirement Income Security Act of 1974.

(15) 'Placed for adoption'. -- The assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of adoption of the child. The child's placement with the person terminates upon the termination of the legal obligation.

(16) 'Small employer'. -- The meaning given to the term in G.S. 58-50-110(22).

(17) 'Small group market'. -- The health insurance market under which individuals obtain health insurance coverage, directly or through any arrangement, on behalf of themselves and their dependents through a group health insurance plan maintained by a small employer.

(b) Excepted Benefits. -- For the purposes of this Article, 'excepted benefits' means benefits under one or more or any combination of the following:

(1) Benefits not subject to requirements. --
   a. Coverage only for accident or disability income insurance or any combination of these.
   b. Coverage issued as a supplement to liability insurance.
   c. Liability insurance, including general liability insurance and automobile liability insurance.
   d. Workers' compensation or similar insurance.
   e. Automobile medical payment insurance.
   f. Credit-only insurance.
   g. Coverage for on-site medical clinics.
   h. Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

(2) Benefits not subject to requirements if offered separately. --
   a. Limited scope dental or vision benefits.
   b. Benefits for long-term care, nursing care, home health care, community-based care, or any combination of these.
   c. The other similar, limited benefits as are specified in federal regulations.

(3) Benefits not subject to requirements if offered as independent, noncoordinated benefits. --
   a. Coverage only for a specified disease or illness.
   b. Hospital indemnity or other fixed indemnity insurance.

(4) Benefits not subject to requirements if offered as separate insurance policy. -- Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act), coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code, and similar supplemental coverage provided to coverage under a group health insurance plan.

(c) Application of certain rules in determination of employer size. -- For the purposes of this Article:

(1) Application of aggregation rule for employers. -- All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer.

(2) Employers not in existence in preceding year. -- In the case of an employer that was not in existence throughout the preceding calendar year, the determination of whether the employer is a small or large employer shall be based on the average number of employees that it is reasonably expected the employer will employ on business days in the current calendar year.

(3) Predecessors. -- Any reference in this subsection to an employer shall include a reference to any predecessor of the employer.

"§ 58-68-30. Increased portability through limitation on preexisting condition exclusions.

(a) Limitation on Preexisting Condition Exclusion Period; Crediting for Periods of Previous Coverage. -- Subject to subsection (d) of this section, a group health insurer may, with respect to a participant or beneficiary, impose a preexisting condition exclusion only if:

(1) The exclusion relates to a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the enrollment date.

(2) The exclusion extends for a period of not more than 12 months, or 18 months in the case of a late enrollee, after the enrollment date.

(3) The period of any preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage, if any, applicable to the participant or beneficiary as of the enrollment date.

(b) Definitions. -- For the purposes of this Part:

(1) Preexisting condition exclusion. --

a. In general. -- 'Preexisting condition exclusion' means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for the coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before the date.

b. Treatment of genetic information. -- Genetic information shall not be treated as a condition described in subdivision (a)(1) of this subsection in the absence of a diagnosis of the condition related to the information.

(2) Enrollment date. -- With respect to an individual covered under a group health insurance plan, the date of enrollment of the individual in the coverage or, if earlier, the first day of the waiting period for the enrollment.

(3) Late enrollee. -- With respect to coverage under a group health insurance plan, a participant or beneficiary who enrolls under the plan other than during:

a. The first period in which the individual is eligible to enroll under the plan, or

b. A special enrollment period under subsection (f) of this section.

(4) Waiting period. -- With respect to a group health insurance plan and an individual who is a potential participant or beneficiary in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan.

(c) Rules Relating to Crediting Previous Coverage. --

(1) Creditable coverage defined. -- For the purposes of this Article, 'creditable coverage' means, with respect to an individual, coverage of the individual under any of the following:

a. A self-funded employer group health plan under the Employee Retirement Income Security Act of 1974.
b. Group or individual health insurance coverage.
c. Part A or part B of title XVIII of the Social Security Act.
d. Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928.
e. Chapter 55 of title 10, United States Code.
f. A medical care program of the Indian Health Service or of a tribal organization.
g. A State health benefits risk pool.
h. A health plan offered under chapter 89 of title 5, United States Code.
i. A public health plan (as defined in federal regulations).
j. A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. § 2504(e)).

'Creditable coverage' does not include coverage consisting solely of coverage of excepted benefits.

(2) Not counting periods before significant breaks in coverage. --

a. In general. -- A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a group health insurance plan, if, after the period and before the enrollment date, there was a 63-day period during all of which the individual was not covered under any creditable coverage.
b. Waiting period not treated as a break in coverage. -- For the purposes of sub-subdivision a. of this subdivision and subdivision (d)(4) of this subsection, any period that an individual is in a waiting period for any coverage under a group health insurance plan or is in an affiliation period shall not be taken into account in determining the continuous period under sub-subdivision a. of this subdivision.
c. Time spent on short term limited duration health insurance not treated as a break in coverage. -- For the purposes of sub-subdivision a. of this subdivision, any period that an individual is enrolled on a short term limited duration health insurance policy shall not be taken into account in determining the continuous period under sub-subdivision. a. of this subdivision so long as the period of time spent on the short term limited duration health insurance policy or policies does not exceed 12 months.

(3) Method of crediting coverage. --

a. Standard method. -- Except as otherwise provided under sub-subdivision b. of this subdivision for the purposes of applying subdivision (a)(3) of this subsection, a group health insurer shall count a period of creditable coverage without regard to the specific benefits covered during the period.
b. Election of alternative method. -- A group health insurer may elect to apply subdivision (a)(3) of this subsection based on coverage of benefits within each of several classes or

categories of benefits specified in federal regulations rather than as provided under sub-subdivision a. of this subdivision. This election shall be made on a uniform basis for all participants and beneficiaries. Under this election a group health insurer shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within the class or category.

c. Health insurer notice. -- In the case of an election under sub-subdivision b. of this subdivision with respect to health insurance coverage in the small or large group market, the health insurer: (i) shall prominently state in any disclosure statements concerning the coverage, and to each employer at the time of the offer or sale of the coverage, that the health insurer has made the election, and (ii) shall include in the statements a description of the effect of the election.

(4) Establishment of period. -- Periods of creditable coverage for an individual shall be established through presentation of certifications described in subsection (e) of this section or in another manner that is specified in federal regulations.

(d) Exceptions. --

(1) Exclusion not applicable to certain newborns. -- Subject to subdivision (4) of this subsection, a group health insurer shall not impose any preexisting condition exclusion in the case of an individual who, as of the last day of the 30-day period beginning with the individual's date of birth, is covered under creditable coverage.

(2) Exclusion not applicable to certain adopted children. -- Subject to subdivision (4) of this subsection, a group health insurer shall not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. The previous sentence does not apply to coverage before the date of the adoption or placement for adoption.

(3) Exclusion not applicable to pregnancy. -- A group health insurer shall not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition.

(4) Loss if break in coverage. -- Subdivisions (1) and (2) of this subsection shall no longer apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any creditable coverage.

(e) Certifications and Disclosure of Coverage. --

(1) Requirement for certification of period of creditable coverage. --

a. In general. -- A group health insurer shall provide the certification described in sub-subdivision b. of this subdivision: (i) at the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision, (ii) in the case of an individual becoming covered under a COBRA continuation provision, at the time the individual ceases to be covered under the COBRA continuation provision, and (iii) on the request on behalf of an individual made not later than 24

months after the date of cessation of the coverage described in clause (i) or (ii) of this sub-subdivision, whichever is later. The certification under clause (i) of this sub-subdivision may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision.

b. Certification. -- The certification described in this sub-subdivision is a written certification of: (i) the period of creditable coverage of the individual under the plan and any coverage under the COBRA continuation provision, and (ii) any waiting period and affiliation period, if applicable, imposed with respect to the individual for any coverage under the plan.

(2) Disclosure of information on previous benefits. -- In the case of an election described in sub-subdivision (c)(3)b. of this subsection by a group health insurer, if the health insurer enrolls an individual for coverage under the plan and the individual provides a certification of coverage of the individual under subdivision (1) of this subsection:

a. Upon request of the health insurer, the entity that issued the certification provided by the individual shall promptly disclose to the requesting plan or health insurer information on coverage of classes and categories of health benefits available under the entity's coverage.

b. The entity may charge the requesting plan or health insurer for the reasonable cost of disclosing the information.

(f) Special Enrollment Periods. --

(1) Individuals losing other coverage. -- A group health insurer shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of the employee if the dependent is eligible, but not enrolled, for coverage under the terms) to enroll for coverage under the terms of the plan if each of the following conditions is met:

a. The employee or dependent was covered under an ERISA group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent.

b. The employee stated in writing at the time that coverage under the group health plan or health insurance coverage was the reason for declining enrollment, but only if the health insurer required the statement at the time and provided the employee with notice of the requirement and the consequences of the requirement at the time.

c. The employee's or dependent's coverage described in sub-subdivision a.: (i) was under a COBRA continuation provision and the coverage under the provision was exhausted; (ii) was not under that provision and either the coverage was terminated because of loss of eligibility for the coverage, including legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment; or (iii) employer contributions toward the coverage were terminated.

d. Under the terms of the plan, the employee requests the enrollment not later than 30 days after the date of exhaustion of coverage described in sub-subdivision c.(i) of this subdivision or termination of coverage or employer contribution described in sub-subdivision c.(ii) of this subdivision.

(2) For dependent beneficiaries. --

a. In general. -- If: (i) a group health insurance plan makes coverage available with respect to a dependent of an individual, (ii) the individual is a participant under the plan (or has met any waiting period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period), and (iii) a person becomes the dependent of the individual through marriage, birth, or adoption or placement for adoption.

The plan shall provide for a dependent special enrollment period described in sub-subdivision b. of this subdivision during which the person (or, if not otherwise enrolled, the individual) may be enrolled under the plan as a dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if the spouse is otherwise eligible for coverage.

b. Dependent special enrollment period. -- A dependent special enrollment period under this sub-subdivision shall be a period of not less than 30 days and shall begin on the later of: (i) the date dependent coverage is made available, or (ii) the date of the marriage, birth, or adoption or placement for adoption described in sub-subdivision a.(iii) of this subdivision.

c. No waiting period. -- If an individual seeks to enroll a dependent during the first 30 days of the dependent's special enrollment period, the coverage of the dependent shall become effective: (i) in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received; (ii) in the case of a dependent's birth, as of the date of the birth; or (iii) in the case of a dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

(g) Use of Affiliation Period by HMO as Alternative to Preexisting Condition Exclusion. --

(1) In general. -- A health maintenance organization that does not impose any preexisting condition exclusion allowed under subsection (a) of this section with respect to any particular coverage option may impose an affiliation period for the coverage option, but only if:

a. The period is applied uniformly without regard to any health status-related factors.

b. The period does not exceed two months (or three months in the case of a late enrollee).

(2) Affiliation period. --

a. Defined. -- For the purposes of this Subpart, 'affiliation period' means a period that, under the terms of the health insurance coverage offered by the health maintenance organization, must expire before the health insurance coverage becomes effective. The health maintenance organization is not required to provide health care services or benefits during the period and no premium shall be charged to the participant or beneficiary for any coverage during the period.

b. Beginning. -- The period shall begin on the enrollment date.

c. Runs concurrently with waiting periods. -- An affiliation period under a plan shall run concurrently with any waiting period under the plan.

(3) Alternative methods. -- A health maintenance organization described in subdivision (1) of this subsection may use alternative methods, as approved by the Commissioner, from those described in that subdivision, to address adverse selection.

"**§ 58-68-35. Prohibiting discrimination against individual participants and beneficiaries based on health status.**

(a) In Eligibility To Enroll. --

(1) In general. -- Subject to subdivision (2) of this subsection, a group health insurer shall not establish rules for eligibility, including continued eligibility, of any individual to enroll under the terms of the health insurer's plan based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

a. Health status.

b. Medical condition (including both physical and mental illnesses).

c. Claims experience.

d. Receipt of health care.

e. Medical history.

f. Genetic information.

g. Evidence of insurability (including conditions arising out of acts of domestic violence).

h. Disability.

(2) No application to benefits or exclusions. -- To the extent consistent with G.S. 58-68-30, subdivision (1) of this subsection shall not be construed:

a. To require a group health insurance plan to provide particular benefits other than those provided under the terms of the plan, or

b. To prevent the plan from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled in the plan.

(3) Construction. -- For the purposes of subdivision (1) of this subsection, rules for eligibility to enroll under a plan include rules defining any applicable waiting periods for the enrollment.

(b) In Premium Contributions. --

(1) In general. -- A group health insurance plan shall not require any individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution that is greater

than the premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor in relation to the individual or to an individual enrolled under the plan as a dependent of individual.

(2) Construction. -- Nothing in subdivision (1) of this subsection shall be construed:

a. To restrict the amount that an employer may be charged for coverage under a group health insurance plan; or

b. To prevent a group health insurer from establishing premium discounts or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

"Subpart 2. Health Insurance Availability and Renewability.

"§ 58-68-40. Guaranteed availability of coverage for employers in the small group market.

(a) Issuance of Coverage in the Small Group Market. --

(1) In general. -- Subject to subsections (c) through (f) of this section, each health insurer that offers health insurance coverage in the small group market in this State:

a. Must accept every small employer that applies for the coverage; and

b. Must accept for enrollment under the coverage every eligible individual who applies for enrollment during the period in which the individual first becomes eligible to enroll under the terms of the group health insurance plan and shall not place any restriction that is inconsistent with G.S. 58-68-35 on an eligible individual being a participant or beneficiary.

(2) Eligible individual defined. -- For the purposes of this section, 'eligible individual' means, with respect to a health insurer that offers health insurance coverage to a small employer in the small group market, such an individual in relation to the employer as shall be determined:

a. In accordance with the terms of the plan,

b. As provided by the health insurer under rules of the health insurer that are uniformly applicable in this State to small employers in the small group market, and

c. In accordance with all applicable State laws governing the health insurer and the market.

(b) Special Rules for Network Plans. --

(1) In general. -- In the case of a health insurer that offers health insurance coverage in the small group market through a network plan, the health insurer may:

a. Limit the employers that may apply for coverage to those with eligible individuals who live, work, or reside in the service area for the network plan; and

b. Within the service area of the network plan, deny coverage to the employers if the health insurer has demonstrated to the Commissioner that: (i) it will not have the capacity to deliver services adequately to enrollees of any additional groups because of its obligations to existing group contract holders and enrollees, and (ii) it is applying this subdivision uniformly to all employers without regard to the claims

experience of those employers and their employees (and their dependents) or any health status-related factor relating to the employees and dependents.

(2) 180-day suspension upon denial of coverage. -- A health insurer, upon denying health insurance coverage in any service area in accordance with sub-subdivision (1)b. of this subsection, shall not offer coverage in the small group market within the service area for a period of 180 days after the date the coverage is denied.

(c) Application of Financial Capacity Limits. --

(1) In general. -- A health insurer may deny health insurance coverage in the small group market if the health insurer has demonstrated to the Commissioner that:

a. It does not have the financial reserves necessary to underwrite additional coverage; and

b. It is applying this subdivision uniformly to all employers in the small group market in the State consistent with this Chapter and without regard to the claims experience of those employers and their employees (and their dependents) or any health status-related factor relating to the employees and dependents.

(2) 180-day suspension upon denial of coverage. -- A health insurer upon denying health insurance coverage in accordance with subdivision (1) of this subsection shall not offer coverage in the small group market in the State for a period of 180 days after the date the coverage is denied or until the health insurer has demonstrated to the Commissioner that the health insurer has sufficient financial reserves to underwrite additional coverage, whichever is later. The Commissioner may apply this subsection on a service-area-specific basis.

(d) Exception to Requirement for Failure to Meet Certain Minimum Participation or Contribution Rules. --

(1) In general. -- Subsection (a) of this section does not preclude a health insurer from establishing employer contribution rules or group participation rules for the offering of health insurance coverage in connection with a group health insurance plan in the small group market, as allowed under this Chapter.

(2) Rules defined. -- For the purposes of subdivision (1) of this subsection:

a. 'Employer contribution rule' means a requirement relating to the minimum level or amount of employer contribution toward the premium for enrollment of participants and beneficiaries; and

b. 'Group participation rule' means a requirement relating to the minimum number of participants or beneficiaries that must be enrolled in relation to a specified percentage or number of eligible individuals or employees of an employer.

(e) Exception for Coverage Offered Only to Bona Fide Association Members. -- Subsection (a) of this section does not apply to:

(1) Health insurance coverage offered by a health insurer if the coverage is made available in the small group market only through one or more bona fide associations.

(2) A self-employed individual as defined in G.S. 58-50-110(21a).

"**§ 58-68-45. Guaranteed renewability of coverage for employers in the group market.**

(a) In General. -- Except as provided in this section, if a health insurer offers health insurance coverage in the small or large group market, the health insurer must renew or continue in force the coverage at the option of the employer.

(b) General Exceptions. -- A health insurer may nonrenew or discontinue health insurance coverage in the small or large group market based only on one or more of the following:

(1) Nonpayment of premiums. -- The policyholder has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the health insurer has not received timely premium payments.

(2) Fraud. -- The policyholder has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

(3) Violation of participation or contribution rules. -- The policyholder has failed to comply with a material plan provision relating to employer contribution or group participation rules, as permitted under G.S. 58-68-40(e) in the case of the small group market or pursuant to this Chapter in the case of the large group market.

(4) Termination of coverage. -- The health insurer is ceasing to offer coverage in the market in accordance with subsection (c) of this section and this Chapter.

(5) Movement outside service area. -- In the case of a health insurer that offers health insurance coverage in the market through a network plan, there is no longer any enrollee in connection with the network plan who lives, resides, or works in the service area of the health insurer or in the area for which the health insurer is authorized to do business and, in the case of the small group market, the health insurer would deny enrollment with respect to the network plan under G.S. 58-68-40(c)(1)a.

(6) Association membership ceases. -- In the case of health insurance coverage that is made available in the small or large group market only through one or more bona fide associations, the membership of an employer in the association, on the basis of which the coverage is provided, ceases but only if the coverage is terminated under this subdivision uniformly without regard to any health status-related factor relating to any covered individual.

(c) Requirements for Uniform Termination of Coverage. --

(1) Particular type of coverage not offered. -- In any case in which a health insurer decides to discontinue offering a particular type of group health insurance coverage offered in the small or large group market, coverage of the type may be discontinued by the health insurer in accordance with this Chapter in the market only if:

a. The health insurer provides notice to each policyholder provided coverage of this type in the market and to the participants and beneficiaries covered under the coverage of the discontinuation at least 90 days before the date of the discontinuation of the coverage;

b. The health insurer offers to each policyholder provided coverage of this type in the market the option to purchase all, or in the case of the large group market, any other health insurance coverage currently being offered by the

health insurer to a group health insurance plan in the market; and

c. In exercising the option to discontinue coverage of this type and in offering the option of coverage under sub-subdivision b. of this subdivision, the health insurer acts uniformly without regard to the claims experience of those sponsors or any health status-related factor relating to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for the coverage.

(2) Discontinuance of all coverage. --

a. In general. -- In any case in which a health insurer elects to discontinue offering all health insurance coverage in the small group market or the large group market, or both markets, in this State, health insurance coverage may be discontinued by the health insurer only in accordance with this Chapter and if: (i) the health insurer provides notice to the Commissioner and to each policyholder and to the participants and beneficiaries covered under the coverage of the discontinuation at least 180 days before the date of the discontinuation of the coverage; and (ii) all health insurance issued or delivered for issuance in this State in the market or markets are discontinued and coverage under the health insurance coverage in the market or markets is not renewed.

b. Prohibition on market reentry. -- In the case of a discontinuation under sub-subdivision a. of this subdivision in a market, the health insurer shall not provide for the issuance of any health insurance coverage in that market in this State during the five-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

(d) Exception for Uniform Modification of Coverage. -- At the time of coverage renewal, a health insurer may modify the health insurance coverage for a product offered to a group health insurance plan:

(1) In the large group market; or

(2) In the small group market if, for coverage that is available in the market other than only through one or more bona fide associations, the modification is consistent with this Chapter and effective on a uniform basis among group health insurance plans with that product.

(e) Application to Coverage Offered Only Through Associations. -- In applying this section in the case of health insurance coverage that is made available by a health insurer in the small or large group market to employers only through one or more associations, a reference to 'policyholder' is deemed, with respect to coverage provided to an employer member of the association, to include a reference to the employer.

"**§ 58-68-50. Disclosure of information.**

(a) Disclosure of Information by Health Insurers. -- In connection with the offering of any health insurance coverage to a small employer, a health insurer:

(1) Shall make a reasonable disclosure to the employer, as part of its solicitation and sales materials, of the availability of information described in subsection (b) of this section, and

(2) Shall upon request of the small employer, provide the information.

(b) Information Described. --

(1) In general. -- Subject to subdivision (3) of this subsection, with respect to a health insurer offering health insurance coverage to a small employer, information described in this subsection is information concerning:
a. The provisions of the coverage concerning the health insurer's right to change premium rates and the factors that may affect changes in premium rates;
b. The provisions of the coverage relating to renewability of coverage;
c. The provisions of the coverage relating to any preexisting condition exclusion; and
d. The benefits and premiums available under all health insurance coverage for which the employer is qualified.

(2) Form of information. -- Information under this subsection shall be provided to small employers in a manner determined to be understandable by the average small employer, and shall be sufficient to reasonably inform small employers of their rights and obligations under the health insurance coverage.

(3) Exception. -- A health insurer is not required under this section to disclose any information that is proprietary and trade secret information under applicable law.

"Subpart 3. Exclusion of Plans.

"**§ 58-68-55. Exclusion of certain plans.**

(a) Exception for Certain Benefits. -- The requirements of Subparts 1 and 2 of this Part do not apply to any group health insurance coverage in relation to its provision of excepted benefits described in G.S. 58-68-25(b)(1).

(b) Exception for Certain Benefits if Certain Conditions Met. --

(1) Limited, excepted benefits. -- The requirements of Subparts 1 and 2 of this Part do not apply to any group health insurance plan in relation to its provision of excepted benefits described in G.S. 58-68-25(b)(2) if the benefits:
a. Are provided under a separate policy, certificate, or contract of insurance; or
b. Are otherwise not an integral part of the plan.

(2) Noncoordinated, excepted benefits. -- The requirements of Subparts 1 and 2 of this Part do not apply to any group health insurance plan in relation to its provision of excepted benefits described in G.S. 58-68-25(b)(3) if all of the following conditions are met:
a. The benefits are provided under a separate policy, certificate, or contract of insurance.
b. There is no coordination between the provision of the benefits and any exclusion of benefits under any group health insurance plan maintained by the same policyholder.
c. The benefits are paid with respect to an event without regard to whether benefits are provided with respect to that event under any group health insurance plan maintained by the same policyholder.

(3) Supplemental, excepted benefits. -- The requirements of this Part do not apply to any group health insurance plan in relation to its provision of excepted benefits described in G.S. 58-68-25(b)(4) if the benefits are provided under a separate policy, certificate, or contract of insurance.

"Part B -- Individual Market Reforms.

"§ 58-68-60. Guaranteed availability of individual health insurance coverage to certain individuals with prior group coverage.

(a) Guaranteed Availability. --

(1) In general. -- Subject to the succeeding subsections of this section, each health insurer that offers health insurance coverage in the individual market in this State shall not, with respect to an eligible individual desiring to enroll in individual health insurance coverage:

a. Decline to offer the coverage to, or deny enrollment of, the individual; or

b. Impose any preexisting condition exclusion with respect to the coverage.

(b) Eligible Individual Defined. -- In this Part, 'eligible individual' means an individual:

(1) (i) For whom, as of the date on which the individual seeks coverage under this section, the aggregate of the periods of creditable coverage is 18 or more months and (ii) whose most recent prior creditable coverage was under an ERISA group health plan, governmental plan, or church plan (or health insurance coverage offered in connection with any such plan);

(2) Who is not eligible for coverage under (i) an ERISA group health plan, (ii) part A or part B of title XVIII of the Social Security Act, or (iii) a State plan under title XIX of the Act (or any successor program), and does not have other health insurance coverage;

(3) With respect to whom the most recent coverage within the coverage period described in subdivision (1)(i) was not terminated based on a factor described in G.S. 58-68-45(b)(1) or (b)(2);

(4) If the individual had been offered the option of continuation coverage under a COBRA continuation provision or under Article 53 of this Chapter, who elected the coverage; and

(5) Who, if the individual elected the continuation coverage, has exhausted the continuation coverage under the provision or program.

(c) Alternative Coverage Permitted. --

(1) In general. -- In the case of health insurance coverage offered in this State, a health insurer may elect to limit the coverage offered under subsection (a) of this section as long as it offers at least two different policy forms of health insurance coverage both of which:

a. Are designed for, made generally available to, and actively marketed to, and enroll both eligible and other individuals by the health insurer; and

b. Meet the requirement of subdivision (2) or (3) of this subsection, as elected by the health insurer.

For the purposes of this subsection, policy forms that have different cost-sharing arrangements or different riders shall be considered to be different policy forms.

(2) Choice of most popular policy forms. -- The requirement of this subdivision is met, for health insurance coverage policy forms offered by a health insurer in the individual market, if the health insurer offers the policy forms for individual health insurance coverage with the largest, and next to largest, premium volume of all the policy forms offered by the health insurer in this State or

applicable marketing or service area (as may be prescribed by rules or regulations) by the health insurer in the individual market in the period involved.

(3) Choice of two policy forms with representative coverage. --

a. In general. -- The requirement of this subdivision is met, for health insurance coverage policy forms offered by a health insurer in the individual market, if the health insurer offers a lower-level coverage policy form (as described in sub-subdivision b. of this subdivision) and a higher-level coverage policy form (as described in sub-subdivision c. of this subdivision) each of which includes benefits substantially similar to other individual health insurance coverage offered by the health insurer in this State.

b. Lower-level of coverage described. -- A policy form is described in this sub-subdivision if the actuarial value of the benefits under the coverage is at least eighty-five percent (85%) but not greater than one hundred percent (100%) of a weighted average (described in sub-subdivision d. of this subdivision).

c. Higher-level of coverage described. -- A policy form is described in this sub-subdivision if: (i) the actuarial value of the benefits under the coverage is at least fifteen percent (15%) greater than the actuarial value of the coverage described in sub-subdivision b. of this subdivision offered by the health insurer in the area involved; and (ii) the actuarial value of the benefits under the coverage is at least one hundred percent (100%) but not greater than one hundred twenty percent (120%) of a weighted average (described in sub-subdivision d. of this subdivision).

d. Weighted average. -- For the purposes of this subdivision, the weighted average described in this sub-subdivision is the average actuarial value of the benefits provided by all the health insurance coverage issued, as elected by the health insurer, either by that health insurer or by all health insurers in this State in the individual market during the previous year, not including coverage issued under this section, weighted by enrollment for the different coverage.

(4) Election. -- The health insurer elections under this subsection shall apply uniformly to all eligible individuals in this State for that health insurer. The election shall be effective for policies offered during a period of not less than two years.

(5) Assumptions. -- For the purposes of subdivision (3) of this subsection, the actuarial value of benefits provided under individual health insurance coverage shall be calculated based on a standardized population and a set of standardized utilization and cost factors.

(d) Special Rules for Network Plans. --

(1) In general. -- In the case of a health insurer that offers health insurance coverage in the individual market through a network plan, the health insurer may:

a. Limit the individuals who may be enrolled under the coverage to those who live, reside, or work within the service area for the network plan; and

b. Within the service area of the plan, deny the coverage to the individuals if the health insurer has demonstrated to the Commissioner that: (i) it will not have the capacity to deliver services adequately to additional individual enrollees because of its obligations to existing group contract holders and enrollees and individual enrollees, and (ii) it is applying this subdivision uniformly to individuals without regard to any health status-related factor of the individuals and without regard to whether the individuals are eligible individuals.

(2) 180-day suspension upon denial of coverage. -- A health insurer, upon denying health insurance coverage in any service area in accordance with sub-subdivision (1)b. of this subdivision, shall not offer coverage in the individual market within the service area for a period of 180 days after the coverage is denied.

(e) Application of Financial Capacity Limits. --

(1) In general. -- A health insurer may deny health insurance coverage in the individual market to an eligible individual if the health insurer has demonstrated to the Commissioner that:

a. It does not have the financial reserves necessary to underwrite additional coverage; and

b. It is applying this subdivision uniformly to all individuals in the individual market in this State consistent with this Chapter and without regard to any health status-related factor of the individuals and without regard to whether the individuals are eligible individuals.

(2) 180-day suspension upon denial of coverage. -- A health insurer, upon denying individual health insurance coverage in any service area in accordance with subdivision (1) of this subsection, shall not offer the coverage in the individual market within the service area for a period of 180 days after the date the coverage is denied or until the health insurer has demonstrated to the Commissioner that the health insurer has sufficient financial reserves to underwrite additional coverage, whichever is later.

(f) Market Requirements. --

(1) In general. -- Subsection (a) of this section does not require that a health insurer offering health insurance coverage only in connection with ERISA group health plans or through one or more bona fide associations, or both, offer the health insurance coverage in the individual market.

(2) Conversion policies. -- A health insurer offering health insurance coverage in connection with group health plans under title XXVII of the federal Public Health Service Act shall not be deemed to be a health insurer offering individual health insurance coverage solely because the health insurer offers a conversion policy.

(g) Construction. -- Nothing in this section shall be construed:

(1) To restrict the amount of the premium rates that a health insurer may charge an individual for health insurance coverage provided in the individual market under this Chapter; or

(2) To prevent a health insurer offering health insurance coverage in the individual market from establishing premium discounts or rebates or modifying otherwise applicable copayments or

deductibles in return for adherence to programs of health promotion and disease prevention.

(h) Other Definitions. -- As used in this section:

(1) 'Church plan'. -- The meaning given the term under section 3(33) of the Employee Retirement Income Security Act of 1974.

(2) 'Governmental plan'. --

a. The meaning given the term under section 3(32) of the Employee Retirement Income Security Act of 1974 and any federal governmental plan.

b. Federal governmental plan. -- A governmental plan established or maintained for its employees by the government of the United States or by any agency or instrumentality of the government.

c. Nonfederal governmental plan. -- A governmental plan that is not a federal governmental plan.

"**§ 58-68-65. Guaranteed renewability of individual health insurance coverage.**

(a) In General. -- Except as provided in this section, a health insurer that provides individual health insurance coverage to an individual shall renew or continue in force the coverage at the option of the individual.

(b) General Exceptions. -- A health insurer may nonrenew or discontinue health insurance coverage of an individual in the individual market based only on one or more of the following:

(1) Nonpayment of premiums. -- The individual has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the health insurer has not received timely premium payments.

(2) Fraud. -- The individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

(3) Termination of plan. -- The health insurer is ceasing to offer coverage in the individual market in accordance with subsection (c) of this section and this Chapter.

(4) Movement outside service area. -- In the case of a health insurer that offers health insurance coverage in the market through a network plan, the individual no longer resides, lives, or works in the service area (or in an area for which the health insurer is authorized to do business) but only if the coverage is terminated under this subdivision uniformly without regard to any health status-related factor of covered individuals.

(5) Association membership ceases. -- In the case of health insurance coverage that is made available in the individual market only through one or more bona fide associations, the membership of the individual in the association (on the basis of which the coverage is provided) ceases but only if the coverage is terminated under this subdivision uniformly without regard to any health status-related factor of covered individuals.

(c) Requirements for Uniform Termination of Coverage. --

(1) Particular type of coverage not offered. -- In any case in which a health insurer decides to discontinue offering a particular type of health insurance coverage offered in the individual market, coverage of the type may be discontinued by the health insurer only if:

a. The health insurer provides notice, notwithstanding G.S. 58-51-20 or G.S. 58-65-60(c)(3)b., to each covered individual provided coverage of this type in the market of the discontinuation at least 90 days before the date of the discontinuation of the coverage;

b. The health insurer offers to each individual in the individual market provided coverage of this type, the option to purchase any other individual health insurance coverage currently being offered by the health insurer for individuals in the market; and

c. In exercising the option to discontinue coverage of this type and in offering the option of coverage under sub-subdivision b. of this subdivision, the health insurer acts uniformly without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for the coverage.

(2) Discontinuance of all coverage. --

a. In general. -- Subject to sub-subdivision c. of this subdivision, in any case in which a health insurer elects to discontinue offering all health insurance coverage in the individual market in this State, health insurance coverage may be discontinued by the health insurer only if: (i) the health insurer provides notice to the Commissioner and to each individual of the discontinuation at least 180 days before the date of the expiration of the coverage, and (ii) all health insurance coverage issued or delivered for issuance in this State in the market is discontinued and the health insurance coverage in the market is not renewed.

b. Prohibition on market reentry. -- In the case of a discontinuation under sub-subdivision a. of this subdivision in the individual market, the health insurer shall not provide for the issuance of any health insurance coverage in the market and this State during the five-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

(d) Exception for Uniform Modification of Coverage. -- At the time of coverage renewal, a health insurer may modify the health insurance coverage for a policy form offered to individuals in the individual market as long as the modification is consistent with State law and effective on a uniform basis among all individuals with that policy form.

(e) Application to Coverage Offered Only Through Associations. -- In applying this section in the case of health insurance coverage that is made available by a health insurer in the individual market to individuals only through one or more associations, a reference to an 'individual' is deemed to include a reference to the association of which the individual is a member.

"**§ 58-68-70. Certification of coverage.**

G.S. 58-68-30(e) applies to health insurance coverage offered by a health insurer in the individual market in the same manner that it applies to health insurance coverage offered by a health insurer in the small or large group market.

"**§ 58-68-75. General exceptions.**

(a) Exception for Certain Benefits. -- This Part does not apply to any health insurance coverage in relation to its provision of excepted benefits described in G.S. 58-68-25(b)(1).

(b) Exception for Certain Benefits if Certain Conditions Met. -- This Part does not apply to any health insurance coverage in relation to its provision of excepted benefits described in G.S. 58-68-25(b)(2), (3), or (4) if the benefits are provided under a separate policy, certificate, or contract of insurance."

Section 2. G.S. 58-50-110 reads as rewritten:

"**§ 58-50-110. Definitions.**

As used in this Act:

(1) 'Accountable health carrier' means that as defined in G.S. 143-622(1).

(1a) 'Actuarial certification' means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the Commissioner that a small employer carrier is in compliance with the provisions of G.S. 58-50-130, and to the extent applicable, the provisions of Article 68 of this Chapter, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.

(1b) 'Adjusted community rating' means a method used to develop carrier premiums which spreads financial risk across a large population and allows adjustments for the following demographic factors: age, gender, family composition, and geographic areas, as determined pursuant to G.S. 58-50-130(b).

(2) Repealed by Session Laws 1993, c. 529, s. 3.3.

(3) 'Basic health care plan' means a health care plan for small employers that is lower in cost than a standard health care plan and is required to be offered by all small employer carriers pursuant to G.S. 58-50-125 and approved by the Commissioner in accordance with G.S. 58-50-125.

(4) 'Board' means the board of directors of the Pool.

(5) 'Carrier' means any person that provides one or more health benefit plans in this State, including a licensed insurance company, a prepaid hospital or medical service plan, a health maintenance organization (HMO), and a multiple employer welfare arrangement.

(5a) 'Case characteristics' means the demographic factors age, gender, family size, and geographic location.

(6), (7) Repealed by Session Laws 1993, c. 529, s. 3.3.

(8) 'Committee' means the Small Employer Carrier Committee as created by G.S. 58-50-120.

(9) 'Dependent' means the spouse or child of an eligible employee, subject to applicable terms of the health care plan covering the employee.

(10) 'Eligible employee' means an employee who works for a small employer on a full-time basis, with a normal work week of 30 or more hours, including a sole proprietor, a partner or a partnership, or an independent contractor, if included as an employee under a health care plan of a small employer; but does not include employees who work on a part-time, temporary, or substitute basis.

(11) 'Health benefit plan' means any accident and health insurance policy or certificate; nonprofit hospital or medical service corporation contract; health, hospital, or medical service corporation plan contract; HMO subscriber contract; plan provided

by a MEWA or plan provided by another benefit arrangement, to the extent permitted by ERISA, subject to G.S. 58-50-115. Health benefit plan does not ~~mean accident only, specified disease only, fixed indemnity, credit, or disability insurance; coverage of Medicare services pursuant to contracts with the United States government; Medicare supplement or long-term care insurance; dental only or vision only insurance; coverage issued as a supplement to liability insurance; insurance arising out of a workers' compensation or similar law; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.~~ include benefits described in G.S. 58-68-25(b).

(12) 'Impaired insurer' has the same meaning as prescribed in G.S. 58-62-20(6) or G.S. 58-62-16(8).

(13) Repealed by Session Laws 1993, c. 529, s. 3.3.

(14) 'Late enrollee' means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer after the end of the initial enrollment period provided under the terms of the health benefit plan in effect at the time the employee first became eligible; provided that the initial enrollment period shall be a period of at least 30 consecutive calendar days. However, an eligible employee or dependent shall not be considered a late enrollee if:

a. The individual was covered under a public or private health benefit plan that provided, at the time the individual was eligible to enroll, benefits equal to or exceeding the same required level of benefits in the basic ~~and~~ or standard health care plans adopted pursuant to G.S. 58-50-120 and either the individual:

1. Lost coverage under another health plan as a result of termination of employment, termination of a spouse's health plan coverage, or the death of a spouse or divorce and requests enrollment in a ~~basic or standard health care plan~~ health benefit plan within 30 days after termination of coverage provided under another health plan; or
2. Stated, in writing, during the enrollment period that coverage under another employer health benefit plan was the reason for declining coverage;

3, 4. Repealed by Session Laws 1993, c. 529, s. 3.3.

b. The individual elects a different health plan offered through the Alliance during an open enrollment period;

c. An eligible employee requests enrollment within 30 days of becoming an employee of a member small employer;

d. A court has ordered coverage be provided for a spouse or minor child under a covered employee's health benefit plan and the request for enrollment for a spouse is made within 30 days after issuance of the court ~~order;~~ order. A minor child shall be enrolled in accordance with the requirements of G.S. 58-51-120; or

e. The individual or employee enrollee makes a request for enrollment of the spouse or child within 30 days ~~of~~ after the

~~individual~~ individual's or employee's marriage or the ~~birth or adoption~~ birth, adoption, or placement for adoption of a child.

(15) Repealed by Session Laws 1993, c. 529, s. 3.3.

(16) 'Pool' means the North Carolina Small Employer Health Reinsurance Pool created in G.S. 58-50-150.

(17) 'Preexisting-conditions provision' means a ~~policy provision that limits or excludes coverage for charges or expenses incurred during a specified period following the insured's effective date of coverage, for a condition that, during a specified period immediately preceding the effective date of coverage, had manifested itself in a manner that would cause an ordinary prudent person to seek diagnosis, care, or treatment, or for which medical advice, diagnosis, care, or treatment was recommended or received as to that condition or as to pregnancy existing on the effective date of coverage.~~ preexisting-condition provision as defined in G.S. 58-68-30.

(18) 'Premium' includes insurance premiums or other fees charged for a health benefit plan, including the costs of benefits paid or reimbursements made to or on behalf of persons covered by the plan.

(19) 'Rating period' means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect, as determined by the small employer carrier.

(20) 'Risk-assuming carrier' means a small employer carrier electing to comply with the requirements set forth in G.S. 58-50-140.

(21) 'Reinsuring carrier' means a small employer carrier electing to comply with the requirements set forth in G.S. 58-50-145.

(21a) 'Self-employed individual' means an individual or sole proprietor who derives a majority of his or her income from a trade or business carried on by the individual or sole proprietor which results in taxable income as indicated on IRS form 1040, Schedule C or F and which generated taxable income in one of the two previous years.

(22) 'Small employer' means any individual actively engaged in business that, on at least fifty percent (50%) of its working days during the preceding calendar quarter, employed no more than ~~49~~ 50 eligible employees, the majority of whom are employed within this State, and is not formed primarily for purposes of buying health insurance and in which a bona fide employer-employee relationship exists. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation by this State, shall be considered one employer. Subsequent to the issuance of a health benefit plan to a small employer and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, the provisions of this Act that apply to a small employer shall continue to apply until the plan anniversary following the date the small employer no longer meets the requirements of this definition. For purposes of this Act, the term small employer includes self-employed individuals.

(23) 'Small employer carrier' means any carrier that offers health benefit plans covering eligible employees of one or more small employers.

(24) 'Standard health care plan' means a health care plan for small employers required to be offered by all small employer carriers under G.S. 58-50-125 and approved by the Commissioner in accordance with G.S. 58-50-125."

Section 3. G.S. 58-50-125(c) reads as rewritten:

"(c) ~~The~~ Except as provided under Article 68 of this Chapter, the plans developed under this section are not required to provide coverage that meets the requirements of other provisions of this Chapter that mandate either coverage or the offer of coverage by the type or level of health care services or health care provider."

Section 4. G.S. 58-50-125(g) reads as rewritten:

"(g) No HMO operating as either a risk-assuming carrier or a reinsuring carrier is required to offer coverage or accept applications under subsection (d) of this section in the case of any of the following:

(1) To a group that is not physically located in the HMO's approved service areas;

(2) To an employee who does not reside within the HMO's approved service areas;

(3) Within an area, where the HMO can reasonably anticipate, and demonstrate, to the Commissioner's satisfaction, that it will not have the capacity within that area and its network of providers to deliver services adequately to the enrollees of those groups because of its obligations to existing group contract holders and enrollees.

An HMO that does not offer coverage pursuant to subdivision (3) of this subsection may not offer coverage in the applicable area to new employer groups with more than 49 eligible employees until the later of 90 days after that closure or the date on which the carrier notifies the Commissioner that it has regained capacity to deliver services to small employers."

Section 5. G.S. 58-50-130(a) reads as rewritten:

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

~~(1) Except in the case of a late enrollee, any preexisting conditions provision may not limit or exclude coverage for a period beyond 12 months following the insured's initial effective date of coverage and must define preexisting conditions as "those conditions for which medical advice or treatment was received or recommended or that could be medically documented within the 12-month period immediately preceding the effective date of the person's coverage".~~

~~(2) In determining whether a preexisting conditions provision applies to an eligible employee or to a dependent, all health benefit plans shall credit the time the person was covered under a previous health benefit plan if the previous coverage was continuous to a date not more than 60 days before the effective date of the new coverage, exclusive of any applicable waiting period under the plan. As used in this subdivision with respect to previous coverage, the meaning of "health benefit plan" is not limited to the definition in G.S. 58-50-115, but includes any health benefit plan provided by a health insurer, as that term is defined in G.S. 58-51-115(a), or any government plan or program providing health benefits or health care.~~

~~(3) The health benefit plan is renewable with respect to all eligible employees or dependents at the option of the policyholder or contract holder except:~~

~~a. For nonpayment of the required premiums by the policyholder or contract holder;~~

~~b. For fraud or misrepresentation of the policyholder or contract holder or, with respect to coverage of individual enrollees, the enrollees, or their representatives;~~

~~c. For noncompliance with plan provisions that have been approved by the Commissioner;~~

~~d. When the number of enrollees covered under the plan is less than the number of insureds or percentage of enrollees required by participation requirements under the plan; or~~

~~e. When the policyholder or contract holder is no longer actively engaged in the business in which it was engaged on the effective date of the plan.~~

~~f. When the small employer carrier stops writing new business in the small employer market, if:~~

~~1. It provides notice to the Department and either to the policyholder, contract holder, or employer, of its decision to stop writing new business in the small employer market; and~~

~~2. It does not cancel health benefit plans subject to this Act for 180 days after the date of the notice required under paragraph 1; and for that business of the carrier that remains in force, the carrier shall continue to be governed by this Act with respect to business conducted under this Act.~~

~~A small employer carrier that stops writing new business in the small employer market in this State after January 1, 1992, shall be prohibited from writing new business in the small employer market in this State for a period of five years from the date of notice to the Commissioner. In the case of an HMO doing business in the small employer market in one service area of this State, the rules set forth in this subdivision shall apply to the HMO's operations in the service area, unless the provisions of G.S. 58-50-125(g) apply.~~

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

(4a) A carrier may continue to enforce reasonable employer participation and contribution requirements on small employers applying for coverage; however, participation and contribution requirements may vary among small employers only by the size of the small employer group and shall not differ because of the health benefit plan involved. In applying minimum participation requirements to a small employer, a small employer carrier shall not consider employees or dependents who have qualifying existing coverage in determining whether an applicable participation level

is met. 'Qualifying existing coverage' means benefits or coverage provided under: (i) Medicare, Medicaid, and other government funded programs; or (ii) an employer-based health insurance or health benefit arrangement, including a self-insured plan, that provides benefits similar to or in excess of benefits provided under the basic health care plan. An accountable health carrier shall not enforce participation or contribution requirements on member small employers, as defined in G.S. 143-622(18), unless those requirements meet with the standards adopted by the State Health Plan Purchasing Alliance Board.

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

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

~~(7) A small employer carrier shall not modify any health benefit plan with respect to a small employer, any eligible employee, or dependent through riders, endorsements, or otherwise, in order to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan.~~

~~(8) In the case of an eligible employee or dependent of an eligible employee who was excluded from or denied coverage by a small employer carrier on or before August 14, 1992, the small employer carrier shall provide an opportunity for such eligible employee or dependent to enroll in the health benefit plan currently held by the small employer not later than the next plan anniversary on or after August 14, 1992.~~

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

Section 6. G.S. 58-50-130(d) reads as written:

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

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

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

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

(4) Provisions affecting any preexisting conditions provision.

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

Section 7. G.S. 58-51-15(a)(2)b. reads as rewritten:

"b. This policy contains a provision limiting coverage for preexisting conditions. Preexisting conditions ~~must be covered no later than one year after the effective date of coverage.~~ are covered under this policy.....(insert number of months or days, not to exceed one year) after the effective date of coverage. Preexisting conditions ~~are defined as~~ mean 'those conditions for which medical ~~advice~~ advice, diagnosis, care, or treatment was received or recommended ~~or that could be medically documented~~ within the one-year period immediately preceding the effective date of the person's coverage.' ~~Preexisting conditions exclusions may not be implemented by any successor plan as to any covered persons who have already met all or part of the waiting period requirements under any previous plan. Credit must be given for that portion of the waiting period that was met under the previous plan. As used in this policy, the term "previous plan" includes any health benefit plan provided by a health insurer, as those terms are defined in G.S. 58-51-115, or any government plan or program providing health benefits or health care. In determining whether a preexisting condition provision applies to an insured person, all health benefit plans must credit the time the person was covered under a previous plan if the previous plan's coverage was continuous to a date not more than 60 days before the effective date of the new coverage, exclusive of any applicable waiting period under the new coverage.~~ Credit for having satisfied some or all of the preexisting condition waiting periods under previous health benefits coverage shall be given in accordance with G. S. 58-68-30."

Section 7.1. G.S. 58-51-15 is amended by adding a new subsection to read:

"(h) Preexisting Condition Exclusion Clarification. -- Sub-subdivision (a)(2)b. of this section does not apply to:

(1) Policies issued to eligible individuals under G.S. 58-68-60.

(2) Excepted benefits as described in G.S. 58-68-25(b)."

Section 8. G.S. 58-51-80(b) reads as rewritten:

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

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

relationship of principal and agent exists, the premium may be paid by the principal, by the principal and agents, jointly, or by the agents. If the premium is paid by the employer and the employees jointly, or by the principal and agents jointly, or by the employees, or by the agents, the group shall be structured on an actuarially sound basis.

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

a. The policy may insure members of the association or associations, employees of the association or associations, or employees of members, or one or more of the preceding or all of any class or classes for the benefit of persons other than the employee's employer.

b. The premium for the policy shall be paid from funds contributed by the association or associations, or by employer members, or by both, or from funds contributed by the covered persons or from both the covered persons and the association, associations, or employer members.

~~c. A policy on which no part of the premium is to be derived from funds contributed by the covered persons specifically for their insurance must insure all eligible persons, except those who reject the coverage, in writing.~~

~~(2) For employer groups of 50 or more persons no evidence of individual insurability may be required at the time the person first becomes eligible for insurance or within 31 days thereafter except for any insurance supplemental to the basic coverage for which evidence of individual insurability may be required. With respect to trusteed groups the phrase "groups of 50" must be applied on a participating unit basis for the purpose of requiring individual evidence of insurability.~~

~~(3) Policies may contain a provision limiting coverage for preexisting conditions. Preexisting conditions must be covered no later than 12 months after the effective date of coverage. Preexisting conditions are defined as "those conditions for which medical advice or treatment was received or recommended or which could be medically documented within the 12-month period immediately preceding the effective date of the person's coverage." Preexisting conditions exclusions may not be implemented by any successor plan as to any covered persons who have already met all or part of the waiting period requirements under any previous plan. Credit~~

~~must be given for that portion of the waiting period which was met under the previous plan. As used in this subdivision, a "previous plan" includes any health benefit plan provided by a health insurer, as those terms are defined in G.S. 58-51-115, or any government plan or program providing health benefits or health care. For employer groups of 50 or more persons and for groups under subdivision (1a) of this subsection and under G.S. 58-51-81. In determining whether a preexisting condition provision applies to an eligible employee, association member, student, or to a dependent, all health benefit plans shall credit the time the person was covered under a previous plan if the previous plan's coverage was continuous to a date not more than 60 days before the effective date of the new coverage, exclusive of any applicable waiting period under the new coverage.~~"

Section 9. G.S. 58-51-80(h) reads as rewritten:

"(h) Nothing contained in this section applies to any contract issued by any corporation defined in Article 65 of this Chapter. ~~Subdivision (b)(3) of this section applies to MEWAs, as defined in G.S. 58-49-30(a).~~"

Section 10. G.S. 58-53-1 reads as rewritten:

"**§ 58-53-1. Definitions.**

As used in this Article, the following terms have the meanings specified:

(1) 'Group policy' means a group accident and health insurance policy issued by an insurance company and a group contract issued by a ~~health~~ service corporation or health maintenance organization or similar corporation or organization.

(2) 'Individual policy' or 'converted policy' means an individual health insurance policy issued by an insurance company or an individual ~~health services~~ contract issued by a ~~health~~ service corporation or health maintenance organization or similar corporation or organization.

(3) 'Insurance' and 'insured' refer to coverage under a group policy, individual policy or converted policy on a premium-paying basis, and do not include coverage provided by reason of a disability extension.

(4) 'Insurer' means the entity issuing a group policy or an individual or converted policy.

(5) 'Medicare' means Title XVIII of the United States Social Security Act as added by the Social Security Amendments of 1965 or as later amended or superseded.

(5a) 'Member' or 'employee' includes an insured spouse or dependent of a member or of an employee.

(6) 'Premium' includes any premium or other consideration payable for coverage under a group or individual policy.

(7) 'Reasonable and customary' means the most frequently used level of charge made for the supplies or for a specific service in the geographic subarea in which such supplies or services are received, of like kind or by physicians, or other practitioners, with similar qualifications."

Section 11. G.S. 58-53-5 reads as rewritten:

"**§ 58-53-5. Continuation of group hospital, surgical, and major medical coverage after termination of employment or membership.**

A group policy delivered or issued for delivery in this State ~~which~~ that insures employees or ~~members, other than the members and their dependents, if they have~~

~~elected to include them, whose eligibility under the group policy does not extend to any employee(s) the insured may have~~ members for hospital, surgical or major medical insurance on an expense incurred or service basis under ~~Articles 1 through 67 of~~ this Chapter, other than for specific diseases or for accidental injuries only, shall provide that employees or members whose ~~insurance for these types of~~ coverage under the group policy would otherwise terminate because of termination of active employment or membership, or termination of membership in the eligible class or classes under the policy, shall be entitled to continue their hospital, surgical, and medical insurance under that group policy, for themselves and their eligible spouses and dependents with respect to whom they were insured on the date of termination, subject to all of the group policy's terms and conditions ~~applicable to those forms of insurance~~ and to the conditions specified in this Part. Provided, the terms and conditions set forth in this Part are intended as minimum requirements and shall not be construed to impose additional or different requirements upon those group hospital, surgical, or major medical plans ~~already in force, or hereafter placed into effect,~~ that provide continuation benefits equal to or better than those required in this Part."

Section 12. G.S. 58-53-35 reads as rewritten:

"**§ 58-53-35. Termination of continuation.**

(a) Continuation of insurance under the group policy for any person shall terminate on the earliest of the following dates:

(1) The date ~~one year~~ 18 months after the date the employee's or member's insurance under the policy would otherwise have terminated because of termination of employment or members;

(2) The date ending the period for which the employee or member last makes his required contribution, if he discontinues his contributions;

(3) The date the employee or member becomes or is eligible to become covered for similar benefits under any arrangement of coverage for individuals in a group, whether insured or uninsured;

(4) The date on which the group policy is terminated or, in the case of a multiple employer plan, the date his employer terminates participation under the group master policy. When this occurs the employee or member shall have the privilege described in G.S. 58-53-45 if the date of termination precedes that on which his actual continuation of insurance under that policy would have terminated. The insurer that insured the group ~~prior to~~ before the date of termination shall make a converted policy available to the employee or member.

(b) Notwithstanding subdivision (a)(4) of this section, if the employer replaces the group policy with another group policy, the employee is entitled to continue under the successor group policy for any unexpired period of continuation to which the employee is entitled."

Section 13. G.S. 58-53-50 reads as rewritten:

"**§ 58-53-50. Restrictions.**

A converted policy shall not be available to an employee or member if termination of his insurance under the group policy occurred because:

(1) Of termination of employment or membership and either he was not entitled to continuation of group coverage under Part 1 of this Article or failed to elect such continuation;

(2) He failed to make timely payment of any required contribution for the cost of continuation of insurance;

(3) He had not been continuously covered under the group policy or for similar benefits under any other group policy that it replaced during the period of three consecutive months immediately prior to termination of active employment ending with such termination;

(4) The group policy terminated or an employer's participation terminated, and the insurance is replaced by similar coverage under another group policy within 31 days of date of termination; or

(5) He failed to continue his insurance for the entire maximum period of ~~one year~~ 18 months following termination of active employment as provided for in Part 1 of this Article, unless that failure to continue was because of change of insurer by the employer and the change of insurer was consummated during the one year continuation period. In that event the employee or member shall be entitled to be issued a converted policy by the insurer that provided the group policy to the employer before the change of insurer."

Section 14. G.S. 58-53-55 reads as rewritten:

"**§ 58-53-55. Time limit.**

In order to be eligible for conversion, written application and the first premium payment for the converted policy must be made to the insurer not later than 31 days after the date of termination of insurance provided under Part 1 of this Article. The effective date of the converted policy shall be the day following the later of:

(1) The termination of insurance under the group policy when it is not replaced by one providing similar coverage within 31 days of the termination date of the immediately prior group plan; or

(2) The termination of the ~~one year~~ period of continued coverage under the group policy or policies."

Section 15. Article 55 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-55-31. Additional requirements.**

(a) No policy shall be used in this State unless it provides for an offer of nonforfeiture, which shall not be less than an offer of reduced paid-up insurance benefits, extended term insurance benefits, or a shortened benefit period. No policy shall pay a cash surrender value unless the dividends or refunds are applied as a reduction of future premiums or an increase in future benefits.

(b) The Commissioner shall adopt rules to provide for annual reports by insurers of the number of claims denied, number of rescissions, and the percentage of sales involving the replacement of policies.

(c) No policy shall be used in this State unless the insurer has developed a financial or personal asset suitability test to determine whether or not issuing long-term care insurance to an applicant is appropriate. For purposes of this section:

(1) All insurers except those issuing life insurance that accelerates the death benefit for long-term care shall use the financial or suitability form and format standards as developed and adopted by the NAIC. A personal long-term care worksheet and disclosure notice of issues an applicant should know before buying long-term care insurance shall be completed and provided before an application is taken.

(2) Each applicant that does not meet the recommended financial or personal asset suitability test criteria shall receive a letter of notification and shall be given an option to waive the results of the

financial suitability test and proceed with the purchase of the policy.

(d) The Commissioner shall adopt standards to handle consumer complaints about noncompliance with State requirements."

Section 16. G.S. 58-65-25 reads as rewritten:

"**§ 58-65-25. Hospital, physician and dentist contracts.**

(a) Any corporation organized under ~~the provisions of~~ this Article ~~and Article 66 of this Chapter~~ may enter into contracts for the rendering of hospital service to any of its subscribers by hospitals approved by the American Medical Association and/or the North Carolina Hospital Association, and may enter into contracts for the furnishing of, or the payment in whole or in part for, medical and/or dental services rendered to any of its subscribers by duly licensed physicians and/or dentists. All obligations arising under contracts issued by such corporations to its subscribers shall be satisfied by payments made directly to the hospitals or hospitals and/or physicians and/or dentists rendering such service, or direct to the subscriber or his, her, or their legal representatives upon the receipt by the corporation from the subscriber of a statement marked paid by the hospital(s) and/or physician(s) and/or dentist(s) or both rendering such service, and all such payments heretofore made are hereby ratified. Nothing ~~herein~~ in this section shall be construed to discriminate against hospitals conducted by other schools of medical practice.

(b) ~~On and after January 1, 1956, all~~ All certificates, plans or contracts issued to subscribers or other persons by hospital and medical and/or dental service corporations operating under this Article ~~and Article 66 of this Chapter~~ shall contain in substance a provision as follows: 'After two years from the date of issue of this certificate, contract or plan no misstatements, except fraudulent misstatements made by the applicant in the application for such certificate, contract or plan, shall be used to void said certificate, contract or plan, or to deny a claim for loss incurred or disability (as therein defined) commencing after the expiration of such two-year period. ~~No claim for loss incurred or disability (as defined in the certificate, contract or plan) commencing after two years from the date of issue of this certificate, contract or plan shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specifically described, effective on the date of loss, had existed prior to the effective date of coverage of this certificate, contract or plan.~~'"

Section 17. G.S. 58-65-60(e) reads as rewritten:

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

~~(1) For employer groups of 50 or more persons no evidence of individual insurability may be required at the time the person first becomes eligible for coverage or within 31 days thereafter except for any insurance supplemental to the basic coverage for which evidence of individual insurability may be required. With respect~~

~~to trusteed groups the phrase "groups of 50" must be applied on a participating unit basis for the purpose of requiring individual evidence of insurability.~~

~~(2) Employer master group contracts may contain a provision limiting coverage for preexisting conditions. Preexisting conditions must be covered no later than 12 months after the effective date of coverage. Preexisting conditions are defined as "those conditions for which medical advice or treatment was received or recommended or which could be medically documented within the 12-month period immediately preceding the effective date of the person's coverage." Preexisting conditions exclusions may not be implemented by any successor plan as to any covered persons who have already met all or part of the waiting period requirements under any previous plan. Credit must be given for that portion of the waiting period which was met under the previous plan. As used in this subdivision, a "previous plan" includes any health benefit plan provided by a health insurer, as those terms are defined in G.S. 58-51-115, or any government plan or program providing health benefits or health care, except that nothing in this section shall apply to a guaranteed issue product designed for uninsurables. For employer groups of 50 or more persons: In determining whether a preexisting condition provision applies to an eligible employee or to a dependent, all health benefit plans shall credit the time the person was covered under a previous plan if the previous plan's coverage was continuous to a date not more than 60 days before the effective date of the new coverage, exclusive of any applicable waiting period under the new coverage.~~

~~(3)~~ (e1) Employees shall be added to the master group coverage no later than 90 days after their first day of employment. Employment shall be considered continuous and not be considered broken except for unexcused absences from work for reasons other than illness or injury. The term 'employee' is defined as a nonseasonal person who works on a full-time basis, with a normal work week of 30 or more hours and who is otherwise eligible for coverage, but does not include a person who works on a part-time, temporary, or substitute basis.

~~(4)~~ (e2) Whenever an employer master group contract replaces another group contract, whether this contract was issued by a corporation under Articles 1 through 67 of this Chapter, the liability of the succeeding corporation for insuring persons covered under the previous group contract is (i) each person is eligible for coverage in accordance with the succeeding corporation's plan of benefits with respect to classes eligible and activity at work and nonconfinement rules must be covered by the succeeding corporation's plan of benefits; and (ii) each person not covered under the succeeding corporation's plan of benefits in accordance with (i) above must nevertheless be covered by the succeeding corporation if that person was validly covered, including benefit extension, under the prior plan on the date of discontinuance and if the person is a member of the class of persons eligible for coverage under the succeeding corporation's plan."

Section 18. G.S. 58-67-85 reads as rewritten:

"**§ 58-67-85. Master group contracts, filing requirement; required and prohibited provisions.**

(a) A health maintenance organization may issue a master group contract with the approval of the Commissioner of Insurance provided the contract and the individual certificates issued to members of the group, shall comply in substance to the other provisions of this Article. Any such contract may provide for the adjustment of the

rate of the premium or benefits conferred as provided in the contract, and in accordance with an adjustment schedule filed with and approved by the Commissioner of Insurance. If the master group contract is issued, altered or modified, the enrollees' contracts issued in pursuance thereof are altered or modified accordingly, all laws and clauses in the enrollees' contracts to the contrary notwithstanding. Nothing in this Article shall be construed to prohibit or prevent the same. Forms of such contract shall at all times be furnished upon request of enrollees thereto.

~~(b) For employer groups of 50 or more persons no evidence of individual insurability may be required at the time the person first becomes eligible for insurance or within 31 days thereafter except for any insurance supplemental to the basic coverage for which evidence of individual insurability may be required. With respect to trusteed groups the phrase "groups of 50" must be applied on a participating unit basis for the purpose of requiring individual evidence of insurability.~~

~~(c) Employer master group contracts may contain a provision limiting coverage for preexisting conditions. Preexisting conditions must be covered no later than 12 months after the effective date of coverage. Preexisting conditions are defined as "those conditions for which medical advice or treatment was received or recommended or which could be medically documented within the 12-month period immediately preceding the effective date of the person's coverage." Preexisting conditions exclusions may not be implemented by any successor plan as to any covered persons who have already met all or part of the waiting period requirements under any previous plan. Credit must be given for that portion of the waiting period which was met under the previous plan. As used in this subsection, a "previous plan" includes any health benefit plan provided by a health insurer, as those terms are defined in G.S. 58-51-115, or any government plan or program providing health benefits or health care. In determining whether a preexisting condition provision applies to an eligible employee or to a dependent, all health benefit plans shall credit the time the person was covered under a previous plan if the previous plan's coverage was continuous to a date not more than 60 days before the effective date of the new coverage, exclusive of any applicable waiting period under the new coverage.~~

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

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

(1) Each person who is eligible for coverage in accordance with the succeeding corporation's plan of benefits with respect to classes eligible and activity at work and nonconfinement rules must be covered by the succeeding corporation's plan of benefits; and

(2) Each person not covered under the succeeding corporation's plan of benefits in accordance with (e)(1) must nevertheless be covered by the succeeding corporation if that person was validly covered, including benefit extension, under the prior plan on the date of discontinuance and if the person is a member of the class of

persons eligible for coverage under the succeeding corporation's plan."

Section 19. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-169. Required coverage for minimum hospital stay following birth.**

(a) Definitions. -- As used in this section:

(1) 'Attending providers' includes:

a. The obstetrician-gynecologists, pediatricians, family physicians, and other physicians primarily responsible for the care of a mother and newborn; and

b. The nurse midwives and nurse practitioners primarily responsible for the care of a mother and her newborn child in accordance with State licensure and certification laws.

(2) 'Health benefit plan' means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by any waiver of or other exception to that Act provided under federal law or regulation. 'Health benefit plan' does not mean any of the following kinds of insurance:

a. Accident,
b. Credit,
c. Disability income,
d. Long-term or nursing home care,
e. Medicare supplement,
f. Specified disease,
g. Dental or vision,
h. Coverage issued as a supplement to liability insurance,
i. Workers' compensation,
j. Medical payments under automobile or homeowners, and
k. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance.
l. Hospital income or indemnity.

(3) 'Insurer' means an insurance company subject to this Chapter, a service corporation organized under Article 65 of this Chapter, a health maintenance organization organized under Article 67 of this Chapter, and a multiple employer welfare arrangement subject to Article 49 of this Chapter.

(b) In General. -- Except as provided in subsection (c) of this section, an insurer that provides a health benefit plan that contains maternity benefits, including benefits for childbirth, shall ensure that coverage is provided with respect to a mother who is a participant, beneficiary, or policyholder under the plan and her newborn child for a minimum of 48 hours of inpatient length of stay following a normal vaginal delivery, and a minimum of 96 hours of inpatient length of stay following a cesarean section, without requiring the attending provider to obtain authorization from the insurer or its representative.

(c) Exception. -- Notwithstanding subsection (b) of this section, an insurer is not required to provide coverage for postdelivery inpatient length of stay for a mother who is a participant, beneficiary, or policyholder under the insurer's health benefit

plan and her newborn child for the period referred to in subsection (b) of this section if:

(1) A decision to discharge the mother and her newborn child before the expiration of the period is made by the attending provider in consultation with the mother; and

(2) The health benefit plan provides coverage for postdelivery follow-up care as described in subsections(d) and (e) of this section.

(d) Postdelivery Follow-Up Care. -- In the case of a decision to discharge a mother and her newborn child from the inpatient setting before the expiration of 48 hours following a normal vaginal delivery or 96 hours following a cesarean section, the health benefit plan shall provide coverage for timely postdelivery care. This health care shall be provided to a mother and her newborn child by a registered nurse, physician, nurse practitioner, nurse midwife, or physician assistant experienced in maternal and child health in:

(1) The home, a provider's office, a hospital, a birthing center, an intermediate care facility, a federally qualified health center, a federally qualified rural health clinic, or a State health department maternity clinic; or

(2) Another setting determined appropriate under federal regulations promulgated under Title VI of Public Law 104-204.

The attending provider in consultation with the mother shall decide the most appropriate location for follow-up care.

(e) Timely Care. -- As used in subsection (d) of this section, 'timely postdelivery care' means health care that is provided:

(1) Following the discharge of a mother and her newborn child from the inpatient setting; and

(2) In a manner that meets the health care needs of the mother and her newborn child, that provides for the appropriate monitoring of the conditions of the mother and child, and that occurs not later than the 72-hour period immediately following discharge.

(f) Prohibitions. -- An insurer shall not:

(1) Deny enrollment, renewal, or continued coverage with respect to its health benefit plan to a mother and her newborn child who are participants, beneficiaries, or policyholders, based on compliance with this section;

(2) Provide monetary payments or rebates to mothers to encourage the mothers to request less than the minimum coverage required under this section;

(3) Penalize or otherwise reduce or limit the reimbursement of an attending provider because the provider provided treatment to an individual policyholder, participant, or beneficiary in accordance with this section; or

(4) Provide monetary or other incentives to an attending provider to induce the provider to provide treatment to an individual policyholder, participant, or beneficiary in a manner inconsistent with this section.

(g) Effect on Mother. -- Nothing in this section requires that a mother who is a participant, beneficiary, or policyholder covered under this section:

(1) Give birth in a hospital; or

(2) Stay in the hospital for a fixed period of time following the birth of her child.

(h) Level and Type of Reimbursements. -- Nothing in this section prevents an insurer from negotiating the level and type of reimbursement with an attending provider for care provided in accordance with this section."

Section 20. G.S. 58-3-170 reads as rewritten:

"**§ 58-3-170. Requirements for maternity coverage.**

(a) Every entity providing a health benefit plan that provides maternity coverage in this State shall provide benefits for the necessary care and treatment related to maternity that are no less favorable than benefits for physical illness generally.

~~(a1) A health benefit plan that provides maternity coverage shall provide coverage for inpatient care for a mother and her newly-born child for a minimum of forty-eight (48) hours after vaginal delivery and a minimum of ninety-six (96) hours after delivery by caesarean section.~~

(b) As used in this section, 'health benefit plans' means accident and health insurance policies or certificates; nonprofit hospital or medical service corporation contracts; health, hospital, or medical service corporation plan contracts; health maintenance organization (HMO) subscriber contracts; and plans provided by a MEWA or plans provided by other benefit arrangements, to the extent permitted by ERISA."

Section 21. G.S. 58-51-55 reads as rewritten:

"**§ 58-51-55. No discrimination against the mentally ill and chemically dependent.**

(a) Definitions. -- As used in this section, the term:

(1) 'Mental illness' has the same meaning as defined in G.S. 122C-3(21); and

(2) 'Chemical dependency' has the same meaning as defined in G.S. 58-51-50

with a diagnosis found in the Diagnostic and Statistical Manual of Mental Disorders DSM-3-R or the International Classification of Diseases ICD/9/CM, or a later edition of those manuals.

(b) Coverage of Physical Illness. -- No insurance company licensed in this State under ~~the provisions of Articles 1 through 64 of~~ this Chapter shall, solely because an individual to be insured has or had a mental illness or chemical dependency:

(1) Refuse to issue or deliver to that individual any policy that affords benefits or coverages for any medical treatment or service for physical illness or injury;

(2) Have a higher premium rate or charge for physical illness or injury coverages or benefits for that individual; or

(3) Reduce physical illness or injury coverages or benefits for that individual.

(b1) Coverage of Mental Illness. -- A policy that covers both physical illness or injury and mental illness may not impose a lesser lifetime or annual dollar limitation on the mental health benefits than on the physical illness or injury benefits, subject to the following:

(1) A lifetime limit or annual limit may be made applicable to all benefits under the policy, without distinguishing the mental health benefits.

(2) If the policy contains lifetime limits only on selected physical illness and injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the policy, the insurer may impose a lifetime limit on the mental health benefits that is based on a weighted average of the respective lifetime limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.

(3) If the policy contains annual limits only on selected physical illness and injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the policy, the insurer may impose an annual limit on the mental health benefits that is based on a weighted average of the respective annual limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.

(4) Except as otherwise provided in this section, the policy may distinguish between mental illness benefits and physical injury or illness benefits with respect to other terms of the policy, including coinsurance, limits on provider visits or days of coverage, and requirements relating to medical necessity.

(5) If the insurer offers two or more benefit package options under a policy, each package must comply with this subsection.

(6) This subsection does not apply to a policy if the insurer can demonstrate to the Commissioner that compliance will increase the cost of the policy by one percent (1%) or more.

(7) This subsection expires October 1, 2001, but the expiration does not affect services rendered before that date.

(c) Mental Illness or Chemical Dependency Coverage Not Required. -- Nothing in this section ~~prevents any insurance company from excluding from coverage any physical illness or injury or mental illness or chemical dependency which has existed previous to coverage of the individual by the insurance company or from refusing to issue or deliver to that individual any policy because of the underwriting of any physical condition whether or not related to~~ requires an insurer to offer coverage for mental illness or chemical ~~dependency.~~ dependency, except as provided in G.S. 58-51-50.

(d) Applicability. -- ~~This~~ Subsection (b1) of this section applies only to group health insurance contracts covering more than 50 employees. The remainder of this section applies only to group health insurance contracts covering 20 or more employees. For purposes of this section, 'group health insurance contracts' include MEWAs, as defined in G.S. 58-49-30(a)."

Section 22. G.S. 58-65-90 reads as rewritten:

"**§ 58-65-90. No discrimination against the mentally ill and chemically dependent.**

(a) Definitions. -- As used in this section, the term:

(1) 'Mental illness' has the same meaning as defined in G.S. 122C-3(21); and

(2) 'Chemical dependency' has the same meaning as defined in G.S. 58-65-75

with a diagnosis found in the Diagnostic and Statistical Manual of Mental Disorders DSM-3-R or the International Classification of Diseases ICD/9/CM, or a later edition of those manuals.

(b) Coverage of Physical Illness. -- No ~~hospital, medical, dental or health~~ service corporation governed by this Chapter shall, solely because an individual to be insured has or had a mental illness or chemical dependency:

(1) Refuse to issue or deliver to that individual any individual or group ~~hospital, dental, medical or health service~~ subscriber contract in this State that affords benefits or coverage for medical treatment or service for physical illness or injury;

(2) Have a higher premium rate or charge for physical illness or injury coverages or benefits for that individual; or

(3) Reduce physical illness or injury coverages or benefits for that individual.

(b1) Coverage of Mental Illness. -- A subscriber contract that covers both physical illness or injury and mental illness may not impose a lesser lifetime or annual dollar limitation on the mental health benefits than on the physical illness or injury benefits, subject to the following:

(1) A lifetime limit or annual limit may be made applicable to all benefits under the subscriber contract, without distinguishing the mental health benefits.

(2) If the subscriber contract contains lifetime limits only on selected physical illness or injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the subscriber contract, the service corporation may impose a lifetime limit on the mental health benefits that is based on a weighted average of the respective lifetime limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.

(3) If the subscriber contract contains annual limits only on selected physical illness and injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the subscriber contract, the service corporation may impose an annual limit on the mental health benefits that is based on a weighted average of the respective annual limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.

(4) Except as otherwise provided in this section, the subscriber contract may distinguish between mental illness benefits and physical injury or illness benefits with respect to other terms of the subscriber contract, including coinsurance, limits on provider visits or days of coverage, and requirements relating to medical necessity.

(5) If the service corporation offers two or more benefit package options under a subscriber contract, each package must comply with this subsection.

(6) This subsection does not apply to a subscriber contract if the service corporation can demonstrate to the Commissioner that compliance will increase the cost of the subscriber contract by one percent (1%) or more.

(7) This subsection expires October 1, 2001, but the expiration does not affect services rendered before that date.

(c) Mental Illness or Chemical Dependency Coverage Not Required. -- Nothing in this section ~~prevents any hospital or medical plan from excluding from coverage any physical illness or injury or mental illness or chemical dependency which has existed previous to coverage of the individual by the hospital or medical plan or from refusing to issue or deliver to that individual any policy because of the underwriting of any physical condition whether or not related to~~ requires a service corporation to offer coverage for mental illness or chemical ~~dependency.~~ dependency, except as provided in G.S. 58-65-75.

(d) Applicability. -- ~~This~~ Subsection (b1) of this section applies only to subscriber contracts covering more than 50 employees. The remainder of this section applies only to group contracts covering 20 or more employees."

Section 23. G.S. 58-67-75 reads as rewritten:

"**§ 58-67-75. No discrimination against the mentally ill and chemically dependent.**

(a) Definitions. -- As used in this section, the term:

(1) 'Mental illness' has the same meaning as defined in G.S. 122C-3(21); and

(2) 'Chemical dependency' has the same meaning as defined in G.S. 58-67-70

with a diagnosis found in the Diagnostic and Statistical Manual of Mental Disorders DSM-3-R or the International Classification of Diseases ICD/9/CM, or a later edition of those manuals.

(b) Coverage of Physical Illness. -- No health maintenance organization governed by this Chapter shall, solely because an individual has or had a mental illness or chemical dependency:

(1) Refuse to enroll that individual in any health care plan covering physical illness or injury;

(2) Have a higher premium rate or charge for physical illness or injury coverages or benefits for that individual; or

(3) Reduce physical illness or injury coverages or benefits for that individual.

(b1) Coverage of Mental Illness. -- A health care plan that covers both physical illness or injury and mental illness may not impose a lesser lifetime or annual dollar limitation on the mental health benefits than on the physical illness or injury benefits, subject to the following:

(1) A lifetime limit or annual limit may be made applicable to all benefits under the plan, without distinguishing the mental health benefits.

(2) If the plan contains lifetime limits only on selected physical illness and injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the plan, the HMO may impose a lifetime limit on the mental health benefits that is based on a weighted average of the respective lifetime limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.

(3) If the plan contains annual limits only on selected physical illness and injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the plan, the HMO may impose an annual limit on the mental health benefits that is based on a weighted average of the respective annual limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.

(4) Except as otherwise provided in this section, the plan may distinguish between mental illness benefits and physical injury or illness benefits with respect to other terms of the plan, including coinsurance, limits on provider visits or days of coverage, and requirements relating to medical necessity.

(5) If the HMO offers two or more benefit package options under a plan, each package must comply with this subsection.

(6) This subsection does not apply to a health benefit plan if the HMO can demonstrate to the Commissioner that compliance will increase the cost of the plan by one percent (1%) or more.

(7) This subsection expires October 1, 2001, but the expiration does not affect services rendered before that date.

(c) Mental Illness or Chemical Dependency Coverage Not Required. -- Nothing in this section ~~prevents any health maintenance organization from excluding from coverage any physical illness or injury or mental illness or chemical dependency which has existed previous to coverage of the individual by the health maintenance organization or from refusing to issue or deliver to that individual any policy because of the underwriting of any physical condition whether or not related to~~ requires an HMO to offer coverage for mental illness or chemical ~~dependency.~~ dependency, except as provided in G.S. 58-67-70.

(d) Applicability. -- ~~This~~ Subsection (b1) of this section applies only to group contracts covering more than 50 employees. The remainder of this section applies only to group contracts covering 20 or more employees."

Section 24. G. S. 58-3-173 is repealed.

Section 25. Sections 1 through 18 of this act apply to all affected contracts that are delivered, issued for delivery, or renewed on and after July 1, 1997. Sections 19, 20, 21, 22, and 23 of this act apply to all affected contracts that are delivered, issued for delivery, or renewed on and after January 1, 1998. For the purposes of this act, renewal of a contract is presumed to occur on each anniversary of the date on which coverage was first effective on the person or persons covered by the contract.

Section 26. This act is effective when it becomes law.

In the General Assembly read three times and ratified this the 30th day of June, 1997.

s/ Dennis A. Wicker
President of the Senate

s/ Harold J. Brubaker
Speaker of the House of Representatives

s/ James B. Hunt, Jr.
Governor

Approved 12:02 p.m. this 1st day of July, 1997

GENERAL ASSEMBLY OF NORTH CAROLINA
1997 SESSION

S.L. 1997-438
HOUSE BILL 1115

AN ACT TO PROHIBIT THE CANCELLATION OF INSURANCE POLICIES THAT PROVIDE COVERAGE FOR CHURCHES FOR LOSSES RESULTING FROM A FIRE.

The General Assembly of North Carolina enacts:

Section 1. Article 43 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-43-40. Cancellation of fire insurance for buildings owned by religious organizations prohibited in certain circumstances.**

(a) An insurer shall not cancel or decline to renew an insurance policy providing coverage for losses resulting from fire for a building owned by a religious organization solely because of:

(1) A previous occurrence of arson, unless the occurrence of arson was the act of a member of the religious organization that owns the building; or

(2) An oral or written statement directed to the religious organization or a member of the religious organization and threatening an act of arson against the religious organization.

This subsection applies only if:

(1) The religious organization reports all arson threats, arson attempts, or acts of arson to the appropriate law enforcement agency within 48 hours of discovery of such event and to the insurer not later than the second business day after the arson threat, arson attempt or act of arson is reported to the appropriate law enforcement agency; and

(2) The members of the religious organization fully cooperate with law enforcement and the insurer in any investigation of and the prosecution of all offenses related to, an arson threat, an arson attempt, or an act of arson.

(b) As a condition of insurance policy renewal or continuance, an insurer may require that a religious organization implement all reasonable mitigation, loss control, and fire control measures recommended by the local law enforcement agency, the local fire department, or the insurer.

(c) As used in this section, 'religious organization' means any church, ecclesiastical, or denominational organization, or any organization that meets at an established physical place for worship in this State at which nonprofit religious services and activities are regularly conducted.

(d) The Commissioner may revoke, suspend, or refuse to renew the license of any insurer that violates this section pursuant to G.S. 58-3-100."

Section 2. This act becomes effective October 1, 1997, and applies to insurance policies issued or renewed on or after January 1, 1998. This act expires January 1, 2000.

In the General Assembly read three times and ratified this the 19th day of August, 1997.

s/ Marc Basnight
President Pro Tempore of the Senate

s/ Harold J. Brubaker
Speaker of the House of Representatives

s/ James B. Hunt, Jr.
Governor

Approved 10:20 a.m. this 28th day of August, 1997

NORTH CAROLINA GENERAL ASSEMBLY
LEGISLATIVE ACTUARIAL NOTE

BILL NUMBER: House Bill 434, House Committee Substitute

SHORT TITLE: State Health Plan Technical Amendments/AB

SPONSOR(S): Rep. Jerry Dockham

SYSTEM OR PROGRAM AFFECTED: Teachers' and State Employees' Comprehensive Major Medical Plan.

FUNDS AFFECTED: State General Fund, State Highway Fund, Other State Employer Receipts, Premium Payments for Dependents by Active and Retired Teachers and State Employees, and Premium Payments for Coverages Selected by Eligible Former Teachers and State Employees.

BILL SUMMARY: The bill is the recommendation of the Executive Administrator and Board of Trustees of the Plan for changes in the Plan's indemnity program. Most of the bill involves codification of administrative policies previously adopted by the Plan into the Plan's statutes. Consequently, these changes do not involve changes in the Plan's claim costs. However, a few of the recommendations do involve claim costs to the indemnity program if they are enacted.

Before describing the cost items, a review of the administrative and clarifying changes requested to be codified into the statutes follows. These changes are already in use by the Plan. The words "benefit or benefits" are defined to mean a service covered by the program (Sec. 1). Since radial keratotomy procedures are not covered by the program, other related surgeries to correct vision when performed in lieu of corrective lenses are also excluded from coverage (Sec 5). Coinsurance amounts paid by Plan members are calculated on the lower of diagnostic related grouping (DRG) amounts paid for inpatient hospitalizations or a hospital's charges for the admission (Sec. 7). Clarification is made on waiting periods for preexisting health condition exclusions so that waiting periods are not applied whenever enrollments are made within 30 days after eligibility to enroll or re-enroll (Secs. 16, 28, 29). Clarification of non-contributory premium statutes is requested to make employees on approved leaves of absence with pay, on approved workers' compensation leaves, and on approved family and medical leave eligible for continued non-contributory premiums (Sec. 17). The State Retirement System is designated the health benefit representative for retired employees and their dependents (Sec. 18). To be eligible to continue participation in the Plan, former members of the General Assembly who do not commence retirement are required to continue their coverage within 30 days after their last term of office (Sec. 19). Spouses of surviving dependents are not eligible for coverage under the Plan nor are dependent children if they were not covered at the time of a Plan member's death (Sec. 20). Dependents of blind vendors are not eligible for coverage under the Plan since federal rulings have determined that the vendors were contractors and not employees of the State (Sec. 21). Eligibility for permanent-hourly employees of state agencies is repealed since the employee classification has been discontinued (Sec. 22). Clarification is made of the statutes that dependent children of deceased former members of the General Assembly and deceased beneficiaries of the

State's Disability Income Plan are eligible for coverage if covered at the time of the Plan member's death (Sec. 23). Employees eligible for coverage as a dependent and as an employee on a fully contributory basis are permitted the lower premium rate (Sec. 24). Disability Income Plan beneficiaries are allowed to continue coverage on a fully contributory basis when they complete five years of retirement service credit (Sec. 25). Disability Income Plan beneficiaries with less than five years of retirement service credit along with their eligible dependents are allowed to continue coverage under the Plan on a fully contributory basis (Sec. 26). Surviving dependents of deceased Plan members are allowed to continue coverage beyond 90 days following a member's death but will be subject to preexisting health condition limitations (Sec. 27). Plan members wishing to change coverage under the Plan's indemnity program are required to notify health benefit representatives or the Plan within 30 days of the effective date of the change (Secs. 29, 30, 31). Medicare-eligible employees who choose Medicare to be the primary payer of health benefits and lose their eligibility for the program's group health benefits are allowed to convert to a non-group plan of health benefits offered by the indemnity program (Sec. 32). Changes in continuation coverage provided to employees and dependents who lose eligibility for Plan benefits are requested to comply with federal law (Secs. 33, 34, 35). Certified physical therapy and certified occupational therapy assistants are allowed to provide physical and occupational therapy respectively (Secs. 36, 37). Foot surgeries, argon laser trabeculoplasty, and radioallergosorbent tests are covered under the indemnity program without prior approval (Secs. 38, 39). Conformity with federal preexisting health condition limitations are also included provided not more than 63 days separate health coverages (Sec. 40).

Sections 2, 3 and 4 of the bill redefine experimental and investigational procedures that are excluded from coverage under the Plan's indemnity program. The program's current definition has not been able to withstand legal challenges which is the reason for the requested change. Section 4 further excludes from the program's coverage complications arising from noncovered services.

Section 8 of the bill deals with the indemnity program's pre-certification of inpatient hospital admissions. The program's current policies provide that failure of a Plan member to secure a certification or the Plan's denial of a requested certification results in a claim payment penalty of 50% of the admission's expenses up to $500 per admission. The Plan's experience has been that, on occasion, Plan members are glad to pay a penalty of only $500 for uncertified admissions in order to have the balance of the claim paid. Under the Plan's recommendation, the entire expense of the claim would be denied to the extent that the expenses were not medically necessary or appropriate.

Section 10 of the bill requires that skilled nursing facility care benefits be medically necessary and that skilled nursing care be provided on a continuing daily basis to patients who otherwise would require continual hospital confinement.

Sections 14 and 15 of the bill remove the maximum benefit limitations for coverage of chemical dependency under the Plan's self-insured indemnity program. These limits for each covered individual are $8,000 per fiscal year, $25,000 for a lifetime, and $200 per day except for medical detoxification treatment. Removal of these specialized limits for substance abuse will result in its coverage being limited only to the same deductibles, coinsurance factors, and durational and other limitations as generally affect physical illnesses and injuries. Similar limitations on other mental health coverages under the Plan's indemnity program were removed by the 1991 Session of the General Assembly effective January 1,

1992. At that time, inpatient mental health benefits were limited to 30 days per year for each covered individual and outpatient treatments were limited to 50 visits and $2,200 in claim payments per year for each person. When these limitations were removed, a managed individualized plan of case-by-case treatment was implemented for mental health benefits, including utilization review and use of available preferred provider networks to contain the expected cost increases from removing the specialized mental health limitations. Sections 14 and 15 of the bill repeat what the 1991 Session of the General Assembly did in requiring that case management be implemented for chemical dependency benefits to contain the cost increases from removing the current limits on substance abuse benefits.

EFFECTIVE DATE: October 1, 1997 except for Section 40 which is effective July 1, 1997.

ESTIMATED IMPACT ON STATE: Based upon information supplied by the Teachers' and State Employees' Comprehensive Major Medical Plan, the consulting actuary for the Plan, Aon Consulting, estimates that the bill will reduce the indemnity program's claim costs by 0.48% to 0.68%. However, using a midpoint value of 0.58%, the Plan's consulting actuary projects the savings to the Plan's indemnity program to be $1,865,000 for 1997-98 and $4,007,000 for 1998-99. The consulting actuary for the General Assembly's Fiscal Research Division, Dilts, Umstead & Dunn, estimates that the bill will reduce the indemnity program's claim costs by $1,238,000 in 1997-98 and $2,916,000 in 1998-99. The major differences between the two actuarial projections involve chemical dependency, denial of inpatient hospital claims not certified, and excluding coverage for complications arising from non-covered services. For chemical dependency, the consulting actuary for the Plan projects that case management activities will reduce claim costs by the amount of increased chemical dependency claims from removal of the dollar limits. The consulting actuary for the Fiscal Research Division projects that the costs for removal of the chemical dependency limits will exceed the savings realized from case management by $193,000 for 1997-98 and that 1998-99 will be the first year that the savings from case management will generally equate to the increased costs from removing the substance abuse limits. Such was the Plan's experience in 1992 regarding mental health benefit limits and case management. The largest single difference between the actuarial projections involves savings estimated from denial of inpatient hospitalization claims when the admission is not certified. The estimates from the Fiscal Research Division's consulting actuary were lower than those from the Plan's consulting actuary by $342,000 in 1997-98 and $889,000 in 1998-99. The lower estimate from the Fiscal Research Division's consulting actuary was due to a decreasing rate of inpatient hospital admissions being experienced by most major medical plans. With these declining inpatient admissions rate, more and more inpatient admissions will become more justified as being medically necessary and appropriate. The remaining difference between the actuarial projections involves the estimated savings from excluding claim payments for complications arising from non-covered services. The estimated savings projected by the Fiscal Research Division's consulting actuary were lower than those of the Plan's consulting actuary by $75,000 in 1997-98 and $161,000 in 1998-99. Using a combined projection from the two actuarial firms based upon the estimates of the Plan's consulting actuary for all items of savings except for the denial of uncertified inpatient hospital claims and the impact of changes upon chemical dependency claims, both of which incorporate the work of the Fiscal Research Division's consulting actuary, produces an estimated savings to the indemnity program of $1,321,000 for 1997-98 and $3,118,000 for 1998-99.

Further using this combined projection, additional savings in the indemnity program for outlying years are expected to be $3,367,000 for 1999-2000, $3,636,000 for 2000-01, and $3,927,000 for 2001-02.

ASSUMPTIONS AND METHODOLOGY: The Comprehensive Major Medical Plan for Teachers and State Employees is divided into two programs. From October, 1982, through June, 1986, the Plan had only a self-funded indemnity type of program which covered all employees, retired employees, eligible dependents of employees and retired employees, and eligible former employees and their eligible dependents authorized to continue coverage past a termination of employment other than for retirement or disability purposes. A prepaid program of coverage by health maintenance organizations (HMOs) was offered in July, 1986, as an alternative to the Plan's self-insured indemnity program. The benefits of the self-insured indemnity type of program are spelled out in Part 3 of Article 3 of Chapter 135 of the North Carolina General Statutes (i.e., $250 annual deductible, 20% coinsurance up to $1,000 annually, etc. paid by the program's members). HMOs are required to offer benefits that are comparable to those provided by the self-insured indemnity program. Employer-paid non-contributory premiums are only authorized for the indemnity program's coverage for employees and retired employees. Whenever employees and office holders first employed or taking office on and after October 1, 1995 become eligible for health benefits as retired employees, the amount of premium paid by the State for individual coverage will be based upon the retiree's amount of retirement service credit at the time of retirement. Only retired employees with 20 or more years of service credit at retirement will be eligible for non-contributory health benefit premiums. Retirees with 10 or more years of service credit at retirement will be eligible for 50% partially contributory health benefit premiums. Retired employees with 5 or more year of service credit at retirement will be eligible to continue their health benefits on a fully contributory basis. All other types of premium in the indemnity program are fully contributory. Premiums paid by employers to HMOs are limited to like amounts paid to the indemnity program with employees and retired employees paying any HMO amounts above the indemnity program's non-contributory rates. Both types of coverage continue to be available in the Plan with twelve HMOs currently covering about 25% of the Plan's total population in about 85 of the State's 100 counties. The Plan's employees and retired employees select the type of program that they wish for themselves and their dependents during the months of August and September of each year for coverage beginning in October. The demographics of the Plan as of December 31, 1996, include:

	Self-Insured Indemnity Program	Alternative HMOs	Plan Total
Number of Participants			
Active Employees	186,400	70,400	256,800
Active Employee Dependents	104,700	51,800	156,500
Retired Employees	84,400	5,400	89,800
Retired Employee Dependents	14,400	1,200	15,600
Former Employees & Dependents with Continued Coverage	2,700	800	3,500
Total Enrollments	392,600	129,600	522,200
Number of Contracts			
Employee Only	206,300	51,800	258,100
Employee & Child(ren)	29,900	14,500	44,400
Employee & Family	36,600	10,100	46,700
Total Contracts	272,800	76,400	349,200

Percentage of Enrollment by Age			
29 & Under	27.3%	44.7%	31.6%
30-44	21.6	28.0	23.2
45-54	20.0	17.8	19.5
55-64	13.8	7.1	12.1
65 & Over	17.3	2.4	13.6
Percentage of Enrollment by Sex			
Male	39.8%	40.0%	39.8%
Female	60.2	60.0	60.2

Assumptions for the Self-Insured Indemnity Program: For the fiscal year beginning July 1, 1996, the self-insured program started its operations with a beginning cash balance of $368.3 million. Receipts for the year are estimated to be $580 million from premium collections, $25 million from investment earnings, and $12 million in risk adjustment and administrative fees from HMOs, for a total of $617 million in receipts for the year. Disbursements from the self-insured program are expected to be $595 million in claim payments and $18 million in administration and claims processing expenses for a total of $613 million for the year beginning July 1, 1996. For the fiscal year beginning July 1, 1997, the self-insured indemnity program is expected to have an operating cash balance of over $372 million with a net operating loss of $54 million for the 1997-98 fiscal year. For the fiscal year beginning July 1, 1998, the self-insured indemnity program is expected to have an operating cash balance of $318 million with a net operating loss of $118 million for the 1998-99 fiscal year. The estimated cash balance for the self-insured indemnity program is expected to be $200 million at the end of the 1997-99 biennium. The self-insured indemnity program is consequently assumed to be able to carry out its operations without any increases in its current premium rates or a reduction in existing benefits until the 1999-2000 fiscal year. This assumption is predicated upon the fact that the program's cost containment strategies (hospital DRG reimbursements, pre-admission hospital testing, pre-admission hospital inpatient certification with length-of-stay approval, hospital bill audits, required second surgical opinions, mental health case management, coordination of benefits with other payers, Medicare benefit "carve-outs", cost reduction contracts with participating physicians and other providers, prescription drug manufacturer rebates from voluntary formularies, and fraud detection) are maintained and improved where possible. Current non-contributory premium rates are $110.08 monthly for employees whose primary payer of health benefits is Medicare and $144.60 per month for employees whose primary payer of health benefits is not Medicare. Fully contributory premium amounts for employee and child(ren) contracts are $68.50 monthly for children whose primary payer of health benefits is Medicare and $90.12 monthly for other covered children, and $164.30 per month for family contracts whose dependents have Medicare as the primary payer of health benefits and $216.18 per month for other family contract dependents. Claim cost trends are expected to increase 8-10% annually. Total enrollment in the program is expected to decrease about one percent (1.0%) annually due to competition from alternative HMOs. The number of enrolled active employees is expected to show a 1-2% loss annually, whereas the growth in the number of retired employees is assumed to be 4% per year. The program is expected to lose about 3-4% of its number of active employee dependents each year, whereas the number of enrolled retiree dependents is assumed to show no

appreciable change from year to year. Investment earnings are based upon a 6% monthly return on available cash balances. The self-insured indemnity program maintains a claim stabilization reserve for claim cost fluctuations equal to 7.5% of annual claim payments without reserving additional funds for incurred but unreported claims.

Assumptions for the Self-Insured Indemnity Program's Savings from the Bill: During the last three calendar years, the indemnity program denied 12 bone marrow transplant cases that were considered experimental and investigational. However, upon legal challenges, the program paid $1,882,796 in claims for these cases. Also, during this three-year period, the program paid $439,002 in claims from complications arising from non-covered bone marrow transplant, breast implant, and radial keratotomy services. For the same three-year period, the program estimates that it would have saved $225,000 in skilled nursing claim payments had the Plan had clearer definitions of skilled care.

For denial of inpatient hospital claims that were not certified by the program, 893 cases were penalized in calendar year 1996 for $331,532. Claim payments for these same cases were $2,977,836. For calendar year 1995, 995 cases were penalized $366,572 for which $3,389,967 was paid.

For the fiscal year ending June 30, 1996, the Plan's indemnity program paid $1,602,720 in claims related to chemical dependency - $1,011,372 for alcohol abuse and $591,348 for drug abuse. Of the total amount paid, $912,761 was paid for inpatient care, $500,015 was paid for outpatient treatment, $155,590 was paid for partial hospitalizations, and the remaining $34,354 was paid for residential treatment programs. Total charges for these paid claims was $2,877,638. Of the total amount of claim payments made during 1995-96, almost 80% were paid on behalf of the program's active employee group including both employees and their enrolled dependents. This active employee group accounted for 215 inpatient admissions involving 2,519 inpatient days for an average length-of-stay of almost 12 days. For outpatient treatment, the active employee group accounted for 3,909 visits by some 654 patients for an average of 6 visits per patient for the year. In comparison to fiscal year 1994-95 claims experience for substance abuse, 1995-96's experience showed a decrease of over $400,000 in paid claims for a 20% drop. In addition, the active employee group's inpatient admissions fell by over 35% for 1995-96 and the number of inpatient days dropped by over 40%. Outpatient visits for the active employee group for 1995-96 however remained about the same as they were in 1994-95.

Since the inception of the Plan in October, 1982, substance abuse benefits in the Plan's indemnity program have been limited. Through December, 1984, the indemnity program's substance abuse benefits were limited to 30 days per person each year for inpatient care and to 50 visits and $2,200 in claim payments annually for outpatient treatment for each covered individual. In addition, outpatient care was subject to a 20% coinsurance rate paid by enrolled members whereas all other care was subject to a 5% or 10% coinsurance rate. Effective January 1, 1985, these limitations were replaced with a 30-day claim payment limit of $3,000, an annual claim payment limit of $5,000, a lifetime claim payment limit of $15,000, and a $100 daily limit for non-medical detoxification treatment for each person. Effective September 1, 1987, the 30-day limit was increased to $3,900, the annual limit was increased to $6,500, the lifetime limit was increased to $20,000, and the daily detoxification limit was increased to $130. Effective October 1, 1989, the 30-day limit was eliminated, the annual limit was increased to $8,000, the lifetime limit was increased to $25,000, and the daily detoxification limit was raised to $200. No further changes have been made to these limits since October, 1989. Over the last

three years, the indemnity program's records show that $1,457,649 in substance abuse claims have been denied by the program in exceeding these benefit limits.

SOURCES OF DATA:
-Actuarial Note, Dilts, Umstead & Dunn, House Bill 435, April 24, 1997, original of which is on file in the General Assembly's Fiscal Research Division.
-Actuarial Note, Aon Consulting, House Bill 435, April 23, 1997, original of which is on file with the Comprehensive Major Medical Plan for Teachers and State Employees and the General Assembly's Fiscal Research Division.

TECHNICAL CONSIDERATIONS: None.

FISCAL RESEARCH DIVISION
733-4910
PREPARED BY: Sam Byrd
APPROVED BY: Tom L. Covington
DATE: July 16, 1997.

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May 13, 1997

MEMORANDUM

TO: Senate Pensions and Retirement & Insurance Committee

FROM: Linwood Jones, Staff Counsel

RE: House Bill 1115 (Church Insurance Coverage)

House Bill 1115 prohibits an insurer from canceling or nonrenewing a fire insurance policy covering a building owned by a religious organization solely because of a previous occurrence of arson or a threat of arson. This prohibition does not apply if the previous act of arson was committed by an official of the religious organization that owns the building.

The bill defines "religious organization" as any church, ecclesiastical, or denominational organization, or any established physical place for worship in this State at which nonprofit religious services and activities are regularly conducted.

The Commissioner may suspend, revoke, or refuse to renew the license of an insurance company that violates this law.

The act takes effect October 1, 1997, and applies to policies issued or renewed on or after January 1, 1998.

H1115-SMRN-001

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

VISITOR REGISTRATION SHEET

Pen. & Ref. — 6-11-97

Name of Committee — Date

VISITORS: Please sign below and return to Committee Clerk.

NAME	FIRM OR STATE AGENCY AND ADDRESS
Tommy Watts	CHS
[illegible]	Insurance Co
V. L. Williams	Bd. Cons & Transp
[illegible]	NCALG
Bruce Watts	Senator Reeves
Stan Williams	State HHS Assn.
[illegible]	Smith Anderson
Amy Nunnelee	Hunton & Williams
[illegible]	NC DOL
Sharon H. [illegible]	NC DOT
[illegible]	citizen
Alan Niles	Bailey & Dixon, LLP
[illegible]	Morris Van Alen
[illegible]	Nationwide
[illegible]	N.C. Podiatry Society
[illegible]	Bode Call & Stroupe
[illegible]	Columbia
[illegible]	Assn NC Life Cos.
[illegible]	[illegible]
Robb Pasichow	Young Moore
Fran Taylor	WRAL-TV

Pensions & Retirement/ Insurance Committee
June 26,1997
10:00
1124 LB
Sen Jenkins, Chairman

AGENDA

SB 778 Fire Marshall Retirement
Sen. Warren

HB 452 Beach Plan Amemdments
Rep. Redwine

Pensions & Retirement / Insurance Committee Meeting

MINUTES

The Pensions & Retirement/ Insurance Committee met June 25, 1997 at 10;00 in room 1124 of the Legislative Building. There were fourteen members in attendance including Sen. Jenkins, who presided. The following bills were acted upon:

SB 778 **Fire Marshall Retirement.** The proposed committee substitute bill was explained by Sen. Warren. Sen. Odom moved for an unfavorable as to original bill, but favorable as to committee substitute. The motion carried. Sen. Jenkins referred the bill to Appropriations.

SB 452 **Beach Plan Amendments.** Rep. Redwine explained the bill. J. Fletcher Willey,Jr, J. Fletcher Willey Agency, Inc. and Gerald W. Bell, National Association of Independent Insurers. Sen. Soles sent forth an amendment that was approved and rolled into a committee substitute. Sen. Odom moved for an unfavorable as to the original bill, but favorable as to committee substitute. The motion carried.

The meeting was adjourned.

Sen. Jenkins, Chairman

Katy Haynes, Clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

PENSIONS & RETIREMENT/ INSURANCE COMMITTEE REPORT
Senator Tommy Jenkins, Chairman

Tuesday, July 01, 1997

SENATOR TOMMY JENKINS,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO C.S. BILL

S.B. 778 Fire Marshall Retirement

Draft Number:	PCS6673
Sequential Referral:	None
Recommended Referral:	Appropriations
Long Title Amended:	No

TOTAL REPORTED: 1

Committee Clerk Comment: None

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

PENSIONS & RETIREMENT/INSURANCE COMMITTEE REPORT
Senator Tommy Jenkins, Chairman

Wednesday, June 25, 1997

SENATOR JENKINS
submits the following with recommendations as to passage:

**UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 1,
BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL**

H.B.(CS #1)452 Beach Plan Amendments/AB

Draft Number:	PCS1412
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 1

Committee Clerk Comment: None

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

S 2

SENATE BILL 778
Pensions & Retirement and Insurance Committee Substitute Adopted 7/1/97

Short Title: Fire Marshal Retirement. (Public)

Sponsors:

Referred to: Appropriations.

April 10, 1997

A BILL TO BE ENTITLED

AN ACT TO INCLUDE COUNTY FIRE MARSHALS IN THE FIREMEN'S AND RESCUE SQUAD WORKERS' PENSION FUND.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-86-25 reads as rewritten:

"**§ 58-86-25. 'Eligible firemen' defined; determination and certification of volunteers meeting qualifications.**

'Eligible firemen' shall mean all firemen of the State of North Carolina or any political subdivision thereof, including those performing such functions in the protection of life and property through fire fighting within a county or city governmental unit and so certified to the Commissioner of Insurance by the governing body thereof, and who belong to a bona fide fire department which, as determined by the Commissioner, is classified as not less than class '9' or class 'A' and 'AA' departments in accordance with rating methods, schedules, classifications, underwriting rules, bylaws or regulations effective or applied with respect to the establishment of rates or premiums used or charged pursuant to Articles 36 or 40 of this Chapter or by such other reasonable methods as the Commissioner may determine, and which operates fire apparatus and equipment of the value of five thousand dollars ($5,000) or more, and said fire department holds drills and meetings not less than four hours monthly and said firemen attend at least 36 hours of all drills and meetings in each calendar year. 'Eligible firemen' shall also mean the fire marshal of each county, provided the board of county commissioners of that county certifies the fire marshal's attendance at no less than 36 hours of all drills and

meetings in each calendar year. 'Eligible firemen' shall also mean those persons meeting the other qualifications of this section, not exceeding 25 volunteer firemen plus one additional volunteer fireman per 100 population in the area served by their respective departments. Each department shall annually determine and report the names of those firemen meeting the eligibility qualifications to its respective governing body, which upon determination of the validity and accuracy of the qualification shall promptly certify the list to the board. For the purposes of the preceding sentence, the governing body of a fire department operated: by a county is the county board of commissioners; by a city is the city council; by a sanitary district is the sanitary district board; by a corporation, whether profit or nonprofit, is the corporation's board of directors; and by any other entity is that group designated by the board."

Section 2. This act becomes effective July 1, 1997.

GENERAL ASSEMBLY OF NORTH CAROLINA
1997 SESSION

SESSION LAW 1997-498
HOUSE BILL 452

AN ACT TO AMEND THE BEACH PLAN PARTICIPATION FORMULA, PROVIDE FOR WINDSTORM AND HAIL INSURANCE IN COASTAL COUNTIES, AUTHORIZE THE LEGISLATIVE RESEARCH COMMISSION TO STUDY THE AVAILABILITY OF PROPERTY INSURANCE IN THE STATE, AND REVISE OTHER STATUTES RELATED TO THE INSURANCE UNDERWRITING ASSOCIATION.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-45-5 reads as rewritten:

"**§ 58-45-5. Definition of terms.**

~~In~~ As used in this Article, unless the context clearly otherwise ~~requires,~~ requires:

(1) 'Association' means the North Carolina Insurance Underwriting Association established ~~pursuant to the provisions of~~ under this Article;

(2) 'Beach area' means all of that area of the State of North Carolina south and east of the inland waterway from the South Carolina line to Fort Macon (Beaufort Inlet); thence south and east of Core, Pamlico, Roanoke and Currituck sounds to the Virginia line, being those portions of land generally known as the Outer Banks;

(2a) 'Coastal area' means all of that area of the State of North Carolina comprising the following counties: Beaufort, Brunswick, Camden, Carteret, Chowan, Craven, Currituck, Dare, Hyde, Jones, New Hanover, Onslow, Pamlico, Pasquotank, Pender, Perquimans, Tyrrell, and Washington. 'Coastal area' does not include the portions of these counties that lie within the beach area.

(3) Repealed by Session Laws 1991, c. 720, s. 6.

(3a) 'Crime insurance' means insurance against losses resulting from robbery, burglary, larceny, and similar crimes, as more specifically defined and limited in the various crime insurance policies, or their successor forms of coverage, approved by the Commissioner and issued by the Association. Such policies shall not be more restrictive than those issued under the Federal Crime Insurance Program authorized by Public Law 91-609.

(3b) 'Directors' means the Board of Directors of the Association.

(4) 'Essential property insurance' means insurance against direct loss to property as defined in the standard statutory fire policy and extended coverage, vandalism and malicious mischief endorsements thereon, or their successor forms of coverage, as approved by the Commissioner;

(5) 'Insurable property' means real property at fixed locations in the ~~Beach area~~ beach and coastal area, including travel trailers when tied down at a fixed location, or the tangible personal property located therein, but shall not include insurance on motor ~~vehicles or farm risks;~~ vehicles; which property is determined by the Association, after inspection and under the criteria specified in the plan of operation, to be in an insurable condition. However, any one and two family dwellings built in substantial accordance with the Federal Manufactured Home Construction and Safety Standards, any predecessor or successor federal or State construction or safety standards, and any further construction or safety standards promulgated by the association and approved by the Commissioner, or the North Carolina Uniform Residential Building Code and any structure or building built in substantial compliance with the North Carolina State Building Code, including the design-wind requirements, which is not otherwise rendered uninsurable by reason of use or occupancy, shall be an insurable risk within the meaning of this Article. However, none of the following factors shall be considered in determining insurable condition: neighborhood, area, location, environmental hazards beyond the control of the applicant or owner of the property. Also, any structure begun on or after January 1, 1970, not built in substantial compliance with the Federal Manufactured Home Construction and Safety Standards, any predecessor or successor federal or State construction or safety standards, and any further construction or safety standards promulgated by the association and approved by the Commissioner, or the North Carolina Uniform Residential Building Code or the North Carolina State Building Code, including the design-wind requirements therein, shall not be an insurable risk. The owner or applicant shall furnish with the application proof in the form of a certificate from a local building inspector, contractor, engineer or architect that the structure is built in substantial accordance with the Federal Manufactured Home Construction and Safety Standards, any predecessor or successor federal or State construction or safety standards, and any further construction or safety standards promulgated by the association and approved by the Commissioner, or the North Carolina Uniform Residential Building Code or the North Carolina State Building Code; however, an individual certificate shall not be necessary where the structure is located within a political subdivision which has certified to the Association on an annual basis that it is enforcing the North Carolina Uniform Residential Building Code or the North Carolina State Building Code and has no plans to discontinue enforcing these codes during that year.

(6) Repealed by Session Laws 1995 (Regular Session, 1996), c. 592, s. 2.

(6a) 'Net direct premiums' means gross direct premiums (excluding reinsurance assumed and ceded) written on property in this State for essential property insurance, farmowners insurance, homeowners insurance, and the property portion of commercial multiple peril insurance policies as computed by the Commissioner, less:

a. Return premiums on uncancelled contracts;
b. Dividends paid or credited to policyholders; and
c. The unused or unabsorbed portion of premium deposits.

(7) 'Plan of operation' or 'plan' means the plan of operation of the Association approved or promulgated by the ~~Commissioner, pursuant to the provisions of~~ Commissioner under this Article."

Section 2. G.S. 58-45-25 reads as rewritten:

"**§ 58-45-25. Each member of Association to participate in its expenses, profits, and losses.**

~~All members of the Association shall participate in its expenses, profits, and losses and shall receive credit annually for essential property insurance voluntarily written as determined by the directors of the Association, with the approval of the Commissioner. Participation of each member in the losses of the Association shall be reduced accordingly. Any insurer authorized to write and engage in writing any insurance, the writing of which requires the insurer to be a member of the Association, pursuant to G.S. 58-45-10, shall become a member of the Association on the January 1 immediately following authorization and the determination of the insurer's participation in the Association shall be made as of the date of membership in the same manner as for all other members of the Association.~~

(a) Each member of the Association shall participate in the expenses, profits, and losses of the Association in the proportion that its net direct premium written in this State during the preceding calendar year for residential and commercial properties outside of the beach and coastal areas bears to the aggregate net direct premiums written in this State during the preceding calendar year for residential and commercial properties outside of the beach and coastal areas by all members of the Association, as certified to the Association by the Commissioner. The Commissioner shall certify each member's participation after review of annual statements and any other reports and data necessary to determine participation and may obtain any necessary information or data from any member of the Association for this purpose. Any insurer that is authorized to write and that is engaged in writing any insurance, the writing of which requires the insurer to be a member of the Association under G.S. 58-45-10, shall become a member of the Association on the first day of January after authorization. The determination of the insurer's participation in the Association shall be made as of the date of membership of the insurer in the same manner as for all other members of the Association.

(b) All member companies shall receive credit each year for essential property insurance, farmowners insurance, homeowners insurance, and the property portion of commercial multiple peril policies voluntarily written in the beach and coastal areas in accordance with guidelines and procedures to be submitted by the Directors to the Commissioner for approval. The participation of each member company in the expenses, profits, and losses of the Association shall be reduced accordingly; provided, no credit shall be given where coverage for the peril of wind has been excluded. The guidelines and procedures for granting credit shall encourage and assist each member company to voluntarily write these coverages in the beach and coastal areas for commercial and residential properties."

Section 3. G.S. 58-45-30(a) reads as rewritten:

"(a) ~~Within 90 days after April 17, 1969, the directors of the Association~~ The Directors shall submit to the Commissioner for his review and approval, a proposed plan of operation. ~~Such proposed~~ The plan shall set forth the number, qualifications, terms of office, and manner of election of the members of the board of directors, and shall grant proper credit annually to each member of the Association for essential property ~~insurance~~ insurance, farmowners, homeowners insurance, and the property portion of commercial multiple peril policies voluntarily written in the beach ~~area~~

and coastal areas and shall provide for the efficient, economical, fair and nondiscriminatory administration of the Association and for the prompt and efficient provision of essential property insurance in the beach and coastal areas of North Carolina ~~so as~~ to promote orderly community development in those areas and to provide means for the adequate maintenance and improvement of the property in ~~such~~ those areas. ~~Such proposed~~ The plan may include ~~a preliminary assessment of all members for initial expenses necessary to the commencement of operation;~~ the establishment of necessary facilities; management of the Association; ~~plan for~~ the assessment of members to defray losses and expenses; underwriting standards; procedures for the acceptance and cession of reinsurance; procedures for determining the amounts of insurance to be provided to specific risks; time limits and procedures for processing applications for ~~insurance~~ insurance; and ~~for such~~ any other provisions ~~as may be deemed~~ that are considered necessary by the Commissioner to carry out the purposes of this Article."

Section 4. G.S. 58-33-100 reads as rewritten:

"**§ 58-33-100. Payment of premium to agent valid; obtaining by fraud a crime.**

(a) Any agent, broker or limited representative who acts for a person other than himself negotiating a contract of insurance is, for the purpose of receiving the premium therefor, the company's agent, whatever conditions or stipulations may be contained in the policy or contract. This subsection does not apply to the Insurance Underwriting Association established under Article 45 of this Chapter or the Joint Underwriting Association established under Article 46 of this Chapter.

(b) ~~Such~~ Any agent, broker or limited representative knowingly procuring by fraudulent representations payment, or the obligation for the payment, of a premium of insurance, shall be guilty of a Class 1 misdemeanor."

Section 5. G.S. 58-45-35(b) reads as rewritten:

"(b) If the Association determines that the property is insurable and that there is no unpaid premium due from the applicant for prior insurance on the property, the Association, upon receipt of the premium, or part of the premium, as is prescribed in the plan of operation, shall cause to be issued a policy of essential property insurance and shall offer additional extended coverage, optional perils endorsements, business income and extra expense coverage, crime insurance, separate policies of windstorm and hail insurance, or their successor forms of coverage, for a term of one year or three years. Short term policies may also be issued. Any policy issued under this section shall be renewed, upon application, as long as the property is insurable property."

Section 6. G.S. 58-45-35(e) reads as rewritten:

"(e) Policies of windstorm and hail insurance provided for in subsection (b) of this section are available only for risks in the beach and coastal areas for which essential property insurance has been written by licensed insurers. Whenever such other essential property insurance written by licensed insurers includes replacement cost coverage, the Association shall also offer replacement cost coverage. In order to be eligible for a policy of windstorm and hail insurance, the applicant shall provide the Association, along with the premium payment for the windstorm and hail insurance, a certificate that the essential property insurance is in force. The policy forms for windstorm and hail insurance shall be filed by the Association with the Commissioner for his approval before they may be used. Catastrophic losses, as determined by the Association and approved by the Commissioner, that are covered under the windstorm and hail coverage in the beach and coastal areas shall be adjusted by the licensed insurer that issued the essential property insurance and not by the Association. Expenses incurred by the licensed insurer in adjusting windstorm and hail losses shall be reimbursed by the Association."

Section 7. G.S. 58-45-45(b) reads as rewritten:

"(b) The rates, rating plans, and rating rules for the separate policies of windstorm and hail insurance described in G.S. 58-45-35(b) shall be filed by the Association with the Commissioner for the Commissioner's approval, disapproval, or modification. The provisions of Articles 40 and 41 of this Chapter shall govern the filings. For windstorm and hail policies issued or renewed in the coastal area, unless otherwise determined by the Commissioner, the Association shall charge ninety percent (90%) of the approved windstorm and hail rates for the coastal area. Policy deductible plans, consistent with G.S. 58-45-1(b), may be filed by the Association with the Commissioner for the Commissioner's approval, disapproval, or modification."

Section 8. Effective January 1, 2000, G.S. 58-45-45(b), as amended by Section 7 of this act, reads as rewritten:

"(b) The rates, rating plans, and rating rules for the separate policies of windstorm and hail insurance described in G.S. 58-45-35(b) shall be filed by the Association with the Commissioner for the Commissioner's approval, disapproval, or modification. The provisions of Articles 40 and 41 of this Chapter shall govern the filings. ~~For windstorm and hail policies issued or renewed in the coastal area, unless otherwise determined by the Commissioner, the Association shall charge ninety percent (90%) of the approved windstorm and hail rates for the coastal area.~~ Policy deductible plans, consistent with G.S. 58-45-1(b), may be filed by the Association with the Commissioner for the Commissioner's approval, disapproval, or modification."

Section 9. G.S. 58-45-1 reads as rewritten:

"**§ 58-45-1. Declarations and purpose of Article.**

(a) It is hereby declared by the General Assembly of North Carolina that an adequate market for essential property insurance is necessary to the economic welfare of the ~~beach area~~ beach and coastal areas of the State of North Carolina and that without such insurance the orderly growth and development of ~~the beach area of the State of North Carolina~~ those areas would be severely impeded; that furthermore, adequate insurance upon property in the ~~beach area~~ beach and coastal areas is necessary to enable homeowners and commercial owners to obtain financing for the purchase and improvement of their property; and that while the need for such insurance is increasing, the market for such insurance is not adequate and is likely to become less adequate in the future; and that the present plans to provide adequate insurance on property in the ~~beach area,~~ beach and coastal areas, while deserving praise, have not been sufficient to meet the needs of this area. It is further declared that the State has an obligation to provide an equitable method whereby every licensed insurer writing essential property insurance in North Carolina is required to meet its public responsibility instead of shifting the burden to a few willing and public-spirited insurers. It is the purpose of this Article to accept this obligation and to provide a mandatory program to assure an adequate market for essential property insurance in the beach ~~area~~ and coastal areas of North Carolina.

(b) The General Assembly further declares that it is its intent in creating and, from time to time, amending this Article that the market provided by this Article not be the first market of choice, but the market of last resort."

Section 10. G.S. 58-46-1(a) reads as rewritten:

"(a) It is the purpose of this Article to provide a program whereby adequate basic property insurance may be made available to property owners having insurable property in the State. It is further the purpose of this Article to encourage the improvement of properties located in the State and to arrest the decline of properties located in the State. It is the intent of the General Assembly in creating and, from time to time, amending this Article that the market provided by this Article not be the first market of choice, but the market of last resort."

Section 11. The Legislative Research Commission may study the provisions of Articles 45 and and 46 of Chapter 58 of the General Statutes, other relevant portions of the North Carolina General Statutes, and the plans and operations of the North Carolina Insurance Underwriting Association and the North Carolina Joint Underwriting Association. The Commission may consider all possible options to improve availability of property and homeowners insurance in the State. The Commission may report its findings and recommendations, along with legislation, to the 1998 Regular Session of the 1997 General Assembly and to the 1999 General Assembly.

Section 12. The North Carolina Insurance Underwriting Association and the Commissioner of Insurance shall consider any further revisions necessary for the participation formulas of the Association for the purpose of encouraging insurance companies to voluntarily write property insurance policies in the beach and coastal areas of the State.

Section 13. The North Carolina Insurance Underwriting Association shall use the "take out" program, as filed with and approved by the Commissioner, in the coastal area.

Section 14. If any section or provision of this act is declared unconstitutional or invalid by the courts, it does not affect the validity of the act as a whole or any part other than the part so declared to be unconstitutional or invalid.

Section 15. Section 4 of this act becomes effective October 1, 1997. Sections 2, 3, 6, 7, 8, 9, 10, and 13 of this act become effective January 1, 1998. The remainder of this act is effective when it becomes law.

In the General Assembly read three times and ratified this the 28th day of August, 1997.

s/ Marc Basnight
President Pro Tempore of the Senate

s/ Harold J. Brubaker
Speaker of the House of Representatives

s/ James B. Hunt, Jr.
Governor

Approved 4:28 p.m. this 11th day of September, 1997

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June 25, 1997

MEMORANDUM

TO: Senate Pensions and Retirement and Insurance Committee

FROM: Linwood Jones, Staff Counsel

RE: House Bill 452 (Beach Plan Amendments)

Overview: *The primary objective of the proposed Senate Committee Substitute for House Bill 452 is to encourage insurance companies to write more insurance policies voluntarily in the beach and coastal areas of the State. The "beach area" is the barrier islands (the strip of land east of the intracoastal waterway). The "coastal area" is the following 18 eastern counties: Beaufort, Brunswick, Camden, Carteret, Chowan, Craven, Currituck, Dare, Hyde, Jones, New Hanover, Onslow, Pamlico, Pasquotank, Pender, Perquimans, Tyrrell, and Washington. The "coastal area" does not include the "beach area" portion of those counties that adjoin the Atlantic Ocean.*

The objective of encouraging more insurers to write coverage in the beach and coastal areas is carried out by the following provisions in the bill:

- *The Beach Plan's wind and hail pool will be extended to the 18 coastal area counties, allowing insurers to underwrite all of a policy except for wind coverage, with the wind coverage being picked up by the Beach plan*

- *The formula for determining an insurer's liability under the Beach Plan is revised to encourage insurers to write the entire policy, including wind coverage, in the beach and coastal areas.*

- *A temporary (2-year) rate ceiling on the cost of a Beach Plan windpool policy will help ensure that homeowners' premiums are not adversely impacted by an insurer's decision to write policies that exclude wind coverage.*

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

- *A special "take-out" program will be used in the coastal and beach areas to assist insurance companies who do not typically write coverage in these areas to voluntarily underwrite some coverage in these areas.*

- *The FAIR and Beach Plans are officially recognized as markets of last resort, and the Beach Plan is authorized to develop hurricane deductibles, subject to the approval of the Commissioner.*

- *An LRC study will continue to look at the issues that affect coastal insurance availability*

In addition, the bill makes the following related changes:

- *Insurers will adjust claims for wind losses when the Beach Plan insures those losses to help ensure there are sufficient adjusters to handle claims following a hurricane or other major windstorm.*

- *Extra expense" coverage is authorized in the Beach Plan to complement the business income coverage that was legislatively authorized last year.*

- *Travel trailers that are tied down at a fixed location will be eligible for coverage in the Beach Plan.*

- *The Beach Plan can issue short-term policies.*

Background: In 1967, concerned about the ability of homeowners and other property owners on the beaches to obtain property insurance coverage, the General Assembly enacted legislation authorizing the Commissioner of Insurance to develop a plan under which insurers would provide this coverage (Chapter 1111, 1967 Session Laws). In 1969, this legislation was repealed and replaced with the "Beach Plan." The Beach Plan was and still is a "residual" market. - i.e., the place to get insurance if the property owner is unsuccessful in getting an insurance company to voluntarily write property insurance coverage for him. All of the insurance companies that write property insurance in this State (except for town and county mutuals and assessable mutuals) participate in the Beach Plan, sharing in its expenses, profits, and losses.

In 1969, the legislature also created a "FAIR" plan as a residual market for property owners in urban areas of the State who were unable to obtain voluntarily-written property insurance from insurers. The FAIR Plan was eventually amended so that it became the residual property insurance market for the entire State except for the area covered by the Beach Plan. The Beach Plan was also amended so that it could offer policies that covered only wind and hail. This allowed the insurance companies to continue writing the more desirable risks, while allowing the Beach Plan to write the

wind and hail coverage -- the biggest exposure to a company writing property insurance on the beaches.

In the 1990s, windstorm activity along the Atlantic seaboard and Gulf Coast, especially Hurricane Andrew in 1992, prompted insurers to review their exposure along the Atlantic and Gulf coasts. Many insurers have since limited their coastal exposure by limiting the number of new policies, nonrenewing some of their existing policies, and placing more underwriting restrictions on coastal and beach properties.

As the market tightened in North Carolina, the legislature became involved. In 1992, a legislative study panel recommended and the General Assembly approved several changes to the operations of the Beach Plan. Additional changes were made administratively by the Association to address other concerns about the Beach Plan. However, none of the 1992 legislative or administrative actions directly addressed overall insurance availability issue in the beach area.

In 1995, a new legislative study panel was formed to examine the issue of insurance availability in the Beach area. Three of the panel's recommendations concerning the Beach Plan were enacted. These three proposals :

- Required the Department of Insurance and the Association that administers the Beach Plan to examine the feasibility of establishing a catastrophic reserve fund to pay for catastrophic insured losses from a hurricane.

- Made business income coverage available through the Beach Plan

- Required the Association that administers the Beach Plan to revise the "participation formula" (the formula that determines each insurance company's liability under the Beach Plan) in a manner that will encourage insurers to write more business voluntarily (rather than the Beach Plan writing that coverage).

House Bill 452: House Bill 452, as originally introduced, contained the implementing legislation to carry out the legislature's objective of encouraging insurers to voluntarily write property insurance coverage for homeowners and business owners living in the beach area. The Association has developed a revised participation formula that is designed to encourage insurers to write more business voluntarily in the Beach area. The revised formula contains a new credit system that recognizes the extent to which an insurer participates in insuring properties in the Beach area. The new credit system contains tiers of credits, with higher participation in the Beach area earning higher credits, up to a maximum credit established by the Board. The new credit system also extends credit for all of the homeowners premium written by an insurer in the Beach area (not just a portion of that premium as in the past) and withholds credit for policies that exclude wind and hail coverage.

House Bill 452, as introduced, makes several additional changes: (1) making coverage available in the Beach Plan for travel trailers that are tied down at a fixed

location; (2) making clear that independent agents are not acting as the Association's agents when insuring property through the Beach Plan; and (3) authorizing short-term policies to be issued in the Beach Plan.

Proposed Senate Committee Substitute: The proposed Senate Committee Substitute retains the changes proposed in the House bill, but makes several additional changes. The most significant of these changes is the expansion of the Beach Plan's "wind and hail pool" into the 18-county coastal area. These 18 counties form what has historically been known for insurance rating and underwriting purposes as the "Seacoast" territory.

The expansion of the Beach Plan's wind and hail coverage into these counties is intended to address insurance availability concerns in these areas by providing insurers an incentive to write more coverage voluntarily. An insurer will be able to write a person in the coastal area an insurance policy that excludes wind and hail coverage. The policyholder can obtain the wind and hail coverage through the Beach Plan. This applies to both homeowners and business owners. For homeowners in the coastal area, the bill also imposes a ceiling during the first two years (calendar years 1998 and 1999) on the rates they will pay to buy wind coverage from the Beach Plan. The rate cap, although not guaranteeing a particular rate, provides assurance to homeowners in the coastal area that they will not see a substantial increase in their homeowners' premium solely because their wind coverage is obtained from the Beach Plan. The Plan can charge only 90% of its approved rate for wind coverage. The insurer writing the wrap-around policy can charge, as under current law, up to the amount filed by the North Carolina Rate Bureau and approved by the Commissioner of Insurance. Neither current law nor this bill prevents an insurer from eliminating its discount program(s).

The rate cap is a temporary measure that eases the transition of the Beach Plan's windpool into the coastal area communities. It expires in two years. The cap applies only in the coastal area, not the beach area. The cap also does not apply to commercial insurance policies because rates on those policies are not regulated in the same manner as homeowners' rates.

The FAIR plan will continue to operate in the coastal area. The FAIR Plan is intended as a residual market for properties that insurers are reluctant to underwrite because of concerns about arson, vandalism, and similar exposures, not necessarily because of concerns about wind damage. However, the FAIR plan remains available for a property where wind exposure is the primary concern if the property owner is unable to find an insurer that will write the basic policy without wind coverage. The Beach Plan's wind and hail pool comes into play in the coastal area only if the insurer is willing to write the wrap-around policy. This marks one of the major differences in this legislation between the beach area and the coastal area: in the beach area, the Beach Plan can write wind-only coverage or it can write the entire policy (a dwelling policy with some extended coverages), but in the coastal area, the Beach Plan can only write a wind-only policy.

The proposed Senate Committee Substitute also makes the following changes:

* Requires insurers who write the basic coverage without wind to adjust the wind-related losses incurred by their policyholders who obtain their wind coverage through the Beach Plan. Under this provision, an insurer, not the Beach Plan Association, would handle the wind loss claim of its policyholder even though the Association, not the insurer, insured the wind loss. However, the insurer would be reimbursed by the Association for the expenses it incurs in adjusting these claims.

* Makes "extra expense" coverage available through the Beach Plan. The legislature added "business income" coverage to the Beach Plan last year.

* Authorizes the Legislative Research Commission to study the Beach Plan and FAIR Plan and to look at additional options to improve property insurance availability in the State.

* Authorizes the Commissioner of Insurance and the Association that administers the Beach Plan to consider any changes in the Beach Plan participation formula in order to encourage insurers to write property insurance voluntarily in the coastal and beach areas. Although a new formula is set to take effect in the beach area on January 1, 1998, the Commissioner and the Association might decide that a different participation formula is called for in the coastal area or that the new beach formula should be adjusted.

* Requires the Association that administers the Beach Plan to use its "take-out" program that was recently developed for the beach area in the coastal area also. The "take-out" program is a voluntary program through which insurance companies that do not write property insurance in the beach or coastal areas can indicate to the Beach Plan their willingness to consider writing a limited amount of coverage in the beach and coastal areas.

* Officially recognizes the FAIR and Beach Plans as the markets of last resort. This is in keeping with the legislative intent to encourage insurance companies to voluntarily write property coverage in the beach and coastal areas of the State. Consistent with this intent, the Association may include hurricane deductibles in the Beach Plan, if approved by the Commissioner, to help manage the Plan's exposure to hurricane losses.

Except for the section that clarifies in G.S. 58-33-100 that insurance agents doing business with the Beach or FAIR plans are not the agents of those plans, this bill becomes effective January 1, 1998.

H452-SMRN-003

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May 1, 1997

MEMORANDUM

TO: Senator Ed Warren

FROM: Stanley Moore SM
Fiscal Research Division

SUBJECT: Actuarial Note (Committee Substitute for Senate Bill 778)

Re: Allows the fire marshal of each county to be a member of the Firemen's and Rescue Squad Workers' Pension Fund

In accordance with North Carolina General Statute 120-114 and applicable Rules of the North Carolina Senate and House of Representatives, attached is a certified copy of an original actuarial note on the above subject as prepared by the General Assembly's Consulting Actuary. A certified copy of an original actuarial note on the same subject from the Plan Administrator's Consulting Actuary is also attached for your review.

cc: Chairman, Senate Committee on Pensions & Retirement/Insurance
Senate Principal Clerk

Attachment(s):
(1) Legislative Actuarial Note
(2) Actuarial Note, Buck Consultants, April 30, 1997
(3) Actuarial Note. Dilts, Umstead & Dunn, April 30, 1997

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

NORTH CAROLINA GENERAL ASSEMBLY

LEGISLATIVE ACTUARIAL NOTE

BILL NUMBER: Committee Substitute Senate Bill 778

SHORT TITLE: Fire Marshal Retirement

SPONSOR(S): Senator Warren

SYSTEM OR PROGRAM AFFECTED: North Carolina Firemen's and Rescue Squad Workers' Pension Fund

FUNDS AFFECTED: General Fund

BILL SUMMARY: Allows the fire marshal of each county to become a member of the Firemen's and Rescue Squad Workers' Pension Fund.

EFFECTIVE DATE: July 1, 1997

ESTIMATED IMPACT ON STATE:

SYSTEM ACTUARY

	FY 1997-98	FY 1998-99	FY 1999-00	FY 2000-01	FY 2001-02
GENERAL FUND	$9,000	$9,000	$9,000	$9,000	$9,000

GENERAL ASSEMBLY ACTUARY

	FY 1997-98	FY 1998-99	FY 1999-00	FY 2000-01	FY 2001-02
GENERAL FUND	$10,200	$10,200	$10,200	$10,200	$10,200

ASSUMPTIONS AND METHODOLOGY: The cost estimates of the System's Actuary are based on the membership data, actuarial assumptions and actuarial methods used to prepare the June 30, 1996 actuarial valuation of the fund. The data included 26,071 active members and 6,949 retired members in receipt of annual pensions totaling $11.1 million. Significant actuarial assumptions used include (a) an investment return rate of 7.5%, (b) the 1974 George B. Buck Mortality Table for deaths after retirement and (c) rates of separation from active service based on Fund experience. The actuarial cost method used was the entry age normal method with open-end unfunded accrued liability. Detailed information concerning these assumptions and methods is shown in the actuary's report which is available upon request from Stanley Moore.

SOURCES OF DATA: System Actuary - Buck Consultant, Inc.
General Assembly Actuary - Dilts, Umstead & Dunn

TECHNICAL CONSIDERATIONS: The cost estimates are based assuming there are 100 county fire marshals eligible to join as a result of being the fire marshal and not as a result of being a member of a fire department.

FISCAL RESEARCH DIVISION The above information is provided in accordance with North Carolina General Statute 120-114 and applicable Rules of the North Carolina Senate and House of Representatives

(919) 733-4910
PREPARED BY: : Stanley Moore
APPROVED BY: Tom Covington
DATE: May 1, 1997

BUCK CONSULTANTS
200 Galleria Parkway, N.W. Suite 1200
Atlanta, Georgia 30339-5945

April 30, 1997

Mr. Dennis Ducker
Deputy Treasurer and Director
Retirement Systems Division
Department of State Treasurer
325 North Salisbury Street
Raleigh, NC 27603-1388

Dear Mr. Ducker:

Re: **Second Proposed Committee Substitute for Senate Bill 778**

We have received your letter of April 29 regarding Second Proposed Committee Substitute for Senate Bill 778 which affects the North Carolina Firemen's and Rescue Squad Workers' Pension Fund.

This legislation appears to allow county fire marshals to become members of the Firemen's and Rescue Squad Workers' Pension Fund, prospectively, effective July 1, 1997.

The estimated cost of this legislation as an appropriation amount required from the General Fund for the fiscal year 1997-1998 would be $9,000 assuming 100 fire marshalls become members. The annual appropriation amount for each prospective active member is $89.45.

As a technical observation, Second Proposed Committee Substitute for Senate Bill 778 does not contain provisions for funding the increased cost for this legislation.

If we can be of further assistance with regard to this legislation, please do not hesitate to contact us.

Sincerely,

Donald M. Overholser
Principal and Consulting Actuary

THIS IS TO CERTIFY THAT THIS IS A TRUE AND EXACT COPY OF AN ORIGINAL ACTUARIAL NOTE

DMO:jq
H:\HOME\ACT\NC\97-97.DOC

Buck Consultants, Inc.
770|955-2488 Fax 770|933-8336

DILTS, UMSTEAD & DUNN

ACTUARIAL CONSULTING

MARK V. HARTMAN, FSA, MAAA, MCA, EA

Phone: (910) 731-4038
Fax: (910) 731-2583

668 Link Road
Lexington, NC 27295

April 30, 1997

Mr. Stanley Moore
Fiscal Research Division
North Carolina General Assembly
300 N. Salisbury Street
Raleigh, NC 27603-5925

Re: Senate Bill 778 Committee Substitute: An Act to Include County Fire Marshals in the NC Firemen's and Rescue Squad Workers' Pension Fund

Dear Mr. Moore:

The committee substitute to this bill would rewrite G.S. 58-86-25 to define 'eligible firemen' to also mean the fire marshal of each county. This would include county fire marshals as members of the Firemen's and Rescue Squad Workers' Pension Fund. This act would become effective July 1, 1997.

This bill does not provide retroactive credit to fire marshals. Thus, the approximate annual cost for this bill will be the normal cost per member multiplied by the number of new entrants. Based on the most recent actuarial valuation prepared as of June 30, 1996, this normal cost is $102 per member. You have indicated that some fire marshals are currently members of the FRSW plan through other eligibility provisions. However, replacements of the individuals in these positions might become eligible only through the provisions of this bill. Thus, assuming one hundred county fire marshals, the estimated annual cost of this bill is $10,200.

If you have any questions, please let me know.

Sincerely,

Mark Hartman

Mark V. Hartman, FSA, MAAA, MCA, EA
Consulting Actuary

MVH/jj

ACTUARIAL NOTE
True & Exact Copy of Original
Certified By: Stanley Moore Date: 5-1-97
Legislative Fiscal Research

VISITOR REGISTRATION SHEET

Pond Retrunt — 6-25-91

Name of Committee — Date

VISITORS: Please sign below and return to Committee Clerk.

NAME	FIRM OR STATE AGENCY AND ADDRESS
R. Paul Wilson	NCMBA
Normalee Holmes	Dowd & Twiddy Inc P.O. Box 43 Edenton 27932
[illegible]	Dowd & Twiddy Inc
R. Glenn Lumpkin	Dowd & Twiddy Inc. Nashville NC 27856
James T. Boyd	Kellogg Morgan Agency Manteo NC 27954
Mac McPherson	Kellogg Morgan agency Kitty Hawk, NC 27949
Bill Vogedes	Vogedes Harbess Ins. Agency Edenton NC 27932
Abby "Gail" Jones	Jones Insurance Agency PO Box 366 Columbia NC 27925
[illegible]	Southern Insurance Agency Inc 1141 Kathern Court Elizabeth City NC 27909
Bob Bind	NCANC
David Wright	GR Little Agency Inc PO Box 386 Elizabeth City NC 27907
Monty Ross	G.R. Little Agency Inc PO Box 386 Elizabeth City NC 27907
PG	NCFB
Steve Council	NCFB
Bob Kendall	Roam Cooper Gas — PO Box 2000 Manteo
Fletcher Willey	Willey Agency Box 248 Nags Head NC 27959
Carl Cross Town Mgr - Southern Shores	Manager BLUE SKY 5 Skyline Rd Southern Shores 27949
J. B. Lewis	Forsyth County Fire Marshal W-S. N.C. 27105
Dave Miller	N.C. State Fireman's Assoc. Farmville NC 27828
[illegible]	NCANC

VISITOR REGISTRATION SHEET

Name of Committee | Date

VISITORS: Please sign below and return to Committee Clerk.

NAME	FIRM OR STATE AGENCY AND ADDRESS
D Stan Hunter	NCIUA
Janet Pittard	OSBM
Kirsten Mitchell	NCFRNG
Roger Langley	NC DOI
Stella N. McKenney	NC DOI
Jim Long	NC DOI
Bill Owens	N.C. House
Eddie Caldwell	CAPIA
Lane Wharton	Both Carr & Strong
Alan Miller	Bailey & Dixon LLP

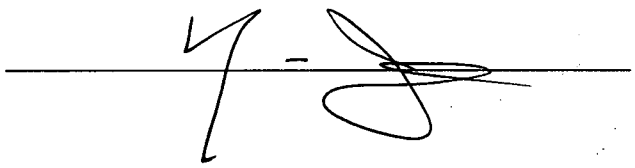
Pensions & Retirement/ Insurance Committee

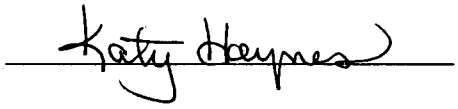
MINUTES

The Pensions & Retirement/ Insurance Committee met July 2, 1997 at 10:00 in room 1124 of the Legislative Building. There were ten members in attendance including Sen. Jenkins, who presided. The following bill was acted upon:

HB 1052 **Exclude Excess Coverage / Covenants.** Rep. G. Miller explained the proposed committee substitute. Robert Pascal, State Farm Insurance Co., spoke for the bill. Sen. Soles moved for an unfavorable as to the original bill, but favorable as to the committee substitute. The motion carried.

The meeting was adjourned.





NORTH CAROLINA GENERAL ASSEMBLY
SENATE

PENSIONS & RETIREMENT/ INSURANCE COMMITTEE REPORT
Senator Tommy Jenkins, Chairman

Thursday, July 03, 1997

SENATOR TOMMY JENKINS,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO SENATE C.S. BILL

H.B. **1052** **Permit Exclude Excess Coverage**

Draft Number:	PCS4127
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 1

Committee Clerk Comment: None

GENERAL ASSEMBLY OF NORTH CAROLINA
1997 SESSION

S.L. 1997-396
HOUSE BILL 1052

AN ACT TO ALLOW INSURERS TO LIMIT OR EXCLUDE EXCESS LIABILITY COVERAGE FOR UNINSURED AND UNDERINSURED MOTORISTS AS PROVIDED BY LAW AND TO ALLOW INJURED PARTIES TO EXECUTE COVENANTS NOT TO ENFORCE JUDGMENT AS CONSIDERATION FOR PAYMENT OF THE APPLICABLE LIMITS OF LIABILITY BY THE INSURER.

The General Assembly of North Carolina enacts:

Section 1. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-152. Excess liability policies; uninsured and underinsured motorist coverages.**

With respect to policy forms that provide excess liability coverage, an insurer may limit or exclude coverage for uninsured motorists as provided in G.S. 20-279.21(b)(3) and for underinsured motorists as provided in G.S. 20-279.21(b)(4)."

Section 2. G.S. 20-279.21(b)(4) reads as rewritten:

"(4) Shall, in addition to the coverages set forth in subdivisions (2) and (3) of this subsection, provide underinsured motorist coverage, to be used only with a policy that is written at limits that exceed those prescribed by subdivision (2) of this section and that afford uninsured motorist coverage as provided by subdivision (3) of this subsection, in an amount not to be less than the financial responsibility amounts for bodily injury liability as set forth in G.S. 20-279.5 nor greater than one million dollars ($1,000,000) as selected by the policy owner. An 'uninsured motor vehicle,' as described in subdivision (3) of this subsection, includes an 'underinsured highway vehicle,' which means a highway vehicle with respect to the ownership, maintenance, or use of which, the sum of the limits of liability under all bodily injury liability bonds and insurance policies applicable at the time of the accident is less than the applicable limits of underinsured motorist coverage for the vehicle involved in the accident and insured under the owner's policy. For the purposes of this subdivision, the term 'highway vehicle' means a land motor vehicle or trailer other than (i) a farm-type tractor or other vehicle designed for use principally off public roads and while not upon public roads, (ii) a vehicle operated on rails or crawler-treads, or (iii) a vehicle while located for use as a residence or premises. The provisions of subdivision (3) of this subsection shall apply to the coverage required by this subdivision. Underinsured motorist coverage is deemed to apply when, by reason of payment of judgment or settlement, all liability bonds or insurance policies providing coverage for bodily injury

caused by the ownership, maintenance, or use of the underinsured highway vehicle have been exhausted. Exhaustion of that liability coverage for the purpose of any single liability claim presented for underinsured motorist coverage is deemed to occur when either (a) the limits of liability per claim have been paid upon the claim, or (b) by reason of multiple claims, the aggregate per occurrence limit of liability has been paid. Underinsured motorist coverage is deemed to apply to the first dollar of an underinsured motorist coverage claim beyond amounts paid to the claimant under the exhausted liability policy.

In any event, the limit of underinsured motorist coverage applicable to any claim is determined to be the difference between the amount paid to the claimant under the exhausted liability policy or policies and the limit of underinsured motorist coverage applicable to the motor vehicle involved in the accident. Furthermore, if a claimant is an insured under the underinsured motorist coverage on separate or additional policies, the limit of underinsured motorist coverage applicable to the claimant is the difference between the amount paid to the claimant under the exhausted liability policy or policies and the total limits of the claimant's underinsured motorist coverages as determined by combining the highest limit available under each policy; provided that this sentence shall apply only to insurance on nonfleet private passenger motor vehicles as described in G.S. 58-40-15(9) and (10). The underinsured motorist limits applicable to any one motor vehicle under a policy shall not be combined with or added to the limits applicable to any other motor vehicle under that policy.

An underinsured motorist insurer may at its option, upon a claim pursuant to underinsured motorist coverage, pay moneys without there having first been an exhaustion of the liability insurance policy covering the ownership, use, and maintenance of the underinsured highway vehicle. In the event of payment, the underinsured motorist insurer shall be either: (a) entitled to receive by assignment from the claimant any right or (b) subrogated to the claimant's right regarding any claim the claimant has or had against the owner, operator, or maintainer of the underinsured highway vehicle, provided that the amount of the insurer's right by subrogation or assignment shall not exceed payments made to the claimant by the insurer. No insurer shall exercise any right of subrogation or any right to approve settlement with the original owner, operator, or maintainer of the underinsured highway vehicle under a policy providing coverage against an underinsured motorist where the insurer has been provided with written notice before a settlement between its insured and the underinsured motorist and the insurer fails to advance a payment to the insured in an amount equal to the tentative settlement within 30 days following receipt of that notice. Further, the insurer shall have the right, at its election, to pursue its claim by assignment or subrogation in the name of the claimant, and the insurer shall not be denominated as a party in its own name except upon its own election. Assignment or subrogation as provided in this subdivision shall not, absent contrary agreement, operate to defeat the claimant's right to pursue recovery against the owner, operator, or

maintainer of the underinsured highway vehicle for damages beyond those paid by the underinsured motorist insurer. The claimant and the underinsured motorist insurer may join their claims in a single suit without requiring that the insurer be named as a party. Any claimant who intends to pursue recovery against the owner, operator, or maintainer of the underinsured highway vehicle for moneys beyond those paid by the underinsured motorist insurer shall before doing so give notice to the insurer and give the insurer, at its expense, the opportunity to participate in the prosecution of the claim. Upon the entry of judgment in a suit upon any such claim in which the underinsured motorist insurer and claimant are joined, payment upon the judgment, unless otherwise agreed to, shall be applied pro rata to the claimant's claim beyond payment by the insurer of the owner, operator or maintainer of the underinsured highway vehicle and the claim of the underinsured motorist insurer.

A party injured by the operation of an underinsured highway vehicle who institutes a suit for the recovery of moneys for those injuries and in such an amount that, if recovered, would support a claim under underinsured motorist coverage shall give notice of the initiation of the suit to the underinsured motorist insurer as well as to the insurer providing primary liability coverage upon the underinsured highway vehicle. Upon receipt of notice, the underinsured motorist insurer shall have the right to appear in defense of the claim without being named as a party therein, and without being named as a party may participate in the suit as fully as if it were a party. The underinsured motorist insurer may elect, but may not be compelled, to appear in the action in its own name and present therein a claim against other parties; provided that application is made to and approved by a presiding superior court judge, in any such suit, any insurer providing primary liability insurance on the underinsured highway vehicle may upon payment of all of its applicable limits of liability be released from further liability or obligation to participate in the defense of such proceeding. However, before approving any such application, the court shall be persuaded that the owner, operator, or maintainer of the underinsured highway vehicle against whom a claim has been made has been apprised of the nature of the proceeding and given his right to select counsel of his own choice to appear in the action on his separate behalf. If an underinsured motorist insurer, following the approval of the application, pays in settlement or partial or total satisfaction of judgment moneys to the claimant, the insurer shall be subrogated to or entitled to an assignment of the claimant's rights against the owner, operator, or maintainer of the underinsured highway vehicle and, provided that adequate notice of right of independent representation was given to the owner, operator, or maintainer, a finding of liability or the award of damages shall be res judicata between the underinsured motorist insurer and the owner, operator, or maintainer of underinsured highway vehicle.

As consideration for payment of policy limits by a liability insurer on behalf of the owner, operator, or maintainer of an underinsured motor vehicle, a party injured by an underinsured

motor vehicle may execute a contractual covenant not to enforce against the owner, operator, or maintainer of the vehicle any judgment that exceeds the policy limits. A covenant not to enforce judgment shall not preclude the injured party from pursuing available underinsured motorist benefits, unless the terms of the covenant expressly provide otherwise, and shall not preclude an insurer providing underinsured motorist coverage from pursuing any right of subrogation.

The coverage required under this subdivision shall not be applicable where any insured named in the policy rejects the coverage. An insured named in the policy may select different coverage limits as provided in this subdivision. If the named insured does not reject underinsured motorist coverage and does not select different coverage limits, the amount of underinsured motorist coverage shall be equal to the highest limit of bodily injury liability coverage for any one vehicle in the policy. Once the option to reject underinsured motorist coverage or to select different coverage limits is offered by the insurer, the insurer is not required to offer the option in any renewal, reinstatement, substitute, amended, altered, modified, transfer, or replacement policy unless a named insured makes a written request to exercise a different option. The selection or rejection of underinsured motorist coverage by a named insured or the failure to select or reject is valid and binding on all insureds and vehicles under the policy.

Rejection of or selection of different coverage limits for underinsured motorist coverage for policies under the jurisdiction of the North Carolina Rate Bureau shall be made in writing by the named insured on a form promulgated by the Bureau and approved by the Commissioner of Insurance."

Section 3. G.S. 20-279.21 is amended by adding a new subsection to read:

"(l) A party injured by an uninsured motor vehicle covered under a policy in amounts less than those set forth in G.S. 20-279.5, may execute a contractual covenant not to enforce against the owner, operator, or maintainer of the uninsured vehicle any judgment that exceeds the liability policy limits, as consideration for payment of any applicable policy limits by the insurer where judgment exceeds the policy limits. A covenant not to enforce judgment shall not preclude the injured party from pursuing available uninsured motorist benefits, unless the terms of the covenant expressly provide otherwise, and shall not preclude an insurer providing uninsured motorist coverage from pursuing any right of subrogation."

Section 4. This act is effective when it becomes law.

In the General Assembly read three times and ratified this the 5th day of August, 1997.

s/ Dennis A. Wicker
President of the Senate

s/ Harold J. Brubaker
Speaker of the House of Representatives

s/ James B. Hunt, Jr.
Governor

Approved 1:52 p.m. this 14th day of August, 1997

North Carolina General Assembly
Legislative Services Office

George R. Hall, Legislative Services Officer
(919) 733-7044

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(919) 733-2578

June 25, 1997

MEMORANDUM

TO: Senate Pensions and Retirement and Insurance Committee

FROM: Linwood Jones, Staff Counsel

RE: House Bill 1052 - PCS (Permit Exclusion of Excess Coverage)

Section 1 of House Bill 1052 allows an insurer to limit or exclude uninsured (UI) and underinsured (UIM) coverage from policies that provide excess liability coverage. The bill does not prohibit an insurer and the policyholder from agreeing to UI or UIM coverage in an excess liability policy (for which the insurer will charge additional premium).

The bill addresses a 1995 Supreme Court decision, *Isenhour v. Universal Writers Insurance Company.* In *Isenhour*, the Court ruled that the statutory requirement that an insurer must provide its policyholder UI/UIM coverage in the same amount as the liability limits under the policy unless rejected in writing by the policyholder applied to excess liability insurance policies. In Isenhour, the excess liability policy provided $2 million in coverage. Because there was no official evidence on record of the UI/UIM coverage having been rejected, the Court ruled that the policyholder in effect had $2 million in UI/UIM coverage.

Sections 2 and 3 of the bill provide that a person injured in an auto accident may execute with the liable party a covenant not to enforce judgment in excess of that party's liability limits. These sections make clear that the execution of this covenant does not extinguish the injured party's claim for uninsured or underinsured benefits as long as the covenant is not worded as a general release or in any any other matter that expressly prevents the injured party from seeking UM or UIM benefits. The covenent also does not prevent the insurer that provides the UM or UIM coverage from pursuing any right of subrogation.

This act would take effect when it becomes law.

H1052-SMRN-002

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

North Carolina General Assembly
Legislative Services Office

George R. Hall, Legislative Services Officer
(919) 733-7044

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Terrence D. Sullivan, Director
Research Division
Suite 545, LOB
300 N. Salisbury St.
Raleigh, NC 27603-5925
(919) 733-2578

June 4, 1997

MEMORANDUM

TO: Senate Pensions and Retirement and Insurance Committee

FROM: Linwood Jones, Staff Counsel

RE: House Bill 1052 (Permit Exclusion of Excess Coverage)

House Bill 1052 allows an insurer to limit or exclude uninsured (UI) and underinsured (UIM) coverage from policies that provide excess liability coverage. The bill does not prohibit an insurer and the policyholder from agreeing to UI or UIM coverage in an excess liability policy (for which the insurer will charge additional premium).

The bill addresses a 1995 Supreme Court decision, *Isenhour v. Universal Writers Insurance Company.* In *Isenhour*, the Court ruled that the statutory requirement that an insurer must provide its policyholder UI/UIM coverage in the same amount as the liability limits under the policy unless rejected in writing by the policyholder applied to excess liability insurance policies. In Isenhour, the excess liability policy provided $2 million in coverage. Because there was no official evidence on record of the UI/UIM coverage having been rejected, the Court ruled that the policyholder in effect had $2 million in UI/UIM coverage.

The LRC Study Committee on Insurance and Insurance-Related Issues first recommended this legislation during the short session last year.

The bill would take effect upon becoming law.

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

VISITOR REGISTRATION SHEET

Senate Pensions Retirement & Insurance — 7/2/97

Name of Committee — Date

VISITORS: Please sign below and return to Committee Clerk.

NAME	FIRM OR STATE AGENCY AND ADDRESS
Stan Williams	HHS Assn.
Susan Valauri	Nationwide
Robert Ross	Assn NC Life Ins. Cos
Robert Pasched	Young, Moore
[illegible]	NCPC
Angie Gio Bain	Smith Anderson
Lucia Peel	NC Medical Society
Karen Gilleskie	Bristol Myers Squibb
Mari S. Lewis	BMS
[illegible]	
[illegible]	NCDOI

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JOSEPH W. WILLIFORD
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DAWN M. DILLON
KRISTIN C. McADAMS

OF COUNSEL
CHARLES H. YOUNG
JOSEPH C. MOORE, JR.
(1919-1988)
CHARLES H. YOUNG, JR.
(1947-1992)

MEMORANDUM

June 3, 1997

TO: Senate Insurance Committee

FROM: Robert C. Paschal, Lobbyist for State Farm Insurance Companies

RE: **H. B. 1052 - Permit Exclusion of Excess Coverage**

Representative George Miller is sponsoring H. B. 1052 (copy attached), which would permit insurers to limit or exclude the coverage provided by "umbrellas" for the uninsured and underinsured portions of auto insurance policies. This legislation was recommended by the 1996 Legislative Research Commission. State Farm and other insurers support this bill, as does the Department of Insurance. In fact, Mr. Bill Hale of the Department drafted the language used in the bill.

The bill became necessary when the North Carolina Supreme Court decided the case of *Isenhour vs. Universal Underwriters*. In *Isenhour*, the Supreme Court extended the underinsured motorists limits of an insured's auto policy to the limits of the insured's umbrella policy, even though no premium was paid and the insured thought it had rejected additional underinsured limits. This occurred because, by mistake or oversight, the rejection form for the increased coverage did not ever get introduced into the court record.

If you want additional uninsured or underinsured coverage under your umbrella, you can buy it. If you do not want these coverages, your insurer can exclude them from your umbrella. This is what H.B. 1052 is all about. The House passed the bill unanimously; it is unopposed. State Farm and other insurers would appreciate your support of this LRC recommendation.

Attachment
cc: Mr. Bill Hale
Legislative Counsel, Department of Insurance

Robert Paschal

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

H 1

HOUSE BILL 1052

Short Title: Permit Exclusion of Excess Coverage. (Public)

Sponsors: Representative Miller.

Referred to: Insurance.

April 21, 1997

A BILL TO BE ENTITLED

AN ACT TO ALLOW INSURERS TO LIMIT OR EXCLUDE EXCESS LIABILITY COVERAGE FOR UNINSURED AND UNDERINSURED MOTORISTS AS PROVIDED BY LAW.

The General Assembly of North Carolina enacts:

Section 1. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-152. Excess liability policies; uninsured and underinsured motorist coverages.**

With respect to policy forms that provide excess liability coverage, an insurer may limit or exclude coverage for uninsured motorists as provided in G.S. 20-279.21(b)(3) and for underinsured motorists as provided in G.S. 20-279.21(b)(4)."

Section 2. This act is effective when it becomes law.

Pensions & Retirement / Insurance Committee

MINUTES

The Pensions & Retirement Committee met at Sen. Jenkins' desk in the Senate Chamber August 20,1997 at 2:35. There were twelve members in attendance including Sen. Jenkins, who presided.

The committee met to consider two appointments to the Board of Trustee of the Teachers' and State Employees Retirement System that had been nominated by Governor Jim Hunt. The two nominations were Ms Mana B. Johnson and Sgt. Michael L. Dupree. Sen. Wellons moved that they be confirmed. The motion carried. Sen. Jenkins announced that the motion would be forwarded to the full Senate for confirmation.

The meeting was adjourned

Sen. Jenkins, Chairman

Katy Haynes, Clerk

STATE OF NORTH CAROLINA
OFFICE OF THE GOVERNOR
RALEIGH 27603-8001

JAMES B. HUNT JR.
GOVERNOR

August 13, 1997

The Honorable Marc Basnight
Senate President Pro Tempore
2007 Legislative Building
Raleigh, NC 27601

Dear Mr. President Pro Tem:

Pursuant to General Statute 135-6, I hereby re-appoint Ms. Mana B. Johnson to serve as a member of the North Carolina Teachers' and State Employees' Retirement System Board of Trustees and submit her name for confirmation by the Senate of the North Carolina General Assembly. Ms. Johnson will serve a term to expire June 30, 2001.

Please feel free to call on her or members of my staff if you need additional information.

My warmest personal regards.

Sincerely,

James B. Hunt Jr.

cc: The Honorable Dennis Wicker
Ms. Janet Pruitt

Janet Pruitt
AUG 18 1997

AUG 15 1997

STATE OF NORTH CAROLINA
OFFICE OF THE GOVERNOR
RALEIGH 27603-8001

JAMES B. HUNT JR.
GOVERNOR

August 13, 1997

The Honorable Marc Basnight
Senate President Pro Tempore
2007 Legislative Building
Raleigh, NC 27601

Dear Mr. President Pro Tem:

Pursuant to General Statute 135-6, I hereby re-appoint Sgt. Michael L. Dupree to serve as a member of the North Carolina Teachers' and State Employees' Retirement System Board of Trustees and submit his name for confirmation by the Senate of the North Carolina General Assembly. Sgt. Dupree will serve a term to expire March 31, 2001.

Please feel free to call on him or members of my staff if you need additional information.

My warmest personal regards.

Sincerely,

James B. Hunt Jr.

cc: The Honorable Dennis Wicker
Ms. Janet Pruitt

AUG 18 1997

AUG 15 1997

North Carolina General Assembly
Senate Chamber
State Legislative Building
Raleigh 27601-2808

August 21, 1997

The President and Members of the Senate
North Carolina General Assembly
State Legislative Building
Raleigh, North Carolina 27601

Dear Mr. President and Members of the Senate:

In compliance with the provisions of G.S. 135-6 requiring appointees to the Board of Trustees of the Teachers' and State Employees Retirement System to be confirmed by the General Assembly, Governor Hunt has submitted his appointees, Mana B. Johnson and Sgt. Michael L. Dupree, for confirmation. Their terms will begin immediately and expire June 30, 2001.

The Senate Committee on Pensions and Retirement has considered the appointments and makes the following recommendation to the Senate.

That the appointment of Mana B. Johnson and Sgt. Michael L. Dupree to the Board of Trustees of the Teachers' and State Employees Retirement System beginning immediately and expiring on June 30, 2001, be confirmed.

Respectfully submitted,

Senator Tommy Jenkins
Chairman
Senate Committee on Pensions &Retirement/Insurance